Nursing Work and Nursing Knowledge:
Exploring the Work of Womens' Health Nurses
Patterns of Power and Praxis

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I certify that the thesis entitled Nursing Work and Nursing Knowledge: Exploring the Work of Womens' Health Nurses. Patterns of Power and Praxis submitted for the degree of Doctor of Philosophy is the result of my own research, except where otherwise acknowledged, and that this thesis in whole or in part has not been submitted for an award including a higher degree to any other university or institution.

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ABSTRACT

The majority of women’s health nurses in this study work in generalist community health centres. They have developed their praxis within the philosophy and policies of the broader women’s health movement and primary health care principles in Australia. The fundamental assumption underlying this study is that women’s health nurses possess a unique body of knowledge and clinical wisdom that has not been previously documented and explored. The epistemological base from which these nurses’ operate offers important insights into the substantive issues that create and continually shape the practice world of nurses and their clients. Whether this represents a (re)construction of the dominant forms of health care service delivery for women is examined in this study.

The study specifically aims at exploring the practice issues and experience of women’s health service provision by women’s health nurses in the context of the provision of cervical cancer screening services. In mapping this particular group of nurses practice, it sets out to examine the professional and theoretical issues in contemporary nursing and women’s health care.

In critically analysing the powerful discourses that shape and reshape nursing work, the study raises the concern that previous analyses of nursing work tend to universalise the structural and social subordination of nurses and nursing knowledge. This universalism is most often based on examples of midwifery and nursing work in hospital settings, and subsequently, because of these conceptualisations, all of nursing is too often deemed as a dependent occupation, with little agency, and is analysed as always in relation to medicine, to hospitals, to other knowledge forms.

Denoting certain discourses as dominant proposes a relationship of power and knowledge and the thesis argues that all work relations and practices in health are structured by certain power/knowledge relations. This analysis reveals that there
are many competing and complimentary power/knowledge relations that structure nursing, but that nursing, and in particular women’s health nurses, also challenge the power/knowledge relations around them. Through examining theories of power and knowledge the analysis argues that theoretical eclecticism is necessary to address the complex and varied nature of nursing work. In particular it identifies that postmodern and radical feminist theorising provide the most appropriate framework to further analyse and interpret the work of women’s health nurses.

Fundamental to the position argued in this thesis is a feminist perspective. This position creates important theoretical and methodological links throughout the whole study. Feminist methodology was employed to guide the design, the collection and the analysis. Intrinsic to this process was the use of the ‘voices’ of women’s health nurses as the basis for theorising. The ‘voices’ of these nurses are highlighted in the chapters as italicised bold script. A constant companion along the way in examining women’s health nurses’ work, was the reflexivity with feminist research processes, the theoretical discussions and their ‘voices’. Capturing and analysing descriptive accounts of nursing praxis is seen in this thesis as providing a way to theorise about nursing work. This methodology is able to demonstrate the knowledge forms embedded in clinical nursing praxis.

Three conceptual threads emerge throughout the discussions: one focuses on nursing praxis as a distinct process, with its own distinct epistemological base rather than in relation to ‘other’ knowledge forms; another describes the medical restriction and opposition as experienced by this group of nurses, but also of their resistance to medical opposition. The third theme apparent from the interviews, and which was conceptualised as beyond resistance, was the description of the alternative discourses evident in nursing work, and this focused on notions of being a professional and on autonomous nursing praxis.

This study concludes that rather than accepting the totalising discourses about nursing there are examples within nursing of resistance—both ideologically and
in practice—to these dominant discourses. Women's health nurses represent an important model of women's health service delivery, an analysis of which can contribute to critically reflecting on the 'paradigm of oppression' cited in nursing and about nursing more generally. Reflecting on women's health service delivery also has relevance in today's policy environment, where structural shifts in Commonwealth/State funding arrangements in community based care, may undermine women's health programs.

In summary this study identifies three important propositions for nursing:

- nursing praxis can reconstruct traditional models of health care;
- nursing praxis is powerful and able to 'resist' dominant discourses; and
- nursing praxis can be transformative.

Joining feminist perspectives and alternative analyses of power provides a pluralistic and emancipatory politics for viewing, describing and analysing 'other' nursing work. At the micro sites of power and knowledge relations—in the everyday practice worlds of nurses, of negotiation and renegotiation, of work on the margins and at the centre—women's health nurses' praxis operates as a positive, productive and reconstructive force in health care.
"Representation of the world, like the world itself, is the work of men; they describe it from their own point of view, which they confuse with absolute truth"

Simone de Beauvoir

"Let not your first thought be your only thought think if there cannot be some other way"

Haemon in Antigone.
CHAPTER ONE: THE STUDY

INTRODUCTION

This thesis is about nursing work, nursing knowledge and nursing praxis; it is about women’s knowledge. Several critical perspectives are drawn upon. Fundamental to the position argued in this thesis is a feminist perspective—feminist in the broadest sense of drawing on the general values that feminist positions invite of a woman-centred analysis and acknowledging the use of women’s experience and knowledge forms as a base for theorising. In addition, specific perspectives from radical feminist theorising and postmodern theory are used to develop a framework for considering the gendered micro-politics of power and knowledge relations that create and recreate certain discourses\(^1\) that shape nursing work.

Notwithstanding the tensions between radical feminist and postmodern theory (these are addressed in chapter 4) both positions are drawn upon to develop ‘a middle ground’. As Fraser and Nicholson (1990:20) suggest ‘... the ultimate stake of an encounter between feminism and postmodernism is the prospect of a perspective which integrates their respective strengths while eliminating their respective weaknesses’.

However, throughout the thesis, tensions exist between traversing the various theoretical and concrete issues that are raised when undertaking feminist research in nursing and using a postmodern framework. For example, tensions exist between the use of experience/knowledge of a specific group of nurses as ‘evidence’ in particular contexts, and then moving to reflecting critically on this vis-à-vis nursing in general, in order to contribute to nursing knowledge in a

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\(^1\) In this thesis the term *discourse* is drawn from Howarth’s (1995) definition and refers to structures of knowledge and systems of meanings that exist as a part of a wider framework of meaning, including institutions and organisations that affect ideas and practices in social and political life.
broader context. In addition, it is necessary to acknowledge that knowledge is mediated by particular social practices, power relations and the subject positions of individuals. Similarly, tensions exist when engaging with broader theoretical considerations and acknowledging my own subject position as a woman, a nurse and a researcher.

It is a challenge to delineate (and honour) women's and nurses' immense diversity whilst seeking also to represent their commonalities, without slipping into the essential and or totalising arguments so often presented in patriarchal analyses about women and nursing. Moreover, using aspects of postmodern analysis in feminist work can be problematic. Not only are there the dangers of being seduced and waylaid by a master discourse, but, through raising the possibility of removing reference points, such as 'woman' (which is so crucial for a feminist politic), we undo important gains for women. It is also vital to be cautious of the limitless possibilities that some postmodern theorising offers and not to fall into a 'relativist pit', thus being unable to make conclusions useful to applied nursing research. It is hoped that, through highlighting these tensions, 'unpacking' them and critically assessing them throughout the thesis, I not only avoid and challenge the 'old traps' of patriarchal analyses but provide important new insights for nursing.

In critically analysing the powerful discourses that shape and reshape nursing work, I raise the concern that previous analyses of nursing work tend to universalise the structural and social subordination of nurses and nursing knowledge. This universalism is most often based on examples of midwifery and nursing work in hospital settings, and subsequently, because of these conceptualisations, all of nursing is too often deemed as a dependent occupation, with little agency, and is analysed as always in relation to medicine, to hospitals, to other knowledge forms. Rather than accepting these totalising discourses, however, there are examples within nursing of resistance—both ideologically and in practice—to these dominant discourses.
At a general level, I do not dispute that nurses, nursing work and nursing knowledge has been (and is) subordinated to dominant discourses (predominantly the discourse of medicine). Rather, I wish to argue that there are examples in nursing of resistance both in theory and in practice to these dominant discourses. This thesis sets out to problematise notions of universal constraints, of inevitable subordination, and of nursing work as always relational to dominant discourses by focusing on Women’s Health Nurses (WHNs) in Victoria.

Through examining the work of WHNs\(^2\) this thesis explores the proposition that there are specific examples of nursing work that allow reconceptualisations of previous analyses of nursing work. I do not claim, to be 'true' to a postmodern position, that this 'truth' negates other truths, but, rather to explicate nursing 'truths', of a given specificity, that extend and challenge previous analyses of nursing work.

In attempting to move away from theorising that locates nursing in a purely relational position to dominant biomedical knowledges, and from theorising from the specific to the general, I hope to demonstrate that nursing and nursing knowledge is (and can be) agentive and proactive and so provides an important strategy in health care provision for the new century. Through examining work in between the dominant discourses and on the margins of the dominant discourses I will illustrate, conceptualise, and theorise other ways of seeing nursing work.

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\(^2\) Women’s Health Nurses in this thesis are Registered Nurses who have completed additional qualifications in order to practise in the area of women’s health care provision.
CONTEXT OF THE STUDY

The study

The role of WHNs in the provision of cervical cancer screening is a new initiative in the state of Victoria and as such, the role and the major issues for nursing (and for women as consumers), of nurse-based cervical cancer screening has yet to be examined. Thus, this project will contribute to nursing knowledge through explicating knowledge and new theoretical propositions of the work of WHNs, and will critically reflect on this in relation to nursing in general. The various issues confronting these nurses seem to reflect and represent current issues in women’s health care and many crucial issues for the nursing profession as a whole.

The study does not specifically address clinical, epidemiological and theoretical issues related to cervical screening of women as health promotion or public health strategies. Rather, it examines, with this group of nurses, a particular component of women’s health practice to explore professional and theoretical issues in contemporary nursing and in women’s health care. Accordingly, consideration is given throughout the thesis to uncovering the salient issues for review through an analysis of the practice of WHNs and the wider socio-political milieu in which nursing takes place.

This project grew out of a concern to explore the experience and practice issues of women’s health services provision by nurses. I was particularly interested in nurses who were pushing the boundaries in terms of extended practice roles and taking on roles that traditionally had been the domain of the medical profession. In addition (and central to this project) I was interested in nursing work that has moved past ‘oppressed group’ conceptualisations and which presents an identity of its own. This interest lies in a concern that nursing, both from the ‘inside’ and

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3 See Bukenham and Parsons (1993); Lane and Lawler (1997), for critiques on public health and health promotion policies and strategies on mammography and cervical cancer screening for women from the point of the discursive practices and discourses that shape ‘truths’ about health screening for women.
the ‘outside’, is often portrayed as socially and structurally ‘caught’ between dominant discourses. More recent nursing scholarship and research is (re)addressing this by attempting to identify epistemological positions from the point of view of nursing caring that identify and recognise unformulated, or possibly undocumented, approaches and theoretical conceptualisations that encapsulate nursing’s uniqueness. In support of this concern, a key theme throughout this thesis is to map and to theorise nursing work that thus far has not been illustrated from a distinct epistemological position. To this end, this work will map the work of a group of WHNs in Victoria.

During 1993 I attended an workshop entitled ‘Shop Talk’; providing background information about Well Women's services, run by the Women's Health Nurses Association (WHNA) of Victoria. As I sat at this training session I was struck by the commitment and enthusiasm of a group of nurses drawn from the Well Women's Community Health Project and the Anti-Cancer Council of Victoria's Pap Test Victoria Program for nurses. This workshop covered clinical practice issues but during the tea breaks (as often is the case!) the general discussion focused on troubling concerns about professional issues. The discussion covered issues related to the extension of the role of nurses, medico-legal issues, and the further development of women health service provision. It also covered issues of autonomy, models of care, conflict and contestation of nursing work, and the immense need in the community for well women’s health services. These nurses seemed to be discussing practice issues from a particular knowledge position that was critical of mainstream health care service. This position is probably familiar to most nurses, but is often accompanied by beliefs about nursing’s powerlessness to effect any change. However, this was not what I was hearing on this particular day. This was an authoritative voice, a voice of conviction, compassion, of autonomy and control. Here, a group of nurses firmly believed in what they were doing, and were articulating their views on the obstacles but also the strengths in their role as nurse practitioners. This positive and proactive position was notable. What was this 'voice' about? Why did this group of nurses express a different
rhetoric from that of oppression and powerlessness so often evident in mainstream health and nursing literature?

From the early 1980s, scholarship in nursing, drawn from critical social theory and feminist theory, has represented an analytical, intellectual and methodological approach to nursing, education and research. This literature has highlighted nursing work relations, and has begun naming the conditions and social practices that reproduce relationships of domination which express the lived reality of nursing (Thompson 1994:58). These critiques have offered theoretical frameworks to uncover, explain and name social conditions related to nursing’s occupational, discipline and client care issues. Thompson (1994:57) describes critical scholarship as ‘... a pattern of thought and action that challenges institutionalised power relations or relations of domination in the social reality of nursing’. It is her belief that an alternative message—one that is shaped by a critical perspective—has important implications ‘for the social institution of nursing and for social definitions of health and well-being’ (1994:58). It was a critical perspective that I was hearing and seeing on this day; it was an approach that encompassed a critical eye and depicted a sense of agency and empowerment in nursing work. It was this perspective that generated the intellectual curiosity to further develop the research project.

The nursing and sociological literature often portrays this critique as negative and inevitable, with no solutions, given society’s undervaluing of occupational caring and nursing’s occupational situation in relation to medicine and the sexual division of labour in health. However, this group of WHNs seemed to occupy a space that was critical, proactive and not aligned to the disempowered rhetoric generally associated with nursing as an occupational group primarily in acute care settings.

Reflecting on these dynamics synthesised the topic for investigation into an exploration of the experience and practice issues of nurse practitioners who have participated in cervical cancer screening services. At a workshop and Annual
General Meeting of the WHN Association in February 1994, the group offered support and encouragement for the proposed research and permission to use the association’s membership to recruit participants through the association’s newsletter. The primary source of empirical data for this project is the semi-structured interview material gathered from the WHNs.

The project is underpinned by feminist theory and methodology. As a nurse, and a feminist, I cannot see occupational and theoretical issues in nursing without a political focus, and consequently, pursue specific projects that sit comfortably with feminist politics. Alliances between feminism and nursing are not new. This is hardly surprising since nursing is the most feminised of professions (92.6% of nurses are women: ABS 1991) and consequently has experienced many structural and social inequalities by virtue of the history of nursing qua the history of women. Initial feminist analysis of nursing located nurses as an ideal example of an ‘oppressed group’ and analysed nurses’ lack of autonomy, low self-esteem and lack of control over nursing within a feminist framework (Speedy 1987). This analysis was very important in highlighting the causes and problems associated with nursing, focusing on work, power and gender issues. In addition, feminist critical analyses of medicine identified medicine as patriarchal and androcentric, defining and exploiting women as patients, wives and nurses (Chinn 1995:274).4

Women’s health has been a particular locus of nursing and feminism. Since the 1970s the women’s health movement has been active in challenging the medicalisation of infertility, childbirth and menopause with regard to reproductive technologies. Nursing entered these debates by challenging medical control and medical dominance in the delivery of health services for women.

4 See Hoffmann (1991); Bunting and Campbell (1990); Horsfall (1996) for reviews and discussion on the relationship between feminism and nursing. Speedy (1987) covers the significant issues in nursing and feminist alliances. For discussions on nursing research and feminism see Horsfall (1996); Hedin and Duffy (1991). Also see Chinn (1995), ‘Feminism in Nursing’; this whole volume is dedicated to nursing and feminism from epistemological and research perspectives.
A significant principle in feminist research methodology is researching with women rather than on women (Klien 1983). In keeping with my feminist position of participating and exchanging resources and information I became an active member of the WHNA. Believing that collaborative exchange between researcher and ‘researched’ is important, I have endeavoured to give something back to the research community and have participated within the committee’s activities since 1994, and have given accounts of the research’s progress back to the group.

However, an important point needs to be raised in relation to the claims of feminist research notions of on, with and for women. The reality is that in the context of this research project (and perhaps all research), an academic process for a PhD entails, in my mind at least, that this research is both on and with women. It is with women that I have consciously tried to be inclusive and to develop a reflexive research process, including the feedback, exchange and communication of results, during and after the research study, with the participants, and by proposing to extend such commentary to the wider nursing community. But, it is also on women, in that the analysis, interpretations and conclusions are mine. These have been extrapolated from the particular to the general, to engage in a debate which concerns nursing and epistemology more generally and with wider significance than just to the specific group of nurses focused upon. They have been the catalyst for more generalised theorising on the broader socio-political, structural and epistemological debates.

Conclusion

In summary, the fundamental assumption underlying this research project is that WHNs possess a unique body of knowledge and clinical wisdom that has not previously been documented and explored. The epistemological base from which these nurses operate offers important insights into the substantive issues that create and continually shape the practice world of nurses and their clients. Thus, the purpose of this study is, on the one hand, to generate a picture and develop a theoretical analysis of the work of women's health nurses in the context of the
provision of cervical cancer screening services, and, on the other, to pose broader questions about nursing and the health care system. The literature review and theoretical framework places the research within the socio-political context of the health care system, which generates and reproduces particular power structures and meanings. In theorising about the relationships between knowledge/power, professional issues, women's health and the health care system in general, this study will examine how these structures impinge upon, create, disempower and also have the potential to empower and reshape the delivery of nursing service.

WHNs can arguably demonstrate a commitment to a woman-centred social model of health, drawing on feminist and women's health movements. Whether this represents a (re)construction of the dominant forms of health care service delivery for women will be examined.

A central concept framing this inquiry is that nursing is a profession shaped by social, cultural and political contexts, which are heavily mediated by dominant paradigms of knowledge and power. Furthermore, WHNs represent an important model of women's health service delivery, an analysis of which can contribute to critically reflecting on the ‘paradigm of oppression’ cited in the nursing literature and about nursing more generally. Wicks (1995:14) provides a crucial theoretical base from which to begin this examination of nursing work, by demonstrating in her research that theorising about nursing work ‘... should not assume a priori that nursing exists only in and through its relationship to medicine’.

Drawing on a number of theoretical positions and analyses of nursing work, this thesis will challenge and extend debates on the ‘universality of nursing oppression and the notion of nurses as victims who are inevitably ‘caught’ between structures of class and patriarchy’ (Wicks 1995:122). Correspondingly, this thesis draws on the analysis developed by Wicks (1994 & 1995) in which she examines and refutes the notions of oppression and subordination in nursing and presents an analysis that explicates examples of nursing’s agency and forms of resistance in nursing work. Moving away from Wicks (1994 & 1995) however, who focuses on the sexual division of labour, resistance and nursing agency, particularly from a
historical perspective and in relation to healing discourses, this thesis examines nursing work not only as resistance, but as beyond resistance. Drawing on sociology, nursing, feminism and postmodern theory this thesis will further explore nursing knowledge grounded in practice to elucidate patterns of knowledge, power and practice in nursing.

In seeking to examine how nurses (re) produce, mediate and contest their professional expertise in the provision of cervical cancer screening services, some questions framed the initial formulation of the study. These are:

- How are WHNs affected as a particular occupational group in relation to constructs such as gender, knowledge, and power in the health system?
- What are the theoretical and practice constructs utilised by WHNs?
- Do WHNs operate from specific knowledge and professional constructs, and why?
- What are the experiences of WHNs in making their professional expertise operational in the socio-political context of the current health care culture?
- Why and how do WHNs develop specific models of care and professional practice?
- What are the major professional issues for WHNs?
- What is the relationship between the policy process and practice outcomes in the context of WHNs’ work?
- Do WHNs fit or transcend the notion of nurses as a handmaidens, as they are often represented in the sociological and medical literature?
- Is there potential for autonomous praxis in WHNs’ work?
Structure of the thesis

The first chapter describes the topic of study and the fundamental assumptions underlying the research, and poses the questions and issues for review. The next two chapters (2 & 3) further analyse the context within which women’s health nurses (WHNs) work, reviewing in particular, the discourses of medical dominance and the professionalisation of nursing. These chapters analyse the impact of these dominant discourses on the work world of WHNs.

Chapter 4 proposes that relations of power and knowledge are central to the discourses that structure nursing and identifies postmodern and radical feminist theories useful for locating and understanding the varied nature of nursing work. A feminist perspective is fundamental to the position argued, and the methodological framework for the study is drawn from feminist epistemological and methodological scholarship. Thus, chapter 5 sets out the research design, methods of collection and analysis of the data using a feminist framework. Intrinsic to this process was the use of the ‘voices’ of WHNs as the basis for theorising. A constant companion along the way in examining WHNs’ work, was the reflexivity with feminist research processes, the theoretical discussions and the ‘voices’ of WHNs. Capturing and analysing descriptive accounts of nursing praxis, is seen in this thesis, as providing a way to theorise about nursing work. This methodology is able to demonstrate the knowledge forms embedded in clinical nursing praxis.

The final section of the thesis, presented over four chapters (6, 7, 8 & 9) presents the data and discussions based on the narratives of the fifty WHNs. The ‘voices’ of the WHNs are identified in these four chapters by the use of italicised bold script. Chapter 6 presents a profile of the participants and illustrates the high level of experience and creativity of the nurses in the study. Chapters 7, 8, and 9 presents the narratives of the WHNs and engages the data with additional theoretical propositions. Chapter 10 reflects on the material presented in the four thematic chapters and provides concluding remarks in relation to the whole study.
CHAPTER TWO: WOMEN'S HEALTH NURSES: THE POLICY CONTEXT AND PRACTICE ISSUES

INTRODUCTION

This chapter describes the public health context within which Women's Health Nurses (WHNs) work. In structuring the examination of the work of WHNs, it became evident that the context within which they work, the development of specific issues in the health system and certain health policy initiatives have indirectly and directly affected the practice world of these nurses.

This chapter introduces and examines some of the contemporary issues related to nursing roles and to health policies that position WHNs in the health care setting. I introduce the context in which these nurses practise, and discuss the evolution of the role as a result of policy initiatives. Furthermore, the health care policy initiatives, and specifically, the women's health policy that intersects and impacts upon women's health nursing work, will be examined. Significantly, the discourse of women's health policy and practice represents a challenge to dominant discourses within health, and the impact of this is explored in this chapter and throughout the thesis. Thus this chapter presents some of the background to the theoretical and empirical material analysed for the study.

WOMEN'S HEALTH NURSES: BACKGROUND

Nurses represent the largest occupational group within the health occupations. They represent 69.2% of persons employed in the health occupations, in contrast to medical personel who represent 14.2% (ABS 1991). Nursing remains the most feminised of occupations, with 92.6% of nurses being female (ABS 1991). The largest proportion of nurses work in acute care and institutional settings. Of the nurses who participated in this study the majority (82%) work in community health settings; the remaining (18%) work in specialist health agencies, and two
participants were independent nurse practitioners. The present ‘positionality’ of WHNs locates them within and against many contemporary issues within nursing.

**Funding**

Major economic reforms have occurred in the health sector in the last decade and these have had an enormous impact on the structure of health work overall, and directly on the work of nurses. The vast majority of Australia’s health spending is on institutions—hospitals, nursing homes, dentistry and pharmaceuticals (Wass 1994:6). The reforms have been required to achieve cost containment and improve efficiency within the health system. The main focus of recent health policy reforms has been to achieve cost containment in the acute and aged health care sector, brought about by the increasing costs of advanced medical technology as well as salary costs (Macklin 1990). The Federal government’s response to cost management was to institute the Casemix funding system in public hospitals and, along with this, the major restructuring of the health sector.

In Victoria, the Casemix funding system and the first of the health sector reforms were introduced in 1993. The philosophy underpinning these new reforms is based on an economic liberalist framework (Bell & Head 1994) in which managerialism, privatization and consumerism are the foundational values (Bell & Head 1994; Bursian 1995). The reform process, oriented towards making acute and aged care sectors more efficient is now being extended to the community health sector (Swerissen 1997) and the developing funding frameworks are similar to the acute and aged care institutional reforms. These funding formulae are based ‘... generally on the episodic nature of service delivery, with various incentives such as volume-related fee discounting and copayments to encourage efficiency’ (Swerissen 1997:8). The new purchasing arrangements developed by the Victorian Aged Community and Mental Health Division (Aged, Community and Mental Health Division Purchasing Framework Final Draft 1997:5), under which women’s health service provision is funded, is described as a ‘framework that reflects an overall shift toward output—and outcome—based purchasing’ and ‘the
aim of output based purchasing systems is to pay providers for the outputs actually produced ...’. Herein lies the concern expressed by community health practitioners—that community health care is often complex, social in nature and requires a variety of resources and services for resolution, in which the outputs are often difficult to define let alone quantify and measure. This creates problems for government funding requirements and for the agencies delivering community health care. Alongside the new funding arrangements, the massive budget cuts have directly affected community health and the work of Women’s Health Nurses. The new funding formulae require substantial accounting in the form of daily statistic sheets in order to measure the inputs and outputs of direct service.

Much of the work of WHNs is social in nature, consists of a large component of health education and promotion, and concern has been raised that this does not fit easily into the output based categories defined for the new purchasing frameworks. Bursian (1995:3) argues that, for community services, which are notably a gendered activity with women providing and receiving the majority of services, health care funding which is informed by economic rationalism, is based on ‘... economic liberalism’ which ‘offers an extreme version of androcentricity that is inherently hostile to women’s interests’. It is within the discourses of economic rationalism, of purchasing frameworks, health, and outputs outcomes, that WHNs are currently practising. The new funding arrangements have clearly impacted on the work of all those working in health and the new output based funding arrangements in community health will inevitably affect the work practices of WHNs. The present culture of economic reform in the health sector and the impact that this has on the work of WHNs will be addressed in the final chapter of the thesis.

**Practice context**

The majority of WHNs work in the community health sector, primarily from community health centres. Community health services were established in Australia under the Whitlam Government in the 1970s, based on a social model of health developed by the World Health Organisation (WHO). Community health
services developed on the principles of WHO's primary health care model are
underpinned by a number of concepts. Wass (1994:8) identifies these as:

- equity;
- participation and maximum community self-reliance;
- socially acceptable technology;
- health promotion and disease prevention;
- involvement of government departments other than health;
- political action;
- cooperation between countries;
- reduction of money spent on armaments in order to increase funds to
  primary health care; and
- world peace.

The philosophical underpinning of community health nursing practice has
developed in relation to primary health care principles, and is central to the
approach used by WHNs. In addition, a women-centred approach based on
feminist principles underpins the practice of these nurses. The stated philosophy
of the Women’s Health Nurse Association is based on a ‘... feminist philosophy
and an holistic approach to health ...’ in which they assert they are ‘... committed
to increasing women’s awareness and knowledge of physical emotional and social
issues affecting their health and ‘... strive to encourage women to actively
participate in making informed decisions about their health care’ (Women’s
Health Nurse Association 1997). Members of the WHNs Association actively
work toward enhancing women’s health experiences through involvement in
policy, research, developing resources and professional development of nurses in
the field of women’s health (Women’s Health Nurse Association 1997). WHNs
represent a small group of highly experienced nurses involved in the delivery of
women’s health services. They are part of the broader women’s health movement
and are funded partly from initiatives under the National Women’s Health policy5.

5 The WHNs participating in this study work in generalist community health
centres, rather than stand-alone women’s health centres, but have developed their
practice within the philosophy and policies of the broader women health
movement in Australia.
Health policy and women’s health

The women’s health movement has a historical context. Whilst women’s health care has been the focus of women through recorded history, women’s health issues and the activism resulting in the establishment women’s health centres is part of the more contemporary feminist movement (Broom 1991). The impetus for the women’s health movement was a desire to challenge the patriarchal values that shaped the mainstream health services to the detriment of women’s well being (Hunt 1994 & 1996; Broom 1990 & 1991; Rowland and Klein 1996). Through the feminist activism of the women’s health movement, women identified that they were dissatisfied with the traditional biomedical model’s approach to explaining and treating their ill health (Broom 1990:1). Through political activism, research and policy development, feminist health activists have noted that women have particular health needs and have identified that these are not adequately and appropriately met within the biomedical (patriarchal) framework of health care. The reasons why women require specific health policies and strategies was recently reiterated in a report commissioned by the Department of Human Services Victoria (DHSV) and are identified as:

- biological differences between women and men;
- women’s social and political position;
- gender inequality;
- specific health issues which have a particular impact on women; and
- the ways in which women access and use health (DHSV 1997:4).

The patriarchal nature of health care has served not only to control women and their bodies but, as Hunt (1996:159) argues, ‘... a specific form of medical patriarchy which emerged in the Western, capitalist context served to devalue women’s traditional health knowledge and to elevate medical knowledge as a

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6 See Hunt (1994; 1996) for discussion on the history of the women’s health movement internationally and in Australia. See Broom (1990 & 1991) for policy issues and the history of women’s health centres in Australia, and Department of Human Services Victoria (1997) for an evaluation of the National Women’s Health Program in Victoria.
highly valued professional commodity’. The women’s health movement constructed a view of health that connected social and political issues to well being, and provided a gender analysis, ultimately calling for a reconstruction of mainstream health care. Fundamental to the analysis was the development of a socially focused view of health issues, which also encompassed empowerment and a self-help philosophy, so that women could understand their bodies and make informed decisions about health care. Central to this approach was the view of this being initiated from women in the community, and that developing self-help, health education, health promotion, prevention and women-sensitive direct services were the primary ways in which health care should be delivered. Eventually, resulting from a long period of activism by women, governments began to place women’s health on the agenda and to develop policies addressing issues raised by this movement.

Women’s health policy

The impact of the women’s health movement was felt in many countries, and since the 1960s and 1970s women-specific health centres emerged to address the inequities in women’s health and to provide women’s health care. In Australia during the 1970s, under the Whitlam Government, the Commonwealth developed the community health program and funding and policy development for women’s health was initiated (Broom 1991:63). The development of the National Women’s Health Policy in Australia during 1989 set the stage for health services to consider the development and management of health issues and health services for women in Australian society. The development of national frameworks and strategies to improve the health of Australian women identified priority health issues for women. Health policy frameworks and strategic frameworks for women’s health provision profess, as a guiding principle, that the health and wellbeing of women is directly related to the social context in which women live their lives.

The impetus for addressing women’s health service provision is relevant today, in that women’s health needs are still not met adequately and appropriately within the mainstream health care system (Hunt 1994; DHSV 1997). The National Women's
Health Policy (1989:80) identifies priority health issues for women, and importantly recognises the following:

[W]omen’s health concerns extend beyond specific health problems to include the structures that deliver health care and information and the processes which influence women’s interactions with the health system. These structures and processes affect the quality of care women receive, their access to appropriate and acceptable services and their health outcomes.

The National Women’s Health Policy: Advancing Women’s Health in Australia (1989) is still the current policy document driving women’s health policy and funding in Australia.

There have been many ups and downs in the last decade in the provision of women's health services and, more recently, fundamental challenges have occurred to women's health nationally, and in particular in Victoria, to stand-alone women's health centres. In Victoria, a recent report, Health Status of Victorian Women A first Report (DHSV 1997) claims that the State Government is still committed to improving the health and well being of women in the State. Another recent report, Evaluation of the Second Phase of the National Women’s Health Program in Victoria Final Report (DHSV 1997), commissioned by the State Government to assess the efficiency of women’s health services funded through the National Women’s Health program also states that:

The National Womens’ Health Program has had a major impact on services for women in Victoria, both directly and indirectly. The CASAs and Women’s Health Services address the priorities of the dual strategy in creative and consistent ways. These services are filling a major gap in service delivery...

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7 For example see Broom’s (1994) paper ‘Taken Down And Used Against Us: Women’s Health Services’ for a discussion on the challenge to women’s health service in the ACT by Dr A Proudfoot.
In the development of health policy and provision of health services the need to consider social class, gender, ethnicity, race and age is well established. The women’s health movement, along with epidemiological and public health research, has clearly validated the contention that curative health services (predominantly clinical medicine) need to include a focus on social, economic, dietary, lifestyle and environmental factors when determining health status (Palmer & Short 1994:53). For example, there is a consistent link between socio-economic status and health. In Australia, for all age groups, men and women from less advantaged backgrounds have higher death and illness rates then their more affluent counterparts (Australian Institute of Health and Welfare 1994). Aboriginal people experience the most serious health inequalities, with infant mortality rates three times as high as Australia’s overall rate, and their life expectancy is 21 years less than for the Australian population overall (Wass 1994:6). Both culture and gender affect health status (Health for all Australians 1988; Sax 1990; Better Health Outcomes for Australians 1994; Wass 1994; Australian Institute of Health and Welfare 1994). For migrants who arrive relatively healthy, their health status in some instances declines as the period of residence increases (Donovan, d’Epaingnet, Merton, & Van Ommeren, 1992). Women have a higher morbidity rate than men, and women’s experience of the health system is often negative (Broom 1991; Hunt 1994; Wass 1994).

Thus there is strong evidence that social, economic and structural dimensions of health are significant issues and these need to be addressed in health policy and provision. The establishment of a new National Women’s Health Policy (1989) was a response to some of the inequities that women experience in relation to health provision. Palmer and Short (1994:246) suggest that, despite being the major users and providers of health care, women are under-represented in the so called corridors of power. They assert that:

The women’s health movement has acted to change the existing health care system in three main ways: first by having women’s special needs recognised by policy makers, and by emphasising that these needs are not restricted to
their child-bearing years or reproductive function; second, by having separate ‘women centred’ health services, managed by and for women, established to meet women’s specific needs; and third, by attempting to reorient health policy more generally (Palmer and Short 1994:246–247).

They further state in relation to the third strategy:

[T]he women’s health movement has contributed to health policy by attempting to shift resource allocation priorities away from an expensive medically dominated model of hospital-based health care towards a participatory model of health care that is consumer based and consumer orientated (Palmer and Short (1994:246–247).

Women’s health and women’s health nurses

The significance of the women’s health movement to this project is the undoubted influence of the philosophy and activism of the women’s health movement underpinning the development of women’s health service provision by nurses. This approach has its origins in feminist activism emanating from frustration with the ‘pattern of care, medical ignorance, trivialisation of women’s problems ...’ (Broom 1991:44). The connection of the social context of peoples’ lives and health status is a fundamental position for the women’s health movement, a position embraced by nurses8. In addition, the activism of women as consumers and as providers of health care represents a resistance to the dominant forms of medical discourse and practice, a resistance that characterises the development of women’s health services. For as Broom (1991:58) states:

Women are not only the objects of medicine: they are also active agents in the constitution of their bodies and themselves, participating in other

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8 The understanding and valuing of the social, emotional, and economic issues associated with health and healing may appear to be a new phenomena, but women healers and nursing over the centuries have embraced such a position. See Ehrenreich & English (1973) and Broom (1991) for further discussion on the role of nurses and women in healing roles.
(sometimes conflicting) discourses, at times accepting and at other times resisting medicine’s impositions. Finally, women may convert their individual concerns and criticisms into organised resistance. The women’s health movement is exactly such organised resistance.

Nurses have been involved as specialist women’s health nurses for over a decade, funded under the National Women’s Health Program. It is in the resistance cited by Broom (1991) above that WHNs are actively engaging as they develop the role of delivering women health services. This will be further examined in this thesis. The discourses of women’s health, the activism and the politics of a feminist analysis of women’s bodies and health needs underlie the philosophy of WHNs practitioners. For example, the stated philosophy of the Women’s Health Nurses Association of Victoria (the association from which participants in this research study were drawn) is as follows:

The philosophy of the Women’s Health Nurses Association of Victoria is based on a feminist philosophy and an holistic approach to health. As nurses we are committed to increasing women’s awareness and knowledge of physical emotional and social issues affecting their health. We strive to encourage women to actively participate in making informed decisions about their health care (WHNA).

The perspective expressed in the above philosophy pertains to perspectives developed from the broader women’s health movement. The women’s health movement was (is) a grassroots social movement (Hunt 1996) that developed against the oppression, regulation, and social control of women by men. It offers a women-centred framework and an analysis of sex, gender and the nature of the social in relation to health that has been a significant force in reconstructing women’s health knowledge and practice. In particular for women’s health, and for nursing, this analysis exposed the ways in which medicine’s attitudes to and definitions of women, their health and the medical focus of treatments, was in many instances harmful. Edwards (1988:166) argues that
Feminists have drawn attention to the sexist, androcentric nature of much of the knowledge and underlying philosophy of western medical science, and of its concepts of health and illness, and consequently to sexist elements in medical practice and the organisation of medical care.

In summary, it is argued that the general philosophy of the women’s health movement has exposed the powerful ideology of medicine in women’s health care. This dominant discourse has had a powerful role in shaping the delivery of health care to women that does not necessarily meet their needs. The women’s health movement and, as this thesis will argue, the work of WHNs, challenges this dominant discourse.

**Health policy: public health**

Another challenge to mainstream medically-oriented health care has been the public health movement. The popularity of curative services with the public and the protection of vested interests by powerful professional bodies has meant that preventative health has not been resourced to the same degree as acute services (Gardner 1989:9 & 116). This is evidenced by the nature of expenditure on health services: 71.5% of recurrent expenditure is on institutional care and non-institutional medical services and only 4.4% of total health expenditure on community and public health (Wass 1994:6).

It has been a commonly-held view that scientific medicine was responsible in the main for health improvements. However, developments in epidemiology and public health provision, research and scholarship suggest that clinical medicine has not been solely responsible for improvements in health status (Palmer & Short, 1994:52–56). The work of public health advocates such as Thomas McKeown (Palmer & Short, 1994; Ashton & Seymour 1988) has been very influential in highlighting the social and political nature of illness and health. Ashton and Seymour (1988:6) trace the developments in public health and present McKeown’s historical analysis. McKeown argues that reductions in deaths are due more to
environmental, political and social measures than to medical and surgical interventions and concluded that clinical medicine was only one factor in determining the health of the population. Public health advocates such as McKeown (1971; 1976), Cochrane (1972), Dubos (1960, 1968), Sax (1990), and sociologists such as Illich (1975, 1976), Turner (1995), and Willis (1989) have challenged clinical medicine’s dominance in health practice and health policy. Palmer and Short (1994:55) claim that:

The main policy implications that flow from the public and epidemiological perspectives are: the need to shift the emphasis away from the provision of acute curative services and towards preventative public health strategies, the need for reappraisal of the ‘pastoral’ or caring, role of medicine: and the need to evaluate critically and comprehensively the effectiveness and efficiency of medical practice.

These critiques contributed to the further development of public health and health promotion strategies and the recognition of the wider political and social aspects of health. In the 1980s with the Ottawa Charter underpinning public health, and with escalating health costs, a recognition grew that new strategies were needed and this has led to new approaches referred to as the ‘new public health’ (McMichael 1993:295; Dean 1994:217).

New public health

This revitalised public health movement focuses on community empowerment, primary care, intersectoralism and health environments to address the salient issues and redirect policy and practice in public health (McMichael 1993:295). In addition, the new public health movement stressed the importance of the social processes and social relations that determine health and illness outcomes. The new public health practice and research has focused on social, environmental health service provision and interventions for populations or marginalised groups. This social health perspective provided the framework for initiatives in health such as the development of the approach termed primary health care. This refers to both the essential—first
point of contact health services required by the community—and equally importantly, to the philosophical underpinnings of the health services. This philosophical approach ‘... emphasises social justice, equity, community participation and responsiveness to the needs of the local populations’ (Wass, 1994:1).

This thesis argues that nurses in general and women’s health nurses in particular emphasise a social model of health, and have been instrumental in developing primary health care approaches to health care provision. This approach is not new in nursing. Nursing scholarship has debated the ontological and epistemological foundations of nursing since the mid-1950s (Meleis 1985:14). Many nursing theorists argue that these foundations reflect a social and contextual position that values the plurality and the complex nature of the social relations and conditions that shape health and illness.⁹

**New public health and nursing**

Nursing delivers a large proportion of primary health care in communities and often implements public health programs through community health centres. Nurses represent the largest proportion of the health care work force¹⁰ and have the opportunity to harness the philosophical and practical approaches of primary health care models to promote health and well being. But as Wass (1994:13) warns:

> It remains to be seen how many nurses will take up the challenge to work as health activists, to promote health in a way which enables communities and individuals to live their lives to the full. It is vital that nurses take up this challenge if our work is to have a positive impact on the health of those we are meant to serve. If we choose to ignore the shift to Primary Health Care and continue to support a burgeoning illness

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⁹ See Watson (1979, 1985, 1990); Taylor (1994, 1995); and Hoffmann (1991). These authors discuss the occupational, social, contextual and healing focus of nursing.

¹⁰See page 18 for statistics on the nursing workforce.
management system, the costs to the health of the community will be immense.

Nurses are in a unique position: able to deliver primary health care and public health strategies when in other disciplines these two domains (public health and primary health care) have often been seen as separate (and divergent) specialities (Bhopal 1995:114).

However, is championing public health approaches and suggesting that nursing has a unique (and longstanding) approach to a social model of health care provision merely rhetoric? Is it, as Baum (1990:148) suggests for public health, an appealing rhetoric that is naive in its notions of intersectorial consensus, of critique on the one hand but striving to become part of the mainstream on the other? Is the reality, as Baum (1990:148) goes on to propose, the juxtapositioning of one professional dominance over another, under the guise of altruism, collaboration, and empowerment? As Baum (1990:148) notes, the

[r]hetoric does not ensure that the new public health will not prove to be a part of a system of social surveillance and control rather than an enlightened way of promoting health in accord with individuals’ and communities’ wishes.

To engage in critical appraisal of the illness focus of health care is vital in contemporary debates on health. Specifically, there appears to be a significant gap in these debates—and this is a visible nursing presence. The most authoritative voices present in the literature regarding public health provision are from medicine and branches of medical science such as epidemiology. Historically, public health has been strongly associated with medicine, but where is the nursing voice? Lupton (1995:2) in her critique of public health’s narrow focus and links with biomedicine, describes public health as a form of social medicine. Drawing on postmodern frameworks she argues that discourses of public health are ‘... highly political and socially contextual ...’ in nature, and contends that critiques of public health have been either concerned with restriction of personal autonomy by
the state, or with the political advocacy role to empower citizens to challenge the
state. This, she claims, is too simplistic an analysis for the complexity of the
social and power relations that shape public health in western societies, she argues
that ‘... power relations are not structured by traditional oppositions between state
and civil society and coercion and consent’ (Lupton 1995:3). She further contends
that, just as biomedicine has created powerful discourses that have served to
create and regulate disease and health, so too has public health. Her analysis seeks
to explore how the knowledges and practices of public health operate. As
biomedical models of medicine and public health represent dominant discourses,
these ‘authoritative’ knowledges have shaped many aspects of health and illness.
Lupton (1995:14) proposes that we need

[t]o undermine and contest accepted
understandings and assumptions about public
health and health promotional practices, to incite
critiques and ask questions about dominant belief
systems; in short, to disrupt the complacency of
the knowledges/discourse systems and to open up
space for alternative ‘truths’ and realities.

Giving consideration to Lupton’s argument provides a window through which to
examine nurses’ roles in public health. Nurses in the community deliver
substantial components of preventative and socially focused health care provision
and contribute to public health programs. This in turn raises the issue of whether
WHNs provide alternative truths and realities, resistances, ways of seeing and
practising that can contribute to insightful epistemological positions for health
care. This thesis contributes to these debates by examining in detail the role of
nursing in the delivery of health care and the implications for public health
practice and theory.

**Health policy and nursing**

Australia’s health and social welfare system is experiencing major changes and
funding cuts. National consensus on how to achieve an improved health status for
all Australians does not exist. Through research and the impetus from the WHO
through the Declaration of Alma-Ata and the Ottawa Charter, developing a focus on primary health care strategies as a way of improving the general health status and reducing health costs is gaining credence (Wass 1994). Gross (1990:190–91) states that nursing can have an input into primary health care through highlighting nurses’ roles

... in policy analysis and formulation within peak organisations affecting the planning of service needs for curative and preventive services for the year 2020. In the nurse's role as researcher/analyst of the costs of disease, the costs of health care, and the costing of strategies to reduce the effects of chronic illness and other risk factors. In the role as a primary health care practitioner in preventing major disorders or in the modification of risk factors.

However, overall, it seems that nurses and the nursing profession have very little input into the development of health policy and the shape of the health care system. The collective potential of nurses affecting the shape of the health care system is clearly immense but remains underutilised. This feature of the health care workforce is well documented by nursing researchers and sociologists (Wass 1994; Palmer & Short 1994). Palmer & Short (1994:140) claim that one of the features of the health care workforce is the discrepancy between the numbers of different occupations and the political influence they are able to assert and their gender composition, where there is a far higher percentage of women working in health. They state:

Most striking is the fact that the dominant profession, medicine, accounts for just over 11 per cent of health practitioners, while a less powerful occupation, nursing, accounts for nearly two-thirds of those in health and health related occupations.

For nursing this is indeed a most significant issue. Does this lack of political power and hence the development of policy initiatives affect nurses’ individual and collective ability to shape and deliver health care? It certainly highlights that
the politics of gender is a significant issue in nursing. Short, Sharman, and Speedy (1993:199–200) claim that nurses need to become more involved in the political arena and play a greater role at all levels of policy and planning in health care reform. They state that:

Nurses need to understand the processes underlying policy formulation, and decision making generally, if they are to have more input into the organisational and political decision making that affects nursing and health care consumers.

The role of nurses is changing in response to a range of factors: the increasing complexity and technological changes in the health care system; the impetus in the community and in governments for health promotion; consumer advocacy groups; cost considerations of the funding formulas and early discharge programs, demands for sensitive service provision and the developments within the discipline of the nursing profession itself. Nurses are often in ideal positions to develop their roles in response to these changing demands. Women’s health philosophy, and policy in women’s health, are discourses that have impacted on the work of WHNs. The ways in which each of these discourses interact and influence each other varies. Health policy, and in particular the allocation of resources to programs, is a highly political process (Gardner 1989:9) with competing political and professional interests. Taking WHNs as a reference point, it seems that the philosophy and policies of women’s health have shaped the work of WHNs, but the interaction between broader policy development and public health is less clear. This may be due to the fact that the main focus of work for WHNs is as service providers, and the opportunity to be involved in policy development and debates in public health is limited. The extent to which WHNs are involved in policy development will be examined later in this thesis.

Health policy and cervical cancer screening

It is within the health policy initiatives of the Health for All Program and the National Women’s Health Policy that WHNs and nurse-based cervical cancer
screening programs were established. Thus, this section will present the policy context in which the nurses in this research study began to develop screening services within their role as WHNs.

The importance of exploring women’s experiences of health care services and health care providers has been well established (National Women’s Health Policy 1989). Service delivery and service providers have been influenced by health policy, the women’s health movement and most importantly, by women as consumers. The development by the World Health Organisation, in the late 1970s of the initiative termed ‘Health for All by the Year 2000’ significantly influenced public policy related to health promotion and disease prevention both internationally and nationally (Health for All Australians 1988). The Australian response to ‘Health for All by the year 2000’ initiative was the establishment of the Health Targets and Implementation (Health for All) Committee, set up to develop health goals and targets for Australia for the year 2000.

During 1988, the National Health for All Committee and the National Program for Better Health proposed five priority health areas. One of these is the primary prevention of lung and skin cancer, and the secondary prevention of breast and cervical cancer (Health for All Australians 1988:11). Concurrently, the development and management of health issues for women at international levels was recognised at a women’s world conference in Nairobi in 1985, which highlighted the commitment to ‘... full and equal participation of women in all spheres of society by the year 2000 ...’, with health identified as particularly important (National Women's Health Policy 1989:1). The development of The National Women’s Health Policy in Australia (1989) grew from these initiatives, and commitments were made to develop frameworks and strategies to improve the health of Australian women. Seven major health care concerns were identified, in which cervical cancer screening was seen as a priority health care issue for women (National Women’s Health Policy 1989:5 & 36–37).

There has been considerable criticism of the development of the Health for All Australians Health Goals and Targets (Gardner 1992:126–31). In general, this
criticism is based on the lack of consensus over the focus and development of primary health care in Australia. In addition, there are concerns about the medicalised nature of the priorities and management rather than evidence of an intersectoral approach to health and concerns over the five priority areas chosen. It is claimed that the only reason the five were chosen was because they had well-developed statements of goals and targets, and not because of national significance or need (Gardner 1992:126; Wass (1994:18)).

Following on from the Health for all Australians (1988) initiatives, more comprehensive reports, papers and goals were developed, culminating in the report Goals and Targets For Australia's Health in the Year 2000 and Beyond (National Health Goals and Targets draft report 1994). These developments revised and refined those set previously, recognising the narrow biomedical focus of Health for All Australians (Wass 1994:17). The National Health Goals and Targets draft report (1994) states that the Commonwealth Government is committed to developing a national health policy, and this was endorsed at the National Health Summit of April 1993. The National Health Summit of April 1993 agreed that ‘... the development of national goals and targets ought to be embedded within the broader framework of a national health policy’ (Nation Health Goals and Targets draft report 1994). The impetus for further reports and a national consultative process on National Goals and Targets during 1994 appears to be founded on the following concern:

It became apparent after several years that these goals and targets had not been widely adopted by the mainstream health system and professions because of their exclusive emphasis on risk factors. They were supported by health promotion practitioners but not understood or embraced by the health system as a whole (National Goals, Targets and Strategies for Cancer Control draft report 1994:6).

In the development of national health strategies, cancer of the cervix remains one of the priority areas. Implementation groups were established for the focus areas
and the cancer implementation working group was established. A draft report, ‘National Goals, Targets and Strategies for Cancer Control’ (1994:42) from the cancer implementation working group, states the goals as being to:
reduce the incidence of, and mortality from, cancer of the cervix;
and proposes the following targets:

- increase the percentage of women aged 50–70 who have been screened in the two year period to 75% by the year 1995;
- reduce the incidence of cancer of the cervix amongst women from age 18 to 70 by 30% by the year 2000; and
- reduce the mortality of cancer of the cervix amongst women 18 to 74 by 15% by the year 2000.

The last thirty years has seen an evolutionary, and in some ways a revolutionary, process occurring for women’s health in general and for the development of specific health policy initiatives for women’s health. It was within the broader health policy framework that cervical cancer screening was identified as a priority and subsequently that Women’s Health Nurses became involved in the provision of screening. Doctors have hitherto been seen as the key service providers in cervical screening and traditionally they have been the service providers in the opportunistic\textsuperscript{11} programs available to Australian women. However, nurses are involved at many levels in health screening, treatment, and illness prevention and more recently, in specified programs providing cervical cancer screening.

The focus of screening programs is a public health approach to preventative strategies and detection. Research into cervical cancer screening suggests that 90% of squamous cell carcinomas of the cervix can be prevented (Australian Institute of Health 1991:3) (AIH). Recent Australian reports (National Health Strategy Issues Paper No. 7 1993; Pap Test Victoria report 1993; Well Women’s Community Health Project report 1991) support this claim and, in addition, support the belief

\textsuperscript{11} ‘Opportunistic’ is the official term used to describe the approach of random cervical screening in communities.
that carefully controlled and organised approaches to cervical cancer screening would be beneficial in economic and health care terms.

Summing up on the above, from the general impetus of the women's health movement in Australia, the Women's Health Policy was established in 1989 by the Federal Government. Nationally, and in Victoria, in the late 1980s, various policy and program initiatives were conceived to address broad concerns in relation to women's health. The National Women's Health Policy particularly recognised that accessibility to preventative and well women's health services should be a major priority for Australia. One area targeted was breast and cervical cancer screening services. At national and state levels, cervical screening programs have been developed in Australia.\(^\text{12}\) It was within these initiatives that Pap Test Victoria was established, and as a consequence, the development of nurse-based cervical cancer screening provision began.

**Nursing: Cervical cancer screening**

In Victoria, opportunistic cervical screening programs have been available through mainstream health practitioners since the 1960s. Twenty years later, critical reviews around the world raised concern about the impact that screening programs were having on the morbidity and mortality rates of women with cervical cancer (IARC working group 1986; Pap Test Victoria 1995). During the 1980s it was recognised that in order to address these concerns, additional funding and policy frameworks were required to implement research findings and implement programs (Pap Test Victoria 1995). Within Victoria, many initiatives were undertaken to increase the level of cervical cancer screening among unscreened and underscreened women. One such initiative was the pilot project known as the Well Women's Community Health Project, in 1989. The principal

\(^{12}\) For more information on the evolution of cervical cancer screening programs and the context of policy frameworks for women's health see the following reports: Why Women's Health Report 1987; National Women's Health Policy 1989; Anti-Cancer Council Working Party Report 1987; Cervical Cancer
aim of this project was to increase the rates of screening in unscreened and underscreened women in Victoria, utilising community health nurses specially trained in women’s health (Well Women’s Community Health Project 1991:14). Through this project and further initiatives from the Anti-Cancer Council of Victoria, the potential role of Registered Nurses in increasing the participation rates of cervical cancer screening was explored. The Anti-Cancer Council of Victoria's Pap Test Victoria project in conjunction with Family Planning Victoria, provided training programs for community health nurses to provide screening services. The Well Women’s Community Health Project (1989), and the Anti-Cancer Council of Victoria Pap Test Victoria project in conjunction with La Trobe University and Family Planning Victoria (1991–1994), were unique programs which established the important role that nurses have in providing cervical cancer screening services to women.

This new initiative was mainly driven by nurses who believed that they could offer a clinical service and educational strategies to broaden the options for women in the community. In particular, these nurses believed they were able to provide a broad-based service in the context of a ‘Well Women’s’ approach rather than the traditional illness-focused model of health care provision. These programs have demonstrated that nurses are successful in attracting otherwise poorly screened women who are disadvantaged by age, geography, culture, disability or when mainstream medical services are in some way inaccessible (Pap Test Victoria reports 1991–1995).

The Pap Test Victoria program (1991–1992) identified that nurses in the regions under the program felt ‘... they could better service the needs of unscreened women in their community if they could offer cervical health education with service provision’ (Pap Test Victoria report 1993:31). This project demonstrated that


through developing the role of nurses, successful and innovative approaches could increase the rate of cervical cancer screening in unscreened and underscreened women in Victoria.

The program recognised that while opportunistic screening had been introduced in Victoria in the 1960s, this approach to screening was failing to capture the identified target groups designated as ‘at risk’. An important but unintentional offshoot of these programs was the development of a training program for the nursing profession to be clinically and theoretically prepared to offer nurse-based cervical screening clinics. In fact, Pap Test Victoria (1991–92) states that:

Finally, as a long term measure Pap Test Victoria began to lobby the Victorian Health Department as well as other agencies to address issues regarding standards of nursing practice, the development of accredited nurse training programs and the acknowledgment of the important role nurses play in offering a women a choice of service providers (Pap Test Victorian report 1991–92:56)

Since 1989 a small group of nurses has provided Pap tests to Victorian women with considerable success in screening a higher proportion of older women and unscreened or underscreened women, compared to all service providers registered through the Victorian Cervical Cytology Registry VCCR (Pap Test Victoria 1995:5). Those community health nurses who were involved in the above programs have become the focus and the participants in this research study.

Building on the practice experience of nurses drawn from the above programs, this thesis examines how nurses mediate and contest their professional expertise in the provision of Pap tests. Since these nurses work outside the dominant acute care sector, their familiarity with the mainstream, yet their distance from it, render

them an appropriate focus for theorising diversity and change within nursing practice.

**Conclusion**

The policy context, and in particular women’s health policy and the broader philosophy and activism of the women’s health movement have clearly impacted on WHNs. Alongside these influences, contemporary funding frameworks have shaped the practices of WHNs. The response of WHNs has not been passive or one of merely reacting to these structural and philosophical influences; they have actively participated in organising the delivery of women’s health programs in their communities. The discourse of women’s health policy and practice represents a challenge to dominant discourses within health and WHNs have been active participants in the struggle for social change in the health care system.

In considering the context within which WHNs work, it is apparent that discourses other than health policies and the women’s health movement affect the actions and practices of WHNs. The socio-political context of the health care system that WHNs function within generates and reproduces particular power structures and meanings. Biomedical science and professionalisation are two of the most authoritative and powerful frameworks of meaning to have structured society. The discourses of medicine and the professionalisation of nursing in particular, have greatly influenced nursing work. These powerful discourses examined in the next chapter, operate at a very broad level and their values are embedded deeply in the theoretical development, research and practices of nursing.
CHAPTER THREE: DISCOURSES AND PRACTICES THAT MEDIATE WOMEN'S HEALTH NURSES' WORK

INTRODUCTION

Nursing takes place within a complex and dynamic health arena in which complementary and competing interests are present. In addition to the various nursing roles and health policy developments discussed in the previous chapter, certain other discourses shape the context in which Women's Health Nurses (WHNs) practise. These discourses shape the critical issues that WHNs face in their day-to-day work. The focus of this chapter is to construct an analysis of the discourses and practices that mediate nursing and women's health nursing work. This entails the identification of conceptual, theoretical and practice issues related to nursing in general, against which the praxis of WHNs is later assessed. Thus the chapter examines some broad issues that intersect with, and influence, nursing at a general level.

Many interests mediate the development of the discipline as a whole and the work practices of nurses as individuals. However, two discourses appear dominant when examining nursing work. The discourse of medical dominance, and the discourse of professionalisation of nursing, have had a fundamental influence on nursing and it is to these discourses that the discussion now turns.

Discourse analysis

In investigating the interests that impact on nursing, and WHNs in particular, the analysis relies on using concepts from discourse theory. Principally, the concept of discourse, as defined by Howarth (1995) provides a tool to view and assess nursing questions. It is applied broadly here to viewing the systems of meaning and knowledge that structure and shape nursing and the health context in which nurses operate. Howarth (1995:115) defines discourse theory and discourses as being concerned with:
[T]he role of meaningful social practices and ideas in political life. It analyses the way systems of meaning or ‘discourses’ shape the way people understand their roles in society and influence their political activities. Discourses are not, however, ideologies in the traditional or narrow sense of the term (that is, sets of ideas by which social actors explain and justify their social action). The concept of discourse includes all types of social and political practice, as well as institutions and organisations, within its frame of reference.

Discourse analysis and the concept of discourse are drawn from the interpretive sciences and utilise insights from postmodernist philosophy and theory (Howarth 1995:116). Central to discourse analysis are the concepts of antagonism, agency, power and hegemony (Howarth 1995); concepts which are of central importance to the arguments developed in this thesis. In particular, the notions of agency, power and hegemony in health care as experienced by nurses historically and at the everyday level by WHNs are addressed. A critical position is taken throughout the analysis that certain discourses have been dominant in determining the rules and meanings of how nursing and nurses are viewed and how nursing is able to be practised. There are, however, ‘counter’ or alternative discourses that also can be seen in nursing and these will be explicated throughout the thesis.

**DOMINANT DISCOURSES AND NURSING**

Discourses within medicine and sociology invariably claim that nursing is subsumed under, or dominated by medicine, that nursing is a ‘semi-occupation’ with little autonomy and power in health care contexts. Some of the scholarship in nursing and feminism has also contributed to conceptions of nurses as disempowered victims of patriarchy and of subordination as inevitable in the present sexual division of labour in the health system.
Throughout this thesis I will examine the assumptions underlying and perpetuated by these discourses in relation to nursing. Drawing on the contemporary nursing practice of WHNs, I argue that alternative interpretations of nursing are possible, and later in the thesis I explore the extent to which this is evident in the daily practice of WHNs. As will become evident through the WHNs practice, the totalising discourses of the universal oppression of nursing can be countered with examples of proactive, critical and emancipatory practice. It is argued here that totalising analyses provide inadequate frameworks for some groups in nursing who challenge dominant notions of medical dominance, nursing subordination and victimology. Moreover their practice is testimony to the existence of ‘pockets’ of resistance and of creative autonomous praxis.

In analysing the discourses that impact upon Women’s Health Nurses I will firstly examine nursing in a historical context. A brief historical overview\textsuperscript{15} demonstrates the pervasive nature of the social, religious and historical influences that shape the occupational and professional identity of nursing. As Castle (1987:17) argues:

\begin{quote}
Nursing work has always been defined in relation to the work of other workers involved in patients care, most obviously and importantly in relation to the work of doctors, but also in relation to domestics, clerks and, in the twentieth century, paramedics like physiotherapists and radiographers.
\end{quote}

This history has shaped public and academic views of the discipline. Arguably, these views are common in today’s society. Secondly, I will review debates on the ‘professional project’ of nursing\textsuperscript{16}, which has been a significant issue in nursing scholarship and practice for more than a century. The uncritical adoption of the

\textsuperscript{15} See Dolan, Fitzpatrick and Herrmann (1983) for a general history of nursing; and Maggs (1987:1) for a collection of essays that illustrates ‘the state of the art in nursing history’.

\textsuperscript{16} The term ‘professional project’ is borrowed from Anne Witz (1992;1994) and encompasses the longstanding occupational strategies of nursing in which a variety of legal and credentialing tactics were (are) utilised to bring about change in nursing.
rhetoric of the professional project is strong in nursing, and in some instances the
restructuring of nursing is unquestioningly based upon values and characteristics
of the professions. The importance of this influence on nursing requires analysis.
Interrelated to the professional project of nursing is the impact of the medical
profession, which has been a dominant influence in health generally, and upon
nursing in particular. Any analysis of nursing that examines roles and professional
issues encounters the vexed issues related to the relationship between medicine
and nursing. The relationship between nursing and medicine is complex; it has a
long historical and social relationship. In reviewing the impact of medicine on
nursing, I have drawn on theorising from sociology, as it is this discipline that has
mostly provided analysis of this relationship. An analysis of medicine and nursing
exposes complementary and contested roles, muddied by the sexual politics of
health care. The joint history (a relatively new phenomenon, as organised nursing
predates professional medical practice!) reflects conflicts and the interdependence
between medicine and nursing and this is explored below.

THE SUBORDINATION OF NURSING

There is much to support the view claimed by Forsyth (1995: 166) that

[h]istorical analysis of the establishment of
nursing as an occupation makes it possible to
uncover some of the factors that influenced
nursing development and how nursing became
dependent, subservient and exploited in the
health division of labour ...

Nursing dates back to ancient civilisations, becoming a more formalised system of
care during the fifteen hundreds, developing further with the crusades, giving rise
to particular religious nursing orders. During the sixteen hundreds, beliefs based
on the Cartesian view of the mind/body split had a significant influence on the
formation and delivery of health care. In Cartesian ideology the body was seen as
an object, and slowly a science concerning its working began to develop, laying
the foundation for splitting cure from care (Dunlop 1988). During the eighteen
hundreds, the effects of the industrial revolution led to the beginning of the sexual division of labour which drove health further into care/cure domains and formalised caring practices into specific gendered occupations. The formal development of nursing was further ‘advanced’ during the eighteen hundreds through adopting caring as an identifying feature of traditional views of womanhood, linked with qualities of nurturance and caring. The influence of founding ‘mothers’ such as Florence Nightingale further determined nursing’s identity in relation to the dominant ideologies of Victorian social values of women as carers, and nursing work defined its practice in relation to male-dominated medicine. Dunlop (1988:17) argues that

[t]he socialisation of women into an ethic of care and responsibility to service the private domain made it appear natural, that, as women moved into the paid workforce, they would occupy positions which demanded caring—a division of labour which is still manifestly with us today.

Moreover, the division of labour and the gendered relations of nursing and medicine rendered nursing care subordinate to medical care and the nurse–doctor relationship as one defined by obedience and servitude. Gamarnikow (1978:109) claims that nursing ‘became an occupation primarily defined by its responsibility for executing medical orders and directives’. She elaborates, utilising a quote from 1894:

The nurse must recognise in the medical man her chief, and it is only by assuming this view of her position that she will thoroughly understand the importance of the duties she has undertaken, and comprehend the necessity of that rigid discipline that should not be second even to that of the soldier ... a sense of duty, an absolute obedience to orders, a thorough comprehension of these orders, are the fundamental principles of nurses (Hospital 14 April 1894, p.xxiii).

The dominant values of Victorian industrialised society shaped the face of nursing and have been a powerful factor in the socialisation of nurses. This history assured
a strong alliance with medicine and the hierarchal hospital system which has served to perpetuate in part the low status and low value of nursing within society. It is this image, and the ramifications of this occupational situatedness, that contemporary nursing is striving to change. Such history has created certain historical and cultural stereotypes of nursing that place nurses’ identities as either conforming to the saintly obediently dedicated persona of Florence Nightingale or, conversely, the whore/harridan persona so often depicted in popular culture. The parallels between women in society—‘damned whores or gods police’, a phrase so aptly coined by Anne Summers in 1975—and nurses is well documented (Littlewood 1991; Muff 1982).17

McMurray (1990:7) claims that ‘historically nursing has been plagued by a vague undifferentiated role and status due to four major factors’, and proposes the following factors: diverse educational preparation, location within a medical framework, employment within hierarchical systems and the lack of scientifically conducted research. Ehrenreich and English’s (1973) often-quoted text provides a historical view of the forces that have shaped contemporary nursing, highlighting the masculine hijacking (particularly by the church) of women’s healing and caring knowledge and practices.18 For Johnstone (1994:2) nursing’s problems—the lack of legitimated legal authority, its exploitation by the state and hence its lack of professional autonomy—have more to do with the patriarchal nature of the law. The law, Johnstone (1994) claims, represents a dominant discourse which, alongside medicine, reinforces and legitimates the dominance and control of these institutions on the practice of nursing.

17 Littlewood, (1991:148–69), presents an analysis from an anthropological perspective of the socially embedded images of nurses as located in either the extension of so-called female characteristics of nurturing, mothering and caring, to being sexually provocative or as the battleaxe sister–dragon matron image. Muff (1982:113–56, examines the fantasies, myths and stereotypes of nurses as handmaidens, battle-axes, or whores.
18 Also see Reverby, ( 1987) ‘Ordered to Care: The Dilemma of American Nursing 1850-1945 as a classic description of the situation of nursing within the patriarchal framework of health care.
Thus, the history of nursing (qua the history of women) reflects the dominant influences of the social, religious and legal contexts within which nursing developed and consequently placed nursing subordinate to male knowledge forms of health care. This view is illustrated by the following editorial in a 1920s medical journal (cited by Woods 1987:157):

> The trained nurse is an indispensable asset, deserving of our greatest respect and appreciation; but it should be understood that, after all she is a nurse not a doctor. Her subordinated position in this respect should be clearly defined, and any tendency which may quite naturally develop to cross the boundary should promptly and courteously be discouraged, in her own interest as well as that of the medical profession and the patient.

**Nursing and professionalisation**

Various phases of scholarly pursuit can be identified in nursing’s history when examining the ontological and epistemological foundations of the discipline. For over a century, pursuit of professional status has occupied nursing (Witz 1992; Hunt & Wainwright 1994). This quest has, in the recent past, been framed in relation to (male) science and the alignment with western science was perceived to be the appropriate paradigm for legitimising nursing as a profession. Alongside the alliance with empiricist frameworks, from the mid-1950s, nursing sought to develop nursing theories (Meleis 1985) and strengthen its ‘professional project’ through claiming and substantiating a distinct body of knowledge. The ‘professional project’ was seen as a key development in nursing, and this strategy was based on the premise that it would gain nursing an autonomous and legitimate professional status. Both nursing and sociological scholarship address nursing’s professional project and it is to these debates that the discussion now turns.

For some eleven decades the ‘professional project’ in nursing in the UK, USA and Australia was based on the premise that attaining full professional status was a desirable goal for nursing (Witz 1992; Johnstone 1994; Forsyth 1995; Turkoski
1995). The professional project in nursing has a long and contentious history, and began in the United Kingdom during the 1880s with the establishment of the British Nurses Association and the ensuing campaign for state registration (Witz 1992:132). Witz (1992:129) argues that the professional project of nursing generated in the United Kingdom has a long history, it challenged three sets of power relations:

- employment relations between the hospital and nurses;
- inter-occupational relations of control of medical men and nursing; and
- control of gender relations between the suffrage of women and the labour market.

In order to gain control of and autonomy in nursing the fundamental strategy was to achieve registration by the state and gain self-governance (Witz:1992). The project to professionalise nursing in Britain had to counter the socio-political culture of the times, the concerns within nursing and the emerging power of medicine. The ongoing pursuit for professional status has been sought in the belief that this strategy will improve nursing’s position industrially and occupationally through nurses gaining control over education, training and practice. This quest was based in part on developing a strong power base to negotiate better conditions and wages, and to articulate a body of knowledge distinct from medicine and thus gain autonomous status and equity in relation to medicine. The development of a distinct body of knowledge remained identified with science as the legitimate knowledge form to pursue. ‘Nursing in its quest for legitimacy through professionalisation, has accepted the scientific method as the route to establish a credible knowledge base’ (De Marco, Campbell, & Wuest 1993:31). Internationally, contemporary debates in nursing have centred on the epistemological foundations of the discipline in order to advance and develop health care practices through the education, practice and research of nursing and debates on the professionalisation of nursing.

Thus the professionalisation strategy was undertaken in the belief that this would increase the status of and gain more control and autonomy for nurses. Discussion and debate about the state of the ‘professional project’ remains a consistent theme
in nursing scholarship today. Hayes (1995:188) contends that this debate has extended to scholarship on the development of defining nursing as a discipline, and argues the following:

The implications for nursing practice, education and research which are the outcomes of exploring these two approaches are presented in the hope of supporting the concept of nursing as both a practice profession and a practice discipline and of the stimulating debate around the logical outcomes of acknowledging the intellectual bases of both.

Short and Sharman (1987:197–200) contend that contemporary nursing is trying to improve its position on two fronts. First, with the help of a professionalisation strategy and second, via trade unionism. They further contend that these strategies have failed to address the class and gender inequities which have been, in their view, the fundamental problem in nursing. Major advances in medical technology and the present complex health care system have dramatically affected the nursing experience. This evolution has motivated nursing to reevaluate its status, image and remuneration, its educational base and future directions. Thus, another view emerging more recently is the critique of adopting the criterion of professionalism for nursing. Turkoski (1995) argues that nursing unquestioningly adopted the ideology of professionalism, and proposes that, as a male paradigm, it is inconsistent with women’s knowledge and the philosophical underpinnings of nursing. Kermode (1993:102) also contends that professionalisation is problematic for nursing, because on the one hand it is trying to be ‘qualitatively different to the established professions’, but on the other, it recognises the ‘power’ to be gained in acquiring professional status. Sociological analyses of nursing have also addressed this question and provide an insight into why nursing historically sought to professionalise, and identify problems for nursing in this quest. Analyses from sociology on nursing’s professional status have placed this debate in the context of the sociology of the professions and have compared nursing to medicine. This approach has considerably influenced the analyses of nursing professional issues inside and outside nursing circles.
Substantive contributions to the study of the professions have been made by various scholars in sociology. Various theoretical perspectives are drawn upon to examine the concept of professions, and these demonstrate how certain occupations lay claim to professional status and how they secure a dominant position within the labour market. A particular focus in the study of professionalisation has been the medical profession. The occupational strategies of medicine have long been the subject of medical sociology. Many sociologists describe medical dominance over nursing to illustrate medical supremacy in terms of professional dominance. The following discussion will review medical dominance as it relates to nursing’s professional project.

**Medical dominance**

Two approaches characterise the development of the professions in the early 20th century. One approach focuses on defining the traits of professions and the other was a functionalist approach ‘which stressed the functionality of professions for the maintenance of the social order’ (Willis 1989:9). The study and definition of the characteristics of professions has largely been the work of sociologists, notably the works of Talcott Parsons in the late 1930s. This author is renowned for his accounts of the nature of the professions and the development of the classification of professional features through defining the attributes or traits that occupations seek in order to attain professional status, with the focus on knowledge and ethics. Another approach, championed by Eliot Freidson (1970;1973;1986) and more recently expanded in Australia by Evan Willis (1989), is the strategy of gaining professional autonomy through exclusionary tactics. Freidson is regarded as a major contributor to the sociology of the professions. Brint (1993:260) claims that Freidson’s work contributed through introducing

A new concept of the professions rooted in the social organisation of occupational labor markets, ...an analysis of the spheres of professional control that result from the knowledge monopolies and gatekeeping activities of
professions ...and provided a measured defence of professions in the face of critics who see their powers as unnecessary, harmful or both.

Such tactics afford the profession a dominant position in the division of labour in which it is able to become autonomous and self-directing (Hunt and Wainwright 1994:6). These professional strategies also maintain certain monopolistic privileges and rewards (Turner 1987). During the 1970s, analyses of professions and professionalisation centred on medicine as an example of professional ideology and the ways in which medicine exerts social, economic and occupational control. Authors such as Freidson (1986;1970) examined medicine as a profession in relation to medical autonomy and the ability to gain occupational control, thus preserving prestige and power (Turner 1985:38). Willis (1989:9) citing Johnson (1972) and (1970; 1986) claims that, during the 1970s, the debates were ‘critical of the traditional approach insisting that professions and professionals were concerned with power and control’. Navarro (1986:9) extends the analyses of medical dominance and looks at ‘... how capitalist or bourgeoisie ideology reproduces capitalist dominance in the spheres of production, politics, and science and medicine’. He highlights the view that, under capitalism, class dominance is significant in the production of knowledge itself. Thus science and medical knowledge developed as the only legitimate knowledge form that was seen as objective, value free, and universal and which rendered other knowledge forms as ‘untrustworthy’ (Navarro 1986:163). Navarro (1986:163) argues that the powerful ideology of science and medicine shapes the nature of knowledge and ‘... thus knowledge is legitimised only and exclusively when it comes from scientists’. The power of this ideology is translated into practices in health where medicine is seen as having ‘expert’ knowledge and other health professionals such as nurses as having non-expert or ‘soft’ knowledge.

Broadly, according to these medical sociologists there are three main areas in which the medical profession shapes health care. It controls other health occupations through legislation and licensing; it defines health and illness and
emphasises the disease/illness focus of health care; and thirdly, it is able to influence health policy and resource allocation for health care.

**Occupational control**

Willis' (1989) thesis is that medical dominance is a central feature of health provision in Australia and that it dominates the structure and organisation of health. This dominance privileges medicine not only in terms of autonomous control over its own work but, significantly for this project, it exerts direct or indirect control over other health occupations. Willis' (1989) analysis reviews elements of Freidson (1970;1986) and Johnson (1972) who reflect a Durkheimian analysis. It is Willis' contention that these analyses are nevertheless related to the traits theories of the professions and represent little class analysis of the professions in capitalist society. In addition Willis (1989:11) reviews other studies (Parry and Parry 1976; Larson 1977) which stress insights '... into the nature of the control medicine has over its own work' evolving from class theory to analyse professionalism, but he claims that the usefulness of these analyses is limited. These authors, Willis (1989) contends, discuss power, control, autonomy and authority in relation to class structure, but he further argues that this is an inadequate conception of class relations because it fails to specify the conditions under which theses notions prosper or the basis on which these interests exist. Willis (1989) insists that traditional approaches are ahistorical, descriptive of the occupational groups that attained privileged positions, accepted the reality, but that they fail to investigate the locus of power of the professions within a wider social context. Such analysis, he contends, is provided by Weber and Marx. Willis (1989) draws on Marxist structuralism for his analysis of medicine's professional dominance. For Willis (1989:2) the division of labour in health care is an organised and complex social structure in which:

[m]edicine dominates the health division of labour economically, socially, intellectually. This phenomenon of medical dominance is the key feature of the production of health care in Australian society and the central analytical focus
in explaining structure and organisation of health care.

Thus, for Willis (1989), medicine has maintained its dominance through subordination, limitation and exclusionary tactics. To illustrate the various tactics that medicine utilises, the case of midwifery is widely cited to demonstrate the constraints faced by nursing (see Willis 1989; Turner 1995). This debate is becoming more contentious in contemporary nursing as midwifery is seeking independence on two fronts—from nursing and from medicine.\(^{19}\) Willis (1989) contends that, stemming from the influence of Florence Nightingale, nursing evolved as a ‘... subordinate occupation and has largely remained that way since’\(^{20}\). He further claims that the subordination process ‘reflects a patriarchal division of labour and relates closely to sexual and occupational divisions in the health workforce’ (Willis 1989:123). Wicks (1994:21) however, claims that although Willis (1989) offers ‘the most comprehensive attempt so far to integrate theories of class, gender, and medical dominance ...’, there are a number of problems with his work. Wicks (1994:21) cites three major concerns. Her first concern is that while Willis pinpoints the structural dominance of medicine over nursing, he fails to address the process of the production or reproduction of this structural location. Second, in his examination of medical dominance over midwifery, his approach is one ‘of the reproduction of an established dominance which is taken as existing \textit{a priori}'. Third, for Wicks (1994:22), Willis fails to problematise scientific knowledge and thus fails to theorise and challenge the dominance of scientific knowledge as part of a process and structure of power.

\(^{19}\) See discussion by Guilliland & Pairman (1995) and Lecky-Thompson (1995) for the view that midwifery is a distinct discipline (from nursing) with its own theoretical base and in relation to the move for midwives to be seen as having a separate professional identity to nursing.

\(^{20}\) Willis (1989:92–124) utilises a Marxist structuralist approach and cites midwifery to illustrate the reproduction of medical dominance through describing subordination tactics utilised by medicine. He also notes that historically midwifery was ‘co-opted’ into nursing.
**Medicine as a form of social control**

Marxist, feminist and postmodern sociology have also offered critical views on the traditional analyses of the professions emphasising class, sexism, domination through professional power and knowledge relations. These analyses highlight the social construction of health and illness. They contend that medicine has, by various means, created definitions of human nature and thus shaped beliefs and practices associated with health and illness. Anne Edwards (1988) provides a comprehensive analysis of the concept of social control through reviewing functionalist, interactionist, Marxist and feminist positions in regard to the legal, medical and welfare systems. This author suggests that, while not all members of society will interact with the judicial or welfare systems, birth, sickness and death are universal experiences, thus medicine does at some stage influence everyone (Edwards 1988:186). Furthermore, she argues that ‘... medicine is a powerful mechanism for the moral, ideological, political and general social control of all members of society ...’ (Edwards 1988:186).

Postmodern analyses of medicine have extended these debates to examining health, culture and society, and the body. Feminist analysis of medicine adds the dimension of gender as central to the analysis of medicine’s power and control. Witz (1994:26), for example, maintains that '[t]wo issues have been highlighted by feminist contributions to the sociology of nursing. First, the gendering both of the content of nursing work and of the context (both in terms of organisation and the health division of labour) within which it is accomplished, and second, the gendering of the professional projects themselves’. Nurse activists were involved in the suffrage movement in both the United Kingdom and the United States of America. However, Bunting and Campbell (1990:19) claim that nurses who joined the social reformers in the early twentieth century did so to support sanitation reforms rather than as a feminist mission, and rejected feminism for professionalism. However, more recently feminist analysis of professionalisation has been addressed in nursing scholarship. Debates about professional issues continue to be a central concern for nursing, and in the early 1980s, material in nursing, drawing on feminist perspectives, began to address issues of nursing
work in a male dominated health care system. Muff’s (1982) text *Socialization, Sexism and Stereotyping* served as a catalyst for other feminist writings to analyse the health care system critically and to provide approaches for empowerment and change (Chinn 1995:273). In addition, critical analysis of professionalisation as a transformative strategy for nursing has received recent feminist attention to refute the use of one paradigm of professionalism based on male occupations and male theories of professional criteria (Witz 1992; Kermode 1993; Turkoski. 1995).

**Health policy and resource allocation**

As professional monopolists in the health care arena, doctors are powerful arbiters of the direction of health policy initiatives and set policy agendas for health (Gardner & Barracough 1992; Degeling & Anderson 1992). Through professional organisations (such as the Australian Medical Association (AMA)) and activities on government committees, the medical professional is a powerful lobby group which is able to influence government decision making in health care (Clinton & Nelson 1995). Moreover, through the legitimation of the medical model as the accepted framework for delivering health, doctors are able to influence the financing of health, the legal requirements of other health professionals’ practices, and affect reimbursement policies of third party funders (Degeling & Anderson 1992:66). Likewise, Daniel (1990:7) argues that ‘medicine exerts its hegemony in the health field and influences profoundly the economic and political processes that determine the provision of health services’. Duckett (1992:160) proposes that:

> Financing arrangements for health care in Australia are complex involving state and federal governments, health insurance funds and consumers. Despite their rhetoric, interests of providers are not identical with those of consumers.

In addition, Duckett (1992:156) claims that analysing health expenditure is problematic because it is generally medical practitioners who decide to admit patients and decide on treatments based on their own perceptions of the success
and benefits, and ‘... [d]octors may well overemphasise the relative success of intervention and the benefits of treatments’. However, in the present climate of change and restructuring of health services, driven largely by the need to use the limited resources effectively, medicine’s influence in affecting health policy and resource allocation is under challenge. Under the microeconomic reform presently occurring in the health care industry the introduction of Casemix payments\(^{21}\) has seen medicine’s autonomy and monopolistic provision of health service under pressure. Under the Casemix funding program medical practice is closely monitored and evaluated for efficacy, and according to Degeling (1993) this has limited the clinical autonomy of doctors. In addition to microeconomic reforms, the advent of social change and the growing disillusionment with scientific medicine has seen unprecedented challenges to medical knowledge and practice. It is this issue that the next section addresses.

**Challenges to medicine**

Since the 1970s, further critique and analysis on medical dominance and the social control of medicine has emerged. Kelleher, Gabe and Williams (1994) argue that beginning in the late 1960s and the early 1970s a more critical sociology developed, which stimulated an alternative to the view of medicine as a rational and benevolent profession; that is, one of viewing medicine as a dominating profession monopolising health provision. These authors contend that in contemporary society, medicine is facing further significant challenges which require a reworking of traditional ideas about professional dominance. Kelleher, Gabe and Williams’ (1994) text proposes that proletarianisation and the deprofessionalisation of medicine is occurring in today’s society, and that these account for the challenges that medicine is facing. In addition, these authors present a number of possibilities that threaten medical dominance in society and

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\(^{21}\) The Casemix payment system was introduced by the Commonwealth Department of Health, Housing and Community Services in 1988, and links hospital reimbursement to outputs based on a patients classification system. It was developed in response significant changes in economic conditions and a need to
suggest that these challenges come from new social movements and the rise of managerialism. In particular they cite rise of ‘... economically and ideologically driven managerialism’; complementary and alternative medicine; professional and lay groups such as lawyers, journalist and self help groups; and social movements such as the women’s movement, animal rights groups and anti-vivisectionists (Kelleher, Gabe and Williams 1994) seeking change. Lupton (1994) too, contends that medicine is facing significant challenges in contemporary society and argues that there are several major reasons behind the critiques of medicine which ‘... have begun to call into question the claims to ‘truth’ and political neutrality of biomedical knowledge’. She cites the disillusionment with scientific medicine by consumers and intellectuals and the influences of feminism and the postmodern movement as behind the challenge to medicines’ effectiveness, benevolence and claims of objective and politically neutral knowledge (Lupton 1994:5).

While authors may differ on their theoretical analysis of how medicine shapes health care, all assert that medicine exercises a strong influence over conceptions of health and health care practices. Edwards (1988:170) claims

> [t]hat the particular combination of market control, state authorisation, specialist expertise, self regulation, public demand, social status and moral worth, not to mention its class and gender characteristics, put medicine as an occupation in the modern world in a uniquely powerful position.

This powerful position is not only evident in the theorising about how other professions are shaped by medicine and the delivery of health care, but it constructs discourses for closely associated health professionals. For example Turner (1995:146 & 151) maintains of nursing:

> One problem for nursing as a profession is its subordination to the medical profession so that nurses in theory merely execute decisions arrived
develop more effective methods of utilising health care resources (Hathaway & Picone 1995:301).
at by doctors. Nursing is subordinated within the technical division of labour surrounding medicine ....

In addition he claims:

Because the nurse occupies a subordinate position within the hospital and little prestige in the market place she is relatively ineffectual in challenging the structure of the hospital system. Nursing has the traditional weaknesses which are often characteristic of feminized labour, namely the presence of a vicious circle where low job satisfaction results in broken careers and inadequate career structures produce low occupational commitment.

For nursing, the discourses and analyses surrounding nursing and medicine have had major implications for nursing practice. Much of nursing’s history, practice and research is constructed in relation to medicine. Analysis of the constraints on nursing usually locates the arguments in terms of nursing as always in relation to medicine and correspondingly as always in subordination to medicine. As Lupton (1994:123) notes ‘[t]hey are constantly positioned as submissive ‘helpmeets’ rather than authoritative agents ...’. This often totalising discourse is one of the themes addressed throughout this thesis. Sociological examination of medicine’s professional dominance has highlighted how medicine has created and maintained a powerful and privileged position at the expense of related occupations (Walby & Greenwell 1994:59). Walby & Greenwell (1994:59) describe this in relation to nursing interests thus:

[t]he relations between doctors and nurses are conventionally analysed by sociologists within the framework of the sociology of the professions. Within this literature the focus is on professionalisation as a struggle for occupational advancement at the expense of related occupations and everyone else. At the centre of this debate is power. The detail of the debate is about the diverse ways this power is negotiated. Hence the interprofessional relations between
doctors and nurses are frequently understood as ones of a struggle over position and power.

The above analysis is well substantiated, and undoubtedly affects nursing, but, as will be argued later in the thesis, this is not the only view available when examining relations between nursing and medicine.

In reviewing the debates on the professional project of nursing from within nursing and from sociology the common position taken is to theorise from both hospital and midwifery contexts. This is problematic for other nursing groups. Hospitals represent the most highly structured and sex segregated contexts within which nurses work. Notwithstanding that these contexts employ the majority of nurses, I would contend that there are dangers in extrapolating these structural and occupational issues to all of nursing.

Conclusion

At first glance, the general view of nursing, is that of nurses working ‘under’, subordinated and oppressed by, the medical and health care system. Nevertheless, there are many instances that reflect a strong professional identity, one in which autonomous practice and equal partnerships in health service occur. Specifically, this thesis will develop an argument that conceptualises nursing work, as demonstrated by WHNs, as work that does not necessarily intersect with medicine in a subordinated way; and as work that need not be described from a sociological perspective as dependent on, or in relation to, medicine.

In examining the context in which WHNs work, I have identified certain dominant discourses that have shaped and directed the practices of this group of nurses. In this thesis the concept of discourse refers to the ways systems of meaning produce and shape social and political life (Howarth 1995; Foucault 1977 & 1980. See footnote 1 and pp 36 & 37 this thesis). Focusing on discourses highlights how meanings and knowledge structure, socially and politically, human activity and in particular, identifies that some discourses are dominant.
In using the concept of discourse for this study I claim that certain discourses are dominant and, in assuming this perspective, denote a relationship between knowledge and power. The concept of discourse is central to the understanding of power and knowledge. Power in some form, whether oppressive or productive, mediates who we are, what we do and how we do it. Moreover, as Radtke & Stam (1994:4) argue, ‘... the exercise of power is implicated in the mechanisms and procedures for producing knowledge, and hence, in knowledge itself. Consequently, all social practices are shaped by power ...’. Work relations, knowledge relations and identities are structured by power in some form. Linking knowledge and power relations highlights their capacity to produce the ‘truths’ we live by (McHoul & Grace 1993:58). For as McNay (1992:25) argues ‘[t]he production of knowledge is always bound up with historically specific regimes of power and, therefore, every society produces its own truths which have a normalizing and regulatory function’.

The examination of health care practices—in this instance the practice of WHNs in the provision of women’s health care—reveals the many competing and complementary knowledge and power relations that structure nursing and are challenged by nursing and women’s health practice and politics. In considering the relationships between nursing, other health practitioners, and the context in which nurses work, an analysis of knowledge and power relations provides the linchpin. Thus, reviewing theories on knowledge and power relations will facilitate further understandings of the topic of concern in this thesis. Accordingly the next chapter will present an analysis of power and knowledge relations.
CHAPTER FOUR: WOMEN, NURSING, POWER AND KNOWLEDGE

INTRODUCTION

The previous chapter has highlighted some of the discourses that have shaped and developed aspects of the work of WHNs and concluded that fundamental to those discourses are relations of power and knowledge. This chapter will extend further the theoretical discussion of power and knowledge, since re-thinking these relations is central to locating and understanding varieties of nursing work and in particular WHNs’ work.

What we know and understand in the world is shaped by certain knowledge forms, and these knowledge forms are constituted and reconstituted by dominant discourses. To make claims about the nature and effects of nursing requires an analysis of knowledge forms in nursing. A core tenet throughout this thesis is that nursing is shaped by multiple discourses and therefore multiple knowledge forms. To understand nursing in terms of what it does requires engaging with epistemological debates. Many nursing authors have traversed this course, from Florence Nightingale to contemporary nurses. Taylor (1994:15) ascertains that, along with more recent writings in nursing,

[N]ursing requires a mixture of epistemological approaches for finding meaning in nursing, and to portray the relative complexity and diversity of knowledge in a practice discipline.

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22 Meleis (1985) provides a review of the milestones in theory development in nursing, claiming that nursings’ theoretical development really only began in earnest in the mid-1950s. Also see Chinn and Kramer (1991) and Kikuchi and Simmons (eds) (1992) for debates on epistemological issues in nursing. Also see Speedy and Kermode (1996) for a contemporary Australian discussion on theory and nursing.
The objective of this thesis is to examine nursing practice and to theorise from such practices to develop insights for practice and policy development in health care. Using an inductive approach with the help of semi-structured interviews, the work and experiences of WHNs is later used to theorise from the narratives of the participants. Recognising that nursing is multifaceted and complex, this chapter will demonstrate that several theoretical perspectives are necessary to capture the meanings embedded in the work of Women’s Health Nurses. Drawing on the material discussed in chapter 3, in which I argued that nursing practice is mediated but also clearly contested by certain power/knowledge relationships, a framework will be developed in this chapter which structures and informs the empirical phase of this project. Accordingly, an examination of knowledge and power theories will be considered.

DISCOURSES ON POWER AND KNOWLEDGE

A central concept of the social sciences and the mainstay of political science in the twentieth century has been power. Power has been conceptualised in many different ways, from the influential mechanistic causal model of the seventeenth century to the more contemporary social construction model. A central feature of many theories of power is that power relationships involve a unidirectional hierarchy that involves a dominant agent and a subordinate agent (Wartenberg 1992). However, contemporary social theory has given rise to many different analyses of power, and has moved from seeing power as only oppressive and coercive to seeing it as having positive possibilities and the potential for empowerment (Wartenberg 1992). As Lukes (1977:29) suggests:

[S]ocial life can only properly be understood as a dialectic of power and structure, a web of possibilities for agents, whose nature is both active and structured, to make choices and pursue strategies within given limits, which in consequence expand and contract over time. Any standpoint or methodology which reduces that dialectic to a one-sided consideration of agents without (internal and external) structural limits,
or structure without agents, or which does not address the problem of their interrelations, will be unsatisfactory.

The trajectory of theories of power is most often highlighted by the works of male scholars from Machiavelli, Hobbes, and Locke, to Russell, Weber, Dahl, Lukes, Parsons, Giddens, and the French postmodern theorists. These master discourses have presented various conceptualisations of power and the influence of power on social organisation and social meanings in the lived world. It is perceived, in many of the theoretical positions on power, that knowledge and power are so intimately involved that to theorise one concept identifies the other; power constitutes knowledge and knowledge constitutes power. From this perspective, power and knowledge are not distinct entities but ‘one begets and infers the other’ (Pearson 1995:110). This approach is adopted here.

The various conceptions of power are, of course, constituted by certain discourses themselves. Clegg (1989:xvi) cites Machiavelli and Hobbes as two of the most significant contributors to the analysis of power from the outset of modernity. The centrality of notions such as causality and human agency in conceptions of power owe much to the seventeenth-century political theorist Thomas Hobbes. Indeed the ‘power’ of his discourse has shaped much of the understanding in the modern world (Clegg 1989). Hobbes’s model of classical mechanics, with its central notions of the causal, atomistic, observable, measurable and mechanical nature of power and, in particular, his notion of the ‘supremely sovereign will’, continues to influence contemporary analyses of power. Of the sixteenth-century Machiavelli, Clegg (1989) argues that he provides a different interpretation of power from Hobbes, but his theorising of the nature of power can be seen to have more sympathy with contemporary post-structuralist theorists such as Michel Foucault. Machiavelli offers an interpretation of power based on organisation and strategy, with an analytical focus on the shifting and unstable nature of power. Clegg (1989:4) suggests that ‘[i]n terms of the subsequent trajectory of mid-twentieth century scholarship and research on power, Hobbes’ conception was to be the
intellectual victor'; and Machiavelli’s subordination was due to the dominant discourse of causality, sovereignty, and the development of modern science.

The antecedent theories of these scholars provided the foundations for many of the theories on power. However, recently many of these theories have been subjected to rigorous critique. Through the decline of positivism as the dominant paradigm in social theory, and the decline of Marxism as the dominant mode of critical social discourse, along with feminist criticism of prioritising class over gender, and the postmodernist rejections of metanarratives, criticism has had a significant effect on the theorisation of power. In particular, the discourses from postmodern and feminist theorists have provided alternative views on power and knowledge in order to match the major material, social and cultural changes and conditions of contemporary society. It is these perspectives that this discussion now addresses.

In reviewing and critically analysing theories of power and knowledge, this discussion will focus firstly on Michel Foucault’s postmodern theorising on power and knowledge relations and secondly on feminist theorising on power. It concludes that a combination of radical feminist and postmodern perspectives on power/knowledge relations is useful for framing the epistemological questions raised in this project and for framing the empirical enquiry.

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23 In this thesis I have opted to use the terms postmodern/ist/ism unless the term poststructuralist/ism is related to a quote from another author. I have adopted the view of Best and Kellner (1991:25) that postmodern theory is a more inclusive phenomenon and interprets poststructuralism as subset of a broader range of theoretical tendencies which constitute postmodern discourses. Thus, in this thesis postmodernism refers to the philosophical, social and cultural movement and the critique of the modern world. In particular the postmodern approach has been to deconstruct notions of rationality and the unified subject and raises questions about truth, language and meanings. Postmodern theory denotes the critique of the universalising and totalising claims of the grand theories of modernity, instead favouring a theoretical view that attends to plurality, multiplicity, fragmentation and indeterminacy of knowledge and subjectivity (Best and Kellner 1992).
Theorising in nursing

This thesis does not attempt to create a postmodern theory of nursing or a feminist theory of nursing, but rather, draws on and critically engages with postmodern and feminist positions to explore the relevance of these perspectives to the central issues in the thesis of power and knowledge relations in nursing. Traditionally, scholars within nursing have drawn on theoretical positions of science and logical positivism to legitimate the epistemological foundations of the discipline. From the 1950s, critiques of natural science as a partial world view and one fraught with biases, began to appear across the human sciences and from the early 1960s nursing began to reflect on the limitations of the paradigm it had adopted. Along with other disciplines, nursing began to critique science and view it as a limited framework for all nursing questions. Consequently, identification with science and medicine to assist in the development of substantive concerns for nursing has been heavily critiqued by nursing scholars. For example, DeMarco, Campbell and Wuest (1993:29) posit the following:

It may be difficult for nursing scholars to ‘see’ bias in medical research because so much of our knowledge has been built on that base. … Yet it has become common knowledge that much of medical knowledge has been based on research using primarily male samples or dominated by male perspectives of women’s biology.

The exploration of alternative paradigms to uncover, examine and establish knowledge in nursing began during the 1970s. Critiques of the classical scientific enterprise, refuting empiricist science as offering objective, value free, universally applicable and replicable methods, was met with an examination of interpretive

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24 From the 1970s spirited debates in the nursing literature have addressed the limitations of science for all nursing questions. See for example Chinn (1985); Hoffmann (1991); DeMarco, Campbell; Wuest (1993) and Chinn (1995).

25 See Lovell (1986); Allan & Hall (1988); Webb (1986); Watson (1990); DeMarco, Campbell; Wuest (1993) and Johnstone (1994) for critiques of medicine’s impact on nursing. In addition see Hoffmann (1991) and Chinn (1995) for summaries on nursing’s critique of science and medicine and the influence these dominant discourses have had on nursing theory and practice.
and critical paradigms for nursing. This critique of science in nursing moved theorists, researchers and practitioners to examine interpretive frameworks, with the aim of developing understandings and explicating systems of knowledge that best capture nursing’s caring mandate. This examination acknowledged that nursing involves scientific as well as humanistic and philosophical knowledge in the development of practice, theory and research. This development called for eclecticism and theoretical breadth in nursing theorising. Holmes (1995) for example, argues the case for using postmodern analyses in nursing. In his view it provides an important critical frame for reviewing science and other dominant paradigms so often used in nursing and claims the following:

The postmodern analysis clearly enjoins us to reject, overthrow or transform, all forms of nursing theory which constitute or rely on grand theories, including those founded on totalising metaphysical, political or ideological metanarratives (Holmes 1995:360).

However, adopting theoretical eclecticism has not been without criticism for widening the so called ‘theory–practice gap’ and of creating a ‘... gap between epistemes, or knowing that versus knowing how’ (Maeve 1994:9, cited in Speedy & Kermode 1996:376). Concern has been raised by nursing scholars that this gap is created through disenfranchising clinical practitioners, who often find abstract theorising difficult to comprehend and of little value to clinical practice, and creating elite academic scholars who theorise far away from the practice setting. Moreover, concern is raised by some that ‘nursing is drowning in eclecticism’ and that nurses find themselves ‘swimming in a theoretical soup’ instead of developing a distinctly nursing-focused theory of knowledge (Cody 1996). Cody (1996:87) asks of nursing:

If it is what she or he does that makes the nurse, and if these actions are guided by non-nursing theories, does that mean any person who can perform those tasks is therefore a nurse? And what differentiates nursing practice in and with communities from the practice of generic public health, epidemiology, social work, or health
education if it is not the theory base that guides
the nurse in practice?

The development of a distinctly nursing focused theory of knowledge remains a vexed issue within the discipline. In a recent debate on nursing theory in the 21st century, Sister Callista Roy, a distinguished nursing theorist, contends that for nursing theory development, pluralism would diminish nursing theory and she sees the need for unity (Randell 1992). However, in contrast, other notable nursing theorists such as Johnson, Neuman, Orem, Parse, and Rogers disagree and posit that diversity and pluralism will advance and enrich nursing (Randell 1992). This does not mean that we should uncritically accept any theory for nursing’s epistemological development; a rigorous review and analysis should occur to find theories or develop theories that befit the substantive specific issues in nursing. In this thesis, theoretical eclecticism and debate in nursing theory development is viewed as an evolution of nursing that will serve to advance and enrich development. Rather than seeing the necessity for a required consensus over the use of multiple theories versus a unified theory, it is argued that in order to develop adequate understandings and perspectives on nursing management of illness, and health, and further develop nursing practice and research in contemporary society, multiple approaches are necessary. To borrow from Turner’s argument for medical sociology and so argue for nursings’ theoretical eclecticism:

The point is to use theory creatively and constructively, rather than to generate narrow and exclusive positions which in a ritualistic fashion attempt to expurgate all previous analyses and conclusions (Turner 1995:14).

Thus, theoretical diversity in nursing provides a more realistic view to frame and examine questions for theory development, research and practice in nursing in the complex health system of the 1990s. As will be argued in the following section, attention to multiple realities is a postmodern position that can serve analyses of nursing work well. This is not to say that postmodern perspectives offer all the
answers. As there are some problems with this approach, these will also be addressed.

**Postmodern perspectives and nursing**

The critique of modernism and the critique of totalising grand narratives by postmodern proponents offers analyses useful to health fields through questioning the ‘existence of essential truths’, thus providing a ‘challenge to taken for granted assumptions in medicine and public health’ (Lupton 1993:298 & 299). The dominant discourses of biomedical science have been influential upon nursing (Parker 1991). Postmodern analyses argue that knowledge and practices are products of social relations and are therefore subject to change (Lupton 1993). This questioning provides alternative views on power and knowledge, and in health, questions the authority of medicine’s claims and practices that dominate health care. For nursing, this presents an opportunity to deconstruct and reconstruct the historical, social and political dynamics that affect nursing. Recent scholarship in nursing draws on postmodern theorists’ discourses on power,knowledge and the body to address epistemological questions in nursing.  

For example, Holmes (1995:351 & 360) argues that ‘postmodernism offers creative and stimulating new ways of viewing nursing’ and claims that:

> Increasing dissatisfaction with conventional epistemologies, and the science founded upon them, is leading nurse theorists ever nearer to a postmodernist ‘antiphilosophical’ position.

Postmodern theorising on the social, historical and cultural constructions of knowledge are able to offer constructive insights into how that knowledge shapes, structures and limits, but also actively constructs alternative discourses (Lupton 1993), and in this way can be utilised in nursing. For nursing, in particular, the work of Foucault provides illuminating analysis for this project’s central themes

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26 For scholarship in nursing which is draws on postmodern theory, see for example Dzurec (1989); Dickson (1989); Parker (1991); Henderson (1994); Hickson and Holmes (1994); Parsons (1995); and Holmes (1995).
of power\knowledge, and supplies a framework to analyse issues central to this thesis. Foucault deconstructs and reconceptulises traditional models of power with an emphasis on the socially constructed nature of the meanings of health/illness. The dominant discourses of (male) science and (male) medicine have been instrumental in defining practice and the 'legitimate' forms of knowledge for nursing. In addition, these androcentric frameworks have been persuasive in ascribing and perpetuating the devaluing of caring work that is the basis of nursing. Moreover, such discourses have socially and politically constructed conceptions of women’s bodies that women, as health consumers, bring to their interactions in the health care context. Drawing on postmodern analyses for nursing projects paves the way for active reconstructions of nursing’s epistemological questions and answers.

**Michel Foucault: Knowledge and power**

Despite Giddens’ (1987:73) portent that ‘[s]tructuralism, and post-structuralism also are dead traditions of thought’, one of the most significant contributors to notions of power is Michel Foucault, the French intellectual associated with postmodernism. He made a significant contribution to postmodern thought through critiquing modernity and humanism and theorising on knowledge, power and discourses. Foucault offers a different conception of power from the traditions of sovereign power in his ‘concern with the history of scientific thought, the development of technologies of power and domination ...’ (Ball 1990:1). Foucault’s analysis of power abandons the view that power is unitary and coercive (Fox 1993). Foucault’s scholarship on power offers a fruitful approach for examining power relations. Contemporary sociology and, in particular, the sociology of the body, has drawn considerably on Foucauldian theory of power as it offers ‘... new post modern perspectives that interpret power as dispersed, indeterminate, heteromorphous, subjectless and productive, constituting individuals' bodies and identities’ (Best and Kellner 1991:49).

It is the concept of power and knowledge constituting bodies and identities that has attracted contemporary social theorists. As Grosz (1990:86) argues ‘[h]e does
not present a theory of power but develops a series of methods examining the
postmodernism as ‘...a term applied to a very loosely connected set of ideas about
meaning, the way in which meaning is made, the way it circulates amongst us, the
impact it has on human subjects and finally, the connections between meaning
and power’.

Postmodernists concern themselves with theorising between language,
subjectivity, social organisation and power, and the term postmodernism refers to
a range of theoretical positions developed in and from the works of Barthes,
Derrida, Lacan, Kristeva, Althusser, Foucault, and Irigaray (Weedon 1987:12;
Grosz 1990; and Kirby 1994). Kirby (1994:120) notes that ‘[a]s an intellectual
phenomenon postmodernism is a critique of Reason and examines the status of
what constitutes knowledge and the “knowing subject”’. These theories vary but
the central tenets revolve around analysing language, meaning, subjectivities,
power and knowledge. Central to these positions is the argument that language
constructs meanings and subjectivities which, in turn, are constructed by
particular knowledges. In addition, these knowledges are constructed and
reconstituted in certain socially and politically different ways in which dominant
forms construct a certain reality. Best and Kellner (1991:35) state:

Foucault’s project has been to write a ‘critique of
our historical era’. Which problematizes modern
forms of knowledge, rationality, social
institutions and subjectivity that seem given and
natural but in fact are contingent sociohistorical
constructs of power and domination.

Grosz (1990) separates Foucault’s works into two approaches: the earlier work, in
which he utilised his archaeological method of analysis and in which power was
considered as primarily repressive, and his later work in which his genealogical
method analyses power as ‘... a productive network of forces that make
connections, produce objects for knowledge, and utilises the effects of
knowledges’ (Grosz 1990:85). Grosz (1990:83–84) interprets Foucault’s notion of
power as one that sees power as creative and productive: ‘[p]ower creates
knowledges, methods and techniques, and this, for Foucault, is its major significance’. His historical essays have fundamentally been concerned with the human sciences, and a consistent theme in his writings is of power and knowledge and how this constructs our social existence. Best and Kellner (1991:68) assert that:

Undoubtedly one of the most valuable aspects of his work is to sensitise theorists to the pervasive operations of power and to highlight the problematic or suspicious aspects of rationality, knowledge, subjectivity, and the production of social norms. In richly detailed analyses, he demonstrates how power is woven into all aspects of social and personal life, pervading the schools, hospitals, prisons and social sciences.

Through his archaeological and genealogical methods of analysis, Foucault theorises on how the individual is shaped and dominated by discourses and practices of the major social institutions of the state such as the penal/medical/psychiatric institutions, and exposes the links between power, truth and knowledge. His works *Madness and Civilization* (1961), *Discipline and Punish* (1975) and the *History of Sexuality* (1976) are most often cited as examples of how power is exercised to shape and 'normalise' truths about human existence and, in particular, about the human body. Through these texts he presents analyses on the discourses of punishment, madness, medicine and sexuality in which the individual ‘... is interpreted not only as a discursive construct, but an effect of political technologies through which its very identity, desires, body and 'soul' are shaped and constituted’ (Best and Kellner 1991:47). To illustrate these ‘political technologies’ Foucault describes techniques and practices of power as microtechniques and develops the theme of the 'clinical gaze'. In order to present his position, Foucault describes techniques and practices as they developed from the late eighteenth century as institutions emerged to house the sick, the insane and the criminal.
It is Foucault's view that these techniques and practices or micropractices, most notably 'the gaze' are definitive of modern power (Fraser 1989:22). The gaze is used to describe the exercise of power through surveillance, in which knowledge gained by this surveillance is used to control and shape subjects. This microtechnique of power was described in detail by Foucault in relation to penal and psychiatric institutions and his descriptions of Bentham’s panopticon exemplifies this perspective. The conceptualisation of microtechniques of power is useful for viewing power relations in nursing. Such analyses diversified power to include not only top-down sovereign power, but also the ‘micropolitics’ of power. It can be used to explain how power is exercised at the everyday level in nursing.

**Power and knowledge regimes: The genealogy of modern power**

Sawicki (1988:163) contends that the main targets of Foucault's genealogies of power/knowledge are 'the grand theories of society, history and politics' and in particular 'liberal humanism and Marxism'. Foucault's reformulation of power relations rejects the notion of power as a unidirectional, repressive force that maintains elite social hierarchies (McNay 1994:90). According to Sawicki (1988:164) he repudiates liberalist and Marxist notions and critiques the ‘... juridico-discursive model of power consisting of the following basic assumptions:

(1) power is possessed, by the presocial individual, a class, a people; (2) power is centralised, in the law, the economy, the state; and (3) power is primarily repressive.

In addition, Sawicki (1988:164) provides a clear description of Foucauldian formulations of power relations that is useful to repeat in full. She claims the following:

In his own analysis, Foucault represented power as exercised rather than possessed, as decentralised rather than exercised from the top down, and as productive rather than repressive. Equipped with this model of power, Foucault was
able to focus on the power relations instead of the subjects related; to show how power relations at the micro level of society make possible global effects of domination such as class or patriarchal power, without taking these theoretical unities as its starting point; and give an account of how subjects are actually constituted through power relations.

Foucault names his analytical process as 'genealogy', whereby he reflects on the nature and development of modern power (Fraser 1989:19). This genealogical method is not a theory of power or history but an approach to critiquing and analysing established theories in terms of power effects. For Sawicki (1988:164) Foucault's analysis provides the following:

Power/knowledge presents a grid of analysis, not a theory of power or history. As such, Foucault's discourse on power attempts not to displace others but, rather, to get us to see them as material events with power effects.

**Problems with Foucault's theorisation of power**

There are however, some serious limitations to Foucault's analysis that must be addressed. It is important to critically assess the work of Foucault in order to appraise the strengths of his theoretical positions and assess some of the contradictions. Best and Kellner (1991) believe that Foucault's work has had a profound and valuable impact on the humanities and the social sciences, but they suggest a number of limitations to his work. Namely, '[h]is critique of modernity remains too one-sided in its focus on repressive forms of rationalisation and fails to delineate any progressive aspects of modernity'(p. 69); 'his analysis of the technologies of domination fails to present a rigorous and specific definition of the terms struggle, force relations, resistance and opposition'; (p. 70), for Foucault, '... power is mostly treated as an impersonal and anonymous force which is exercised apart from the actions and intentions of human subjects' (p.
70); and he addresses the ‘microlevel of resistance’ but fails to address the more
global and ‘macrostruggles’ (p. 70–71). In fact, for Best and Kellner (1991:72),

Foucault is beset by competing theoretical
commitments. He is a conflicted thinker whose
work oscillates between totalizing and
detotalizing impulses, discursive and bio-politics,
destroying the subject and resurrecting it,
assailing forms of domination but eschewing
normative language and metadiscourse.

Critiques of Foucault’s work come from other philosophers and theorists on
power, from feminist critiques of the phallocentrism of post-structuralist
discourses and to the malestream critiques of modernity. For example, Fraser
(1989) argues that he fails to address clearly certain issues in giving a value-
neutral account of modern power without utilising some normative framework to
guide political practice. For Fraser (1989:18–19) ‘[h]e tends to assume that his
account of modern power is both politically engaged and normatively neutral. At
the same time, he is unclear as to whether he suspends all normative notions or
only the liberal norms of legitimacy and illegitimacy’.

Another major criticism of Foucault’s work, which is of crucial interest to the
feminist framework of this project, is that it fails to explicate gender in the
production and reproduction of powerful bodies of knowledge. For feminists,
Foucault fails to identify that these very constructions are phallocentric, and that
alternative forms of knowledge, such as women’s knowledge, have been
essentially missing from the theorising of power and knowledge (Weedon 1987;
Grosz 1987 & 1990; Diamond & Quinby 1988; Martin 1988). In reference to
Derrida, Althusser and Foucault, Grosz (in Gunew 1990:100) argues that ‘[e]ach
has a certain blindness to the specificity of female subjectivity, the interests of
feminist theory and politics, and the concrete particularities of the (culturally
inscribed ) female body’. These are serious omissions for a project such as this,
whose central interest is the examination of women’s knowledge.
In addition, Clegg (1989:151) suggests that ‘... with post-structuralism there are evident dangers of a relapse into epistemological relativism, because of its tendency to dissolve all points of reference’. Dissolving all points of reference is a frequent concern of many postmodern critics, and in particular of radical feminists, who have highlighted the danger of removing the category ‘women’. Women is the crucial central reference point for radical feminist politics. In presenting power as continually shifting and circulating, all social relations are problematic. As Featherstone (1996:185) argues ‘[e]mphasing the shifting nature of power can obscure how often there are limits to the shifts and lead us to an unhelpful celebration of limitless possibilities’.

Another major problem of postmodern discourse is the language its proponents often use: the language of high theory (MacDonald 1990), in which the theoretical arguments and the language is often so dense, that understanding for most becomes difficult. The complexity of language often used in postmodern discourse leaves postmodernists open to charges of hypocrisy, given that they are exponents of uncovering the ‘taken for granted’, and thus emphasises the hegemonic nature of the grand narratives. Macdonald (1990:558), for instance, argues that ‘[t]he postmodernist call for opening up “discourse” to previously silenced voices represents a facile radicalism that masks a passion for conformity and exclusivity’. For nursing, Holmes (1995:365) cautions us ‘not to commit intellectual suicide in the name of postmodernist enquiry’.

**Foucault: Utility in health and illness**

Notwithstanding the critiques of Foucault’s theorising, there is a certain utility in his ideas for this thesis. Lupton (1993), for example, sees the positive contributions of Foucault. She argues that:

> [A]lthough Foucault and his followers have been taken to task for nihilistic ‘discourse determinism’ or for reducing the agency of social actors under the power of language, most social constructionist scholars nowadays argue for the possibility of resistance. That is, that individuals
do have the scope to step beyond the confines of dominant discourses, to oppose them actively and to construct alternative discourses (Lupton 1993:298).

It is Foucault’s later works, conceptualising power as a productive force and offering points of resistance, that have found utility here. For analyses in health and nursing in particular, it provides a framework for viewing the agency and proactive nature of nursing work within the complex and ever-changing health system. Grosz (1990:89), drawing on Foucauldian analysis of power, contends that:

[P]ower is not exterior to knowledge or to social relations, but is their condition of existence. Because power can be conceptualised as an everchanging grid with specific points of intensity, sites of greatest force, it can also be seen as a grid that necessarily generates points of resistance. This implies that knowledge’s, methods, procedures which at one time support forms of power, at another time or in a different context, can act as sites of resistance, struggle and change.

Overall, Foucault’s treatise on power/knowledge is highly regarded as a crucial contribution to the 'politics of truth' and the 'politics of the body' in philosophy, the humanities, the social sciences, feminist discourses, and more recently, in nursing. Many contemporary scholars in sociology and health have embraced postmodern theories for frameworks to address social organisation and social meanings in health.

Foucault postmodern analysis is useful to uncover the relations of knowledge production in health and illness and the type of knowledges produced. Foucauldian postmodernism, in particular, has been utilised in understanding and framing theorising on how the health care system operates, who has the power in the discourses of 'health and illness', who practises in health care, and conceptualisations of the body as a site of social, cultural, historical and political
existence. The utility of Foucault’s conceptualisations for this thesis is located in the view, described judiciously by Turney (1996:190): who states ‘... knowledge and the conditions of its possibility are caught up in forms of power which are constitutive of social relations. In this view, all social relations are power relations and power is shifting and fluid and thus technically available to all’.

The postmodern project challenges the idea of a single transcendent reality in which certain truths are privileged. In this challenge, postmodern theorists have questioned the very criteria by which truth and knowledge and hence power have been constructed. Foucault provides an analysis of power and knowledge relations with a focus on the development of institutions—schools, prisons, health facilities and the practices of health providers—to substantiate his arguments. His texts provide descriptions of the powerful nature of medicine as an institution of control that has relevance to this thesis.

Important also to this thesis is the nexus between power and knowledge. Through his analyses Foucault highlights the socially constructed nature of power/knowledge and is thus able to offer the view that there is always the potential for struggle and change. It is this framework that can contribute to an understanding of how nurses work and rework their practice and have the potential to influence others. However, the androcentricity of Foucault’s postmodern theorising and his failure to address the gendered nature of domination are deeply problematic. As Faith (1994:36) argues, ‘Foucault examines the dynamics through which power relations are engendered. He fails, however, to identify the centrality of gender in the power relations he analyses’. And ‘... his published work is conventionally androcentric, with only fleeting or incidental references to women’. Another serious failure of Foucault’s analysis of power is the ‘level of abstraction from experience’ (Ramazanaoglu 1993:1).

These criticisms necessitate an examination of other theoretical perspectives. In the following, I argue that feminist theorising can, in part, address the problems associated with Foucault’s conceptualisation of power. The point is not to replace
one with the other, or to solve the omission by adding ‘women’ and feminist theorising to the analysis, but to extend and utilise conceptualisations from each—postmodern and feminist theorising—for this project.

FEMINIST THEORISING ON POWER RELATIONS

The relationship between nursing and feminism has been an interesting one. Diverse opinions exist as to the nature and usefulness of the relationship: from feminists who see dangers in nursing as the ‘ultimate female ghetto’ of subservience to a dominant knowledge form (medicine), to nursing rejecting the radicalism of the feminist movement (Speedy 1987, 1988 and 1997). Nevertheless, critiques drawing on feminist frameworks have offered nursing ways to explore the biases of science, and particularly of medicine, from which so much nursing knowledge has sprung. De Marco, Campbell and Wuest (1993:31) argue that the ‘[f]eminist critique offers a means for nursing to remove the blinders of dominant culture and consider individual research studies and bodies of nursing knowledge for androcentric, ethnocentric, and class bias’. Furthermore, Hoffmann (1991:53) claims that ‘[w]hile it is true that feminism and nursing have had an uneasy relationship in nursing’s quest for identity, it is also true that feminist analyses of work, power, and gender offer rich potential for envisioning nursing’s future’. Embedded in the issues that nursing, feminism and feminist nursing scholarship identifies, are issues of power and control. Speedy (1988:49) claims ‘... feminism has a great deal to offer nursing, since it provides an analysis of the causes, dynamics and consequence of oppression’. Power permeates the settings in which nurses practise and the development of nursing knowledge.

Central to this thesis is the feminist consciousness of the researcher, which creates an explicit feminist lens, both theoretically and empirically. Operating from this world view, and considering the social context in which nursing has developed, an examination of feminist scholarship on power is crucial. In paying attention to the various forms of male domination, feminists have reviewed and critiqued
conceptualisations of power in order to redefine and reformulate power relations that reflect the experience of women (Oldersma & Davis 1991). For, as Featherstone (1996:184) claims,

The issue of power, particularly men’s power, has been central to feminist thought and practice. The position of women in the world is the result of asymmetrical power relations. Consequently, analyses of women’s lives are undertaken bearing that fundamental truth in mind.

However, to enter into an analysis of feminist theorising on power is to enter a complex and unresolved debate. A contemporary discussion of feminist perspectives requires acknowledgment of the diversity of positions from which some address and some do not specifically address power relations. ‘But as there are many and varied voices within feminism, so there are multiple contexts for the use of power’ (Radtke & Stam 1994:1). In general, analysis of power relations for feminist theorising is justified because it can offer useful insights into how dominant forms of power produce and reproduce certain social relations. Central to feminist theory (of different schools) is that social relations are, for women, structured by male power. The structures of society—economic, political, legal, religious, health systems, language—are constructed and reflect forms of male dominance that oppress women.

Feminist accounts of power are generally theorised as power over others and ‘when power is understood as a possession, the corollary is usually to juxtapose the powerful with the powerless’ (Hollway 1996:73). Hartsock (1984:6) argues that feminist theorising has in particular called to attention the genderedness of power. She draws attention to the connection of male theorising of power with sexuality and virility, citing Kissinger’s remark, ‘power is the ultimate aphrodisiac,’ as a case in point. Within feminist debates on power relations, whether theorised in relation to class, gender, sexual specificity or socio-economic status, feminists have assumed an exercise of power is an exercise in domination (Hartsock 1984). Contemporary feminist scholarship identifies a number of
distinct feminist positions, usually labelled as liberal, Marxist, radical, psychoanalytic, socialist, existentialist, cultural and postmodern. Each of these perspectives provides a different approach to explaining women’s oppression, and prescribes strategies for women’s liberation (Tong, 1989:1). In structuring the theoretical framework for this specific study on WHNs, to address each of these feminist positions in detail is neither appropriate nor desirable, as it is nursing, not feminist theory, that is under detailed examination. However, it will be argued in the following pages that there are important links between feminist theorising on relations of power and knowledge and the issues pertinent to this thesis.

Having identified that power/knowledge relations are pivotal to this project, I shall narrow the discussion to a more general focus on feminism’s theorising on power/knowledge relations to assist in understanding the work of WHNs. I will address only briefly the central tenets of the differing theoretical positions in order to assess the utility of the theorisation of power inherent in the varied perspectives for this project. I will also narrow the discussion to contemporary feminism, the origins of which can be traced back to the end of the eighteenth century to writers such as Mary Wollstonecraft (1759–1799). This is not to negate feminists from the fifteenth century through to important figures such as Aphra Benn (1640–89), and Mary Astell (1666–1731) in the seventeenth century (Bryson 1992), but delving deeper here would be a divergence, albeit interesting from the task at hand.

**Feminist approaches and power**

In reviewing the various feminisms for utility for this study, I argue below that insights from liberal feminism, Marxist and socialist feminism, psychoanalytic feminism and cultural feminism do not offer appropriate frameworks for

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27 For a detailed discussion of specific feminist positions, see texts such as Tong (1989), Bryson (1992), Kourany, Sterba, & Tong (1992), and Bell & Klein (1996). These texts provide in-depth discussions and critiques of the different feminist theoretical positions.
considering the central issues of this research, whilst the insights of radical feminism are useful.

Liberal feminism is invariably identified with early treatises by Mary Wollstonecraft, John Stuart Mill and his wife Harriet Taylor and, in the twentieth century, Betty Friedan, organisations in the United States such as the National Organisation for Women and, in Australia, the Women's Electoral Lobby. The thrust of liberal feminism developed alongside the development of the libertarian ideology of the notion of rational man and the utilitarian theories espoused by Locke and Rousseau. Liberal feminists have argued that women have the right to education, employment, political participation and full legal equality, and that the lack of civil rights and educational opportunities has been the cause of lack of involvement in public life (Bryson 1992; Tong 1989). Liberal feminists contend that if women were given the same civil rights and economic opportunities, in today's language—equal opportunity—then gender justice would be achieved. Thus, they do not analyse oppression/discrimination on the basis of (male) power difference. Central to the liberal philosophy is the principle of individualism and autonomy as being integral to human nature and, therefore, the belief that each person can make the best of his or her own life given the right opportunities. However, this fails to identify the significance for women of power relationships. As Bryson (1992:3) argues:

[...]liberal feminism concentrates on rights in the public sphere and does not analyse power relationships that may exist within the home or private life; it assumes that the justice of its cause will ensure its success and that men will have no reason to oppose it.

Critics would further suggest that, even with legalisation for equal pay and equal opportunity, sexual equality has not been achieved. Liberal feminism fails to address the genderedness of the major institutions of law, education, medicine and the family, and does not conceptualise these institutions as dominant power structures which exploit and oppress women. In addition, much criticism
identifies that liberal feminism has ignored the perspectives of colour and of social class (Bryson 1992; Tong 1989). Knowledge and power relations are fundamental to the oppression experienced by women of colour. By not specifically addressing power relationships, liberal feminism fails to offer an elucidating framework for this project.

Marxist and socialist feminism address women’s oppression as a product of political, social, and economic structures associated with capitalism (Tong 1989). The focus of Marxist and socialist feminism is an analysis based on economics and class structure and deals with power relations in terms of the exploitative relations of labour exchange. Derived from dissatisfaction with Marxist feminism as being gender blind (Tong 1989), socialist feminism’s main focus is on gender and class as the root of women’s oppression. Marxism does identify power relations as integral to capitalism, in fact it views ‘capitalism primarily as a system of exploitative power relations’ (Tong 1989:41). Bryson (1992:235) suggests, quoting Catharine MacKinnon’s often cited maxim ‘sexuality is to feminism what work is to Marxism’, that while both feminism and Marxism are concerned with analysing power to some extent, feminism is concerned with understanding sexuality and its exploitation, while Marxism focuses on work. Given that the locus of these two perspectives is class and gender rather than power per se, more detailed attention to these schools of feminism is not appropriate.

Feminists have engaged with psychoanalytic theory in order to reinterpret the psychoanalytic doctrines based on Freud’s work (Rowley & Grosz 1990). A well-known proponent of reconstructing psychoanalytic doctrines for women is Juliet Mitchell, who used a feminist perspective to reconsider Freud’s work as a way of understanding patriarchal social reproduction (Rowley & Grosz 1990). Central to psychoanalytic feminism is ‘the ways in which males and females acquire their socially ordained sexual roles and their correlative psychical attitudes and structures’ (Rowley & Grosz 1990:175). Thus, the focus of psychoanalytic feminism is reproduction and sexuality as the source of women’s oppression. The aim of such analyses is the reconstruction of sexuality through refuting biological
determinism. Hence, explicit theorisation of power/knowledge is secondary to an examination of sex roles.

Existentialist feminism is identified with Simone de Beauvoir, and her book, *The Second Sex* deserves its status as a classic in feminist thought. This text has 'helped many feminists understand the full significance of women's otherness' (Tong 1989:195) and is exemplified by de Beauvoir's (1972:16) famous statement:

She is defined and differentiated with reference to man and not he with reference to her; she is the incidental, the inessential as opposed to the essential. He is the subject, he is the Absolute—she is the other.

The focus of this theoretical position is based in the philosophical tradition of existentialism and the focus is on the ontological status of being human, and for de Beauvoir (1972) her analysis centred on the explanations of women's ontological being (Tong 1989:205)\(^{28}\). Her analysis is located very much in the traditions of the French radicals of the time and the debate draws on Marxist and Freudian theory. Given the philosophical nature of existentialist feminism's inquiry and the focus on the ontological status of women it is not used here.

Cultural feminism, a more contemporary perspective which developed in the second wave of feminist theorising and practice (Evans 1995), is based on developing and identifying a distinct women's culture. There is considerable controversy about this perspective from other feminist positions \(^{29}\), the concern being that this position leads to the dangerous path of essentialism. This approach, often joined wrongly to radical feminism (Lienert 1996; Raymond 1996), claims

\(^{28}\) See Tong (1989) and Bryson (1992) for a detailed examination and critical appraisal of the existentialist feminist theory of de Beauvoir.

\(^{29}\) See Bell and Klein (1996), in particular Richardson, Lienert, & Raymond's papers in section two, for analysis on the misrepresentations of radical feminism and the difference between cultural and radical feminist positions. Evans (1995) also provides two chapters on an analysis of cultural feminism.
an essential female nature, in which women’s capacity to nurture, to be more caring than men and to be naturally non violent is identified. Chinn (1995:269) describes cultural feminism as a view that

[C]elebrates rather than denigrates that which has been associated with being female in patriarchal cultures, and offers visions of transformation rooted in a concern for the social and psychological liberation of women that will ultimately benefit all.

In this way, cultural feminism asserts that there is indeed a difference between women and men. It rejects the usual feminist theorising on gender as a social construct, and maintains that women are different, that there is a gender difference, and emphasises the valuing of women’s characteristics and values that patriarchy has debased (Evans 1995). Interestingly, Chinn (1995:269) claims this position ‘struck a powerful chord’ with nursing scholars because it ‘... reflected values and traditions that had long been a part of nursing ideology but were not treated with respect in the mainstream cultural mores of systems in which nurses lived and worked’. For the analytical framework that I require, however, to view knowledge and power relations in the context of WHNs’ work, cultural feminism, with its locus on championing so-called women’s characteristics, neglects the substantial theorising of power needed for this project.

Each of the above ‘schools’ of feminist thought address the ‘women question’ in different ways, providing illuminating analysis of the complex reasons for women’s position in society. From this brief reading, however, with perhaps the exception of Marxist /socialist feminist theory, the above positions do not explicitly pay attention to analysing power as a phenomenon, and its relationship to knowledge, or the ways in which dominant power structures impact on, and exploit women economically, intellectually, physically, emotionally, and sexually. Marxist feminism’s focus on a socio-economic analysis of power attends to the ways in which capitalist society precludes women from reaching their full potential in the private and public world. Both Marxist and socialist feminism
address power relations as a consequence of capitalism and gender relations, whereas my interest here is the specific and explicit analyses of power and knowledge relations *vis à vis* women’s knowledge and practice. One ‘school’ of feminist theorisation that addresses power explicitly is radical feminism and it is to this perspective that the discussion will now turn.

**Radical feminism**

The key to radical feminism is male power. Bryson (1992:181) describes radical feminism thus:

> In the first place, it is essentially a theory of, by and for women; as such, it is based firmly in women’s own experience and perceptions and sees no need to compromise with existing political perspectives and agendas. Secondly, it sees the oppression of women as the most fundamental and universal form of domination, and its aim is to understand and end this; here patriarchy is a key term.

Radical feminist analysis of the oppression of women highlights the connections between the existence of male domination and power relations.

I will argue that *aspects* of radical feminism’s theoretical analysis on power/knowledge relations offers a useful framework for viewing the substantive issues in the research. Moreover, radical feminism’s attention to the connection between theory and practice, located in the experience of women’s lives, can serve to anchor the contextual nature and the principles that guide the work of WHNs. There are, however, some issues that need to be addressed in radical feminist theorising. Firstly, a reading of some radical feminist theorising portrays men’s power as a monolithic force—men posses power over women and that makes women’s agency and ability to transform social structure seemingly a daunting task. This traditional model of power conceptualises power as an individual possession in which there are the powerful (men) and powerless (women). For example, Hollway (1996:73) argues that:
A now frequent criticism of the use of such a model of power within feminism—even if implicit or unintentional—is that it tends to construe women as victims and hence lose sight of women’s own power.

Another legitimate issue that radical feminism has been called to address, is the charge of universalism, particularly with reference to class issues and women of colour. bell hooks (1984) maintains that:

Much feminist theory emerges from privileged women who live at the centre, whose perspectives on reality rarely include knowledge and awareness of the lives of women and men who live in the margin. As a consequence, feminist theory lacks wholeness, lacks the broad analysis that could encompass a variety of human experiences. Although feminist theorists are aware of the need to develop ideas and analysis that encompass a larger number of experiences, that serve to unify rather than to polarise, such theory is complex and slow in formation. At its most visionary, it will emerge from individuals who have knowledge of both margin and the centre.’ (hooks 1984: preface)

This is a frequent challenge to radical feminist theorising, and, as Richardson (1996:147) claims:

I would not want to claim that radical feminism has, in the past, dealt adequately with class, ethnic variation and racism, because I do not believe it has [my emphasis]

But, in radical feminism’s defence, Richardson (1996) maintains that no other form of feminism has done so either, and refutes the claim that positing the universal nature of patriarchal oppression ignores difference. She asserts that differences between women and the universalism of women’s oppression are two different issues. Richardson (1996:148) claims that these two issues are often wrongly joined together and confused in critiques of radical feminist explanations
of women’s oppression. She demonstrates that patriarchy is an important concept for theorising the ‘common and specific oppression of women’, and that radical feminism also recognises ‘difference’, and argues the following:

In offering accounts of women’s subordination most radical feminists are keenly aware of the need to theorise how and why patriarchal structures affect women differently according to, for instance, class, race, ethnicity and sexual identity.

While such charges are significant, another important point is Richardson’s (1996) comment ‘in the past’, as I would argue that contemporary radical feminist theorising is now addressing these issues.\(^{30}\)

**Radical feminism and power**

Radical feminism posits that men’s patriarchal power over women is the primary power relationship in human society (Bryson 1992:3). Thus, patriarchy and power become the defining features of women’s position in society. Unlike other feminist perspectives, this analysis is extended to all areas of life; for example, the major public institutions, the private sphere and the family. This position contends that women’s oppression cannot be abolished by economic and social changes alone. Through this analysis, radical feminist theorising has highlighted a variety of areas in which patriarchy has oppressed women. In general, the argument runs that this created ‘man’ and masculine knowledge as the norm. Thus, knowledge production, what counts as truth, is male defined, controlled and inherently imbued with masculine values and characteristics. In defining radical feminism Robyn Rowland and Renate Klein (1996:11) state:

The first and fundamental theme is that women as a social group are oppressed by men as a social group and that this oppression is the primary

\(^{30}\) The recent publication of Bell & Klein’s (1996) *Radically Speaking, Feminism Reclaimed*, provides a variety of papers on current radical feminist positions on these issues.
oppression for women. Patriarchy is the oppressing structure of male domination.

Radical feminism and women’s experience

Radical feminists have analysed many aspects of women’s existence, uncovering the deeply entrenched nature of patriarchal oppression. The system of patriarchy is expressed through creating, recreating and sustaining power over women in all spheres of life. In particular, issues related to reproduction, biological motherhood, gender and sexuality have been analysed, providing understandings of the personal and political nature of women’s oppression (Tong 1989). The crucial tenet of these analyses is that this oppression is located in the experience of women’s lives. As Robyn Rowland and Renate Klein (1996:9) state:

[R]adical feminism has concentrated on creating its theory in the writings of women’s lives and the political analysis of women’s oppression. ... [R]adical feminism creates an original political and social theory of women’s oppression, and strategies for ending that oppression which come from women’s lived experience.

Radical feminist theorisation is women-centred, beginning with women’s experience. One aspect of this analysis is that it has generated major innovative women-focused methodological and epistemological developments. In this process, the interdependence between theory and experience is identified as an essential feature (Rowland & Klein, 1996). Stressing the connection between theory and experience or practice, and emphasising the situated nature of women’s knowledge, is a common theme in radical feminist theorising. Likewise, a major theme in this thesis is the connection of theory and practice, the contextual nature of women’s knowledge, needs and nursing work. I will return to this important issue later in the discussion.
Radical feminism and nursing

As stated above, radical feminism has critiqued a broad range of issues to uncover the hegemonic nature of male power, and these issues are very relevant to health in general and to nursing specifically. For nursing, there are important links between radical feminist theorisation in the areas of clinical nursing practice and epistemological development. Cheek and Rudge (1995:312) also argue the following:

[T]he major impact of feminist approaches on nursing thought has emanated from the attempt to trace the effect of the exclusion of women’s knowledge from the essentially patriarchal arena of health care both on the production of nursing knowledge, and on the form of nursing practice.

The women’s health movement, developed from the general impetus of feminist criticism, and in particular from the activism of radical feminism, sought to develop an appropriate (women-centred) collection of knowledge about women’s bodies and to improve clinical care for women. Nursing took up this challenge and nurses have been involved in teaching women about their bodies and have been actively involved in creating change in the provision of women’s health. 31

Radical feminism and clinical nursing practice

Uncovering the biases and dangers in the way female bodies are viewed, controlled and constructed to serve men’s needs, in areas such as reproduction, contraception, abortion, child bearing, mothering and sexuality have been radical feminist projects. All of these issues have direct connections to nursing work in the practice settings and in knowledge development. The masculine perspective—reread as the medical perspective—has created a certain view of women’s emotional and physical nature in illness. ‘Medicine was founded on the model of

31 See the following articles which highlight the involvement of nursing in the feminist and in the women’s health movement: Webb (1986); Gillette (1988);
the male body, with women as ‘other’ (Harrison 1993:62). This view underpinned much of nursing’s clinical education. As Delacour and Short (1993:45) claim ‘[m]edical discourse is accepted uncritically, in the main, by the nursing profession. This has important implications for discourse and practice’. Moreover, they argue:

Medical discourse is ideologically significant, containing many important political statements about women, and the web of discourses which ensnare women within medical discourses represent a colonization of women’s bodies and lives (Delacour and Short 1992:54).

Critiques from radical feminism have provided an analysis of the ways in which women’s health care was practised clinically to the detriment of women’s health, and offer alternative views for nursing. Macpherson (1991:32) argues that nursing scholarship has taken up a radical feminist analysis and applied it to caring and nursing. Citing nursing work, from Connors (1980) and Lovell (1986), Macpherson (1991:32) states: ‘[h]rough address medical dominance, the silencing of nursing, medicine as iatrogenic, and the abusive care of women by physicians’. Through this deconstruction, nursing practitioners have been able to identify problems with the ‘malestream’ nature of the health system and actively work to change them. In the areas of midwifery, community health and women’s health, nurses have been active in reconstructing women’s health care and providing women-centred health care that focuses on a wellness model of health as distinct from an illness model so prevalent in health care systems.

Radical feminism has maintained the importance of starting from women’s experience for theoretical development and has criticised the notion of objectivity versus subjectivity. One focus of this aspect of radical feminist analysis has been friendships and the connected nature of women’s relationships. Likewise, in nursing, the significance of the therapeutic nature of the nurse–patient relationship

has been an important theme (May 1992a & b, 1995; Taylor 1995). Calling for a valuing of subjectivity and women’s ways of knowing, feminism provides an analysis useful to clinical nursing in recognising ‘... the nurse and the client are both embodied people ...’ and nursing ‘... contains subjective and intuitive elements which are at least as valuable as objective and technical elements’ (Horsfall 1996:353). For nursing, the philosophy of the caring relationship is, in part, based on a connected, patient-centred perspective and involvement in interpersonal relationships, a stance that masculine culture has not valued. Radical feminism supplies a framework for nursing to analyse and further develop scholarship on the therapeutic relationship of nurses and clients. It is in this way that perspectives from radical feminism provide links for nursing’s commitment to the contextual and engaged nature of nursing work.

Radical feminism and theory development in nursing

There is considerable scholarship in nursing in the areas of methodology and epistemology reflecting radical feminist principles. MacPherson (1991:31–2) reviews radical feminist theorising in relation to nursing and claims that it provides a ‘lens’ through which to view medicine as yet another patriarchal system that plays a major role in the oppression of women. Moreover, she argues that radical feminist analysis can ‘... help nurses and other health care workers become aware of the deficiencies in the health delivery system’. In addition, she highlights that radical feminists have established rape crisis centres, and women’s shelters, and points out that nurses can play important roles in recognising and assisting abused women (MacPherson 1991:31–2). Another contribution that Macpherson (1991:33) argues radical feminism can make to caring and nursing is through addressing nurses’ relationships with each other, and their relationships with doctors, and through this analysis and critique important insights into caring, friendships, horizontal violence and domination may be uncovered. Sandra

32 See Lovell (1986); Chinn (1991, 1995); and MacPherson (1991). Also see authors such as DeMarco, Cambell and Wuest (1993); and Webb (1984,1986,1993) for discussions on feminist research methodology and nursing.
Speedy (1988:49), an Australian nurse scholar, advocates that feminist theory in its various forms can provide a useful contribution to nursing practice. Christine Webb (1984 & 1993) also promotes the usefulness of feminist methodological approaches reflecting radical feminist positions for nursing and women’s health research, and claims the following:

[In the case of nursing and women’s health a feminist perspective offers opportunities for mutual consciousness-raising for working together to challenge male medical control over these aspects of women’s lives (Webb 1984:249).]

Drawing on radical feminist research methodology provides nursing with innovative and creative ways of further developing appropriate nursing research methodologies, which not only recognise the male bias inherent in traditional research, but also the contextual and situated nature of nursing and health care provision. In framing the analysis of male power, radical feminists articulate various structures that maintain the oppression of women, and the institution of the family is identified as a ‘central part of society’s power structure’ (Bryson 1992:198). Nursing has further developed this critique, drawing on a radical feminist perspective in which ‘... the medical profession is seen as yet another system which conforms to the patriarchal pattern established by the modern family’ (MacPherson 1991:31). In this analysis, the doctor (father) runs the family (health care services), made up of the nurse (mother) and the patient (child). In this way the male doctors have been able to control health in several ways. First, by shaping what actually constitutes disease and treatments and structurally shaping health care provision financially and through promoting the illness model in health. Second, by controlling practice, research, and knowledge development in some spheres of nursing, and third, by controlling patients. This analysis provides critical insights for nursing to understand the structural and epistemological issues confronting nursing and thus contributes to challenge and change this situation for nursing and, more importantly, for patients.

33 See and Muff (1982) and Fee (1983) for a more detailed analysis of the patriarchal pattern of the family in health care and nursing.
Radical feminism’s theoretical challenge to and reconstruction of women’s health, along with the practical activism of the women’s health movement, has provided links for nursing. Nursing continues to address practice and health care issues with the aid of radical feminist theorisation of patriarchal and power relations.

Radical feminist scholarship has identified power as the key to women’s oppression. Through the power relations of patriarchal structures, men have been able to create what counts as knowledge and, equally, knowledge determines who has power. Davis (1994:175-176) identifies this point in radical feminist theorising and claims the matter of knowledge and power has been given a great deal of attention by radical feminism. Drawing on Catharine MacKinnon’s scholarship she states:

Traditionally knowledge has been seen as power: to have knowledge is potentially to have access to a form of power. Those who know can use their knowledge to their own ends. More recent thought on this matter, including that of radical feminist and postmodernists of all varieties, suggests that the inverse is also the case: that the conditions of what counts as ‘knowledge’ are in fact determined by relations of power. The structures and institutions which control society determine what is ‘true’ and what is not. What feminists have pointed out, often in conjunction with detailed explanations of the forms of male power and the ways in which the (male) culture defines women, is that the definitions we occupy are socially (not biologically) male, and that this is related to the empirical fact that men have power over women. It is men who traditionally have taken the position of ‘knowers’, and one of the things men have ‘known’ is women. (Davis 1994:175–76).

The analysis of power by radical feminists attends to the broad structures of oppression between men and women (Davis 1994:218). By claiming the universal nature of women’s oppression, radical feminism has been criticised for creating a ‘false universalism’ (Rowland & Klein 1996:18). This point has been
debated at length in feminist and non-feminist scholarship, but this charge is defended by Rowland & Klein (1996:18) recently, when they argue that:

Indeed radical feminism does see the oppression of women as universal, crossing race and culture boundaries, as well as those of class and other delineating structures such as sexuality, age and physical ability. Radical feminism makes no apologies for that ... We have been accused of ignoring difference—of being indifferent to difference. Yet radical feminism has always welcomed and acknowledged the diversity of women, while stressing our commonality.

In support of their position they cite the works of many radical feminists and show the common, world-wide oppression of women in areas of illiteracy, work, pornography, sexual slavery and violence, and identify works that address differences in class, race, and sexual preference amongst women.34 Thus, radical feminism is able to support strong arguments that attest to the broad and universal nature of male power and knowledge relations in society while also claiming attention to difference.

Radical feminism: Utility in nursing

Through reviewing radical feminist theorisation of power and knowledge I would argue that analyses from this ‘school of feminism’ have great relevance to projects that deal with nursing. For nursing, its location as a significantly feminised occupation has been affected by male historical, cultural and structural forces. As well consequential power/knowledge relations have enscribed nursing’s knowledge and practice. The restrictions on nursing flowing from these forces have been felt universally. Hence, addressing the gender-based inequities in society has a certain resonance for nursing, and applying a broad analysis from

34 See Bell & Klein’s (1996) Radically Speaking Feminism Reclaimed, and in particular papers by Richardson, Lienert, Rowland & Klein, and Raymonds on the charges of universalism.
radical feminisms to the nature of these power/knowledge relations is useful for interpreting these issues for the discipline.

Equally, however, it is important to view the local and specific power/knowledge relations that enscribe nursing practice. There are many accounts of the agency of nursing in creating a challenge to, and managing change within, patriarchal society. Nursing has been a significant agent of social change, and has managed to address many of the inequities in nursing, and in the delivery of health care. Borrowing on the notion of difference that feminist theory addresses, ‘nursing’ can be theorised simultaneously as a universal concept, with commonalities across countries and indeed the world, but, also conceptualised as diverse. There exist, in nursing, many diverse specialities, realities and, consequently, distinctive issues for practitioners. Nurses work in many different contexts and the relations of power and knowledge vary to the extent that these contexts are oppressive or emancipatory.

To theorise this aspect of nursing requires an additional conceptualisation of the ubiquity of male power. This does not require the dismissal of radical feminist theorisations of power/knowledge, but a recognition that certain aspects are useful, and must be held on to, while it is necessary to reflect on other conceptualisations that in addition can interpret the phenomenon of local power in nursing.

Before I develop this argument further, I wish to add a caveat. I am not suggesting for one moment that radical feminism has not operated at a local level or addressed power relations between men and women in very concrete ways. Indeed much of the activism and immense social change in women’s health can be attributed to radical feminism. The connection between theory and practice and the notion of the ‘personal is the political’ is, of course, fundamental to radical feminist theory and practice. But, for the purposes of this specific phase of the project, I am looking for theoretical understandings that best assist in conceptualising the phenomenon of power/knowledge relations at local sites of activity in nursing.
Thus, to move from the universal view of power/knowledge to understanding the local view, any theoretical framework for nursing research must attend to the specificities of context, and the actual, or potential for change and action. This requires, in my assessment, a conception of power/knowledge at the micro-level of social relations that is ‘... multiple not monolithic, and in its multiplicity provides different expressions of power can contradict each other and offer openings for change’ (Hollway 1996:73). Hence such a conceptualisation of power is seen as contextual, productive and available to the seemingly powerless. Conceptualisations of power/knowledge in this form are closely associated with postmodern theorisation.

Earlier in the chapter I dealt with Foucault’s conception of power and knowledge which highlights the productive and multiple sites of power. This theorisation is useful for conceptualising power/knowledge, but was found to be wanting on various other counts. Of particular concern to this project’s central focus of examining women’s knowledge was, first, the gender blindness of Foucault’s constructions of power, and second, the problem of postmodernism’s technique of removing all reference points, of deconstructing ‘women’ right out of the picture (Ramazanoglu 1993). Third, in positing such a diffuse view of power, there is a potential to fall into relativist pits of limitless possibilities. Finally, the high level of abstraction away from women’s experiences is a concern to any feminist project. These problems with Foucault’s analysis led to an examination of feminist theorisation of power. I have argued that of the varied perspectives available, radical feminist theorisation of power holds the most utility for this project.

A comprehensive theoretical framework is required to address the universal nature of gendered power/knowledge relations and to conceptualise specific sites of productive, agentive power in the micro-social relations of nursing work. As will be argued below, feminist postmodern perspectives provide a gendered analysis of
power/knowledge relations in conjunction with highlighting the diffuse and changing nature of these relations.

**Feminist and postmodern theory**

In striving to construct new positions, feminist theorists have adapted, critically assessed and borrowed from other theories. In the quest to move beyond critique and begin constructing feminist theories of knowledge, Gunew (1990:25) argues that, ‘the central paradox in this area is the question of where feminist knowledge should situate itself, from where does it derive an authority or legitimacy which is not constructed by the prevailing structures of knowledge?’ One answer can be found in Grosz’s (1990:60) argument that:

[F]eminist theory need not commit itself to the values and assumptions governing patriarchal knowledge, but in order to go beyond them, it must work through them, understand them, displace them in order to create a space of its own, a space designed and inhabited by women, capable of expressing their interests and values.

One theory that has been utilised in this way is postmodern theory, and developed further as feminist postmodern theory to challenge the monolithic and universal theories of patriarchy. Hekman (1990:1) claims that:

Both feminism and postmodernism challenge the epistemological foundations of western thought and argue that the epistemology that is definitive of enlightenment humanism, if not all of western philosophy, is fundamentally misconceived.

The usefulness of postmodernism has been identified as being able to uncover how knowledge is socially, culturally, historically and politically shaped. Grosz (1990:61) claims that the examination of the French postmodern theorists by feminists has been important for two major reasons. First, because they have been so influential in the development of analyses related to theories of subjectivity and power in the twentieth century, and second, because they have been so influential
in the further development of feminist theory. The adoption of the French theorists by feminists has been instrumental in highlighting the social construction of knowledge which has been useful in 'deconstructing' patriarchal claims of 'truths' and universal knowledge. As stated at the beginning of this chapter, although postmodernist thought is located in a range of disciplines and authors, I have selected the work of Foucault specifically, for his insightful analyses in the area of health, illness and power/knowledge relations. Consequently, the following discussion will focus on the connection between Foucault and feminist approaches.

In the convergence of feminism and postmodern theories, Diamond and Quinby (1988:x) propose that '[b]y respecting differences without seeking absorption or dialectical synthesis, feminism and Foucauldian analyses can interact with each other to create dialogical rather than monological descriptions'. They identify four ways in which feminism and Foucault intersect. These four convergences are:

Both identify the body as the site of power, that is, as the locus of domination through which the docility is accomplished and subjectivity constituted. Both point to the local and intimate operations of power rather than focusing exclusively on the supreme power of the state. Both bring to the fore the crucial role of discourse in its capacity to produce and sustain hegemonic power and emphasise the challenges contained within marginalised and/or unrecognised discourse. And both criticize the ways in which Western humanism has privileged the experience of the Western masculine elite as it proclaims universals about truth, freedom, and human nature (Diamond & Quinby 1988:x).

A central goal of feminist theorising is to challenge patriarchal knowledge and create strategies and theories that expose both the hegemonic nature of male knowledge and reconstruct theories that represent women's interests. For Weedon (1987:40) a feminist poststructuralist position is ‘... a mode of knowledge production which uses poststructuralist theories of language, subjectivity, social
processes and institutions to understand existing power relations and to identify areas and strategies for change.

**Relations of power and knowledge and the body**

Theorising the body and identifying the body as a site of power and resistance are important to feminist issues of exploitation, sexual assault, pornography, and reproduction and offer theoretical frameworks for discussion. However, as Grosz (1990:92) notes, Foucault did not identify the ‘... sexual particularity of bodies, and the implications of this for understanding regimes and technologies of power. Male and female bodies may well entail two different forms of control, modes of knowledge and forms of resistance’. Further into her debate in *Contemporary Theories of Power and Subjectivity* Grosz (1990:107) claims ‘[p]ower inscribes male and female bodies in quite different ways, with different goals and consequences. The body is not a sexually neutral or indifferent, pliable, flesh; it is a body that is sexually concrete ...’. Feminist postmodern debates have taken postmodernism further and addressed this most salient issue; the sexed nature of power/knowledge.

Female bodies have been a focal point of discussion and political activity for feminists. Allen and Grosz (1987:vii) argue that feminists have been ambivalent about the female body because, on the one hand it has been identified as a source of women's oppression. In trying to overcome this limitation, feminists have tried to 'degenderise' and neutralise women's bodies and concentrate on the mind, strategically placing 'the body' outside feminist concerns. On the other hand, the female body has been central to the feminist movement, with concerns about sexual exploitation and reproductive issues (Allen and Grosz 1987:vii). In her discussion of a feminist philosophy of the body, Gatens (in Caine, Grosz, & de Lepervanche 1988:59) raises the question of the relation between a woman's body and the state, as feminist campaigns have often been in conflict with the state and the church. She argues that in order to develop a coherent theory of the body, the relation between women's bodies and the body politic must be addressed. In addition, drawing on anti-humanist, postmodern and antibiological determinist
perspectives, Gatens (in Caine, Grosz, & de Lepervanche 1988:62) proposes that we should be asking ‘how does culture construct the body so that it is understood as a biological given?’ Gatens’ (1988) premise is that women have been seen as nature itself, relegated to the private and family spheres, missing from public and state matters. This has rendered women passive in public spheres, missing from the body politic, and mute in the political and social arena, except as a corporeal ‘natural’ reproductive resource. Moreover, women’s bodies were seen as hysterical, dysfunctional and passionately dangerous, and biologically unsuitable for political participation. In contrast, male bodies were seen as rational, concrete, with the mind being able to dominate the body. Thus, male corporeality is seen as appropriate for social, political and ethical participation in the body politic.

Postmodern feminists have redressed the sexed nature of power/knowledge. They argue that in analysing how power is constructed, how it operates and how it is reproduced through the technologies and instruments of power/knowledge, many male postmodern theorists fail to acknowledge that these techniques are sexed. The punishing, supervising, and knowing nature of knowledge/power creates a gendered specificity that produces male and female bodies (Grosz, in Gunew (ed.) 1990).

Notwithstanding the tensions from the different positions, as identified previously, approaches from both can provide new insights. Eckerman (1994:92), for example, states, in relation to addressing women’s specific experiences of health:

I argue that postmodern and post-structural analyses along with sociology of the body have provided invaluable tools for understanding gendered experiences of health and illness. I put forward the thesis that feminism, postmodernism and the sociology of the body are mutually constitutive.

Although severely criticised by radical feminism (see Bell & Klien 1996 for an analysis of postmodernism and feminism) postmodern feminism has further
developed notions of difference and has challenged the perspective of the unitary view of 'woman' and provided a lens to view the often contradictory nature of women's lives (Cheek and Rudge 1995). Contrary to some radical feminist scholarship (see Bell & Klein 1996), postmodern feminists assert that unpacking categories about women and binary oppositions in language can be useful in exposing systems of domination that are constructed through language (Davies 1994; Cheek and Rudge 1995). Language is the carrier of knowledge and meanings and the 'power' of the maleness of language in constructing and legitimising social meanings and experience is paramount in postmodern feminist theories. Central to these formulations are revealing the power relations embedded in language and knowledge and exposing the socially constructed nature of such 'truths'. By fracturing these discourses, postmodern feminists are able to go beyond uncovering male power to create new formulations. In joining feminist and postmodern analyses in this way, this perspective allows for multiplicity of truths as well as locating the focus in women’s lived experience.

For nursing, there are several aspects of postmodern feminist analyses that can be readily utilised. First, challenging the notion of unitary woman. The view of the essential nature of women and the concomitant values and freedom that this has deemed for women is replicated in nursing. Nursing can borrow from this conceptualisation and challenge the view of the universal nature of nurses and nursing practice (Cheek and Rudge 1995). As claimed previously, nursing is a very diverse activity, experienced differently depending on context. Second, the focus on the connections between language and power/knowledge can help nurses understand how and why nursing struggles, because of its location in powerful male systems of health and illness.

Analysing gender, sex, bodies, and language, and so providing alternative views of power and highlighting shifting multiple realities, has given openings to evaluate some of the vexed issues in feminist analysis of essentialism and biological reductionism. Equally, it has raised the problem of the fragmentation of the category 'women', so important to feminist politics. However, I would still
argue that drawing on aspects of each has the potential to provide creative ways to be helpful to women-centred epistemological questions. This project is about nursing and women and power and knowledge. To engage in an examination of nursing, it is necessary to consider the socio-political context in which nursing takes place and in which women experience health care. Feminist postmodern theory addresses some of the gaps that Foucault’s conceptualisations omit and, as claimed by Doering (1992:25), ‘[t]wo philosophies, feminism and postmodernism, are particularly relevant to nursing because they incorporate the concepts of the female experience and of power’.

Conclusion

Chapters 1, 2 and 3 have described the context of the research and have raised central issues relevant to the work of WHNs. Several dominant discourses have shaped the development of nursing work, and fundamental to those discourses, are power and knowledge relations. This led to a review of theories about power and knowledge from Foucauldian and feminist perspectives in this chapter (4). During this process I held the following statement by Ann Daniel (1993:6) close at hand. As she states:

In all research the business of theorising continues before throughout and after the empirical enquiries are finished. It is essential to begin with a theoretical perspective, a way of ordering and interpreting what is found. But research is an exploration and theory must be held lightly and discarded or revised according to what is discovered.

With this in mind, reflecting on the analysis thus far, and holding on to the belief that theoretical eclecticism is necessary to address the complex nature of the issues at hand, I contend that each perspective I have reviewed only provides a partial framework. Accordingly, aspects from each will be drawn upon in framing and interpreting this research.
In summary, various tenets from the theoretical perspectives reviewed are adopted for this thesis. In particular, from Foucault’s analysis—his conceptualisations of the diffuse and circulating nature of power, in which it is conceived as a productive force available to all at the micro level of social relations—has the potential to be useful in making sense of the diversity and varied nature of meanings in nursing work. Notably, it can provide a way of viewing agency and proactive practice in nursing work that hitherto has been silenced.

Radical feminism’s theorisation of power and women’s knowledge also provides an illuminating framework, given that nursing is a predominantly female occupation located in a health system that is dominated by masculine values. In addressing the biases of patriarchal knowledge forms, radical feminism provides a corrective lens through which to view the case of nursing which is hampered by comparisons with male knowledge forms such as biomedical science. In addition, radical feminism’s attention to a women-centred analysis, in which women’s experience is the starting point, has connections for this study. The position adopted here is that starting from the practice, experience and actions of nurses has the potential to generate and highlight the knowledge embedded in those practices. Through connecting the ‘lived experience’ with theory, radical feminism balances the postmodern tendency to abstract relativism.

Finally, feminist and postmodern perspectives provide a framework for viewing nursing questions through making connections between the sexed nature of power, and identifying the multiple and fluid nature of discourses that shape and reshape social relations. Identifying the sexed nature of social relations in conjunction with a postmodern analysis of power is a useful framework for a feminised profession such as nursing. Thus, as is argued in this chapter, aspects from these theoretical perspectives offer insights for issues in health work and nursing; accordingly, connections will be made, in the discussions to follow, between these theoretical positions and the experiences of WHNs.
A key theme throughout the analysis thus far is uncovering the knowledge embedded in the practices of WHNs. The next stage of the research requires a methodological approach commensurate with the central themes of women, nursing, power and knowledge. Integrating theory and practice is a fundamental feminist position and, likewise, the relationship between theory and practice is an important perspective in nursing’s epistemology. Feminist methodology offers a link between theory and practise and positions ‘women’ and women’s knowledge as central to the methodological processes. Therefore the next chapter (5) will explore feminist methodology and argue that it provides an appropriate methodological framework for examining the work of WHNs.
CHAPTER FIVE: METHODOLOGY

INTRODUCTION

This chapter first outlines the theoretical approach utilised to gather and analyse the data. Second, it introduces the research design, methods of collection and analysis of the data. A feminist framework was employed to guide the design, the collection of data and the subsequent analysis of the material gathered. There has been much discussion as to what identifies a distinctly feminist approach to research (see Harding 1987, 1991; Reinharz 1992; Stanley & Wise 1983 & 1993), and the debates highlight the diversity of the epistemological and methodological issues and methods used in feminist projects. Consequently, discussions on feminist research are located in the realm of debates on epistemology and methodology and it is these debates that this chapter will address.

A guiding structure for this debate is borrowed from Harding (1987:2–3), who distinguishes between epistemology, methodology and method. She argues:

epistemology:

Is a theory of knowledge. It answers questions about who can be a ‘knower’ (can women?); what tests beliefs must pass in order to be legitimated as knowledge (only tests against men’s experience and observations?); what kinds of things can be known (can ‘subjective truths’ count as knowledge ?) ...

methodology:

Is a theory and analysis of how research does or should proceed; it includes accounts of how "the general structure of theory finds its application in particular scientific disciplines" ...

method:

Is a technique for (or a way of proceeding in) gathering evidence.
FEMINIST EPISODEMOLOGY AND METHODOLOGY

There are some common epistemological and methodological characteristics of feminist approaches to research which emphasise the subjective, contextual, relational and women-centered nature of feminist inquiry (Allan 1994:529). The feminist 'lens' adopted in this thesis necessitates particular approaches that integrate feminist epistemological positions of women as knowers (in this case nurses as knowers) drawn from their experience of the world (in the context of women's health care). The following discussion introduces the central tenets that shape feminist approaches to research and presents the particular research design used here.

The purpose of this study is to generate a detailed analysis of WHNs' work and to develop a theoretical analysis of that work within the socio-political context of health services related to the provision of cervical cancer screening services. In order to place the research process in a framework that is commensurate with the theoretical issues raised earlier in the study, I will summarise the theoretical and conceptual issues that underpin the study:

- nursing takes place in a socio-political health care system which generates and reproduces particular structures and meanings;
- these structures and meanings are gendered and imbued with knowledge and power relations that create and recreate those structures and meanings;
- WHNs possess a unique body of practical knowledge and clinical wisdom that has not been documented or explored in relation to dominant relations of power/knowledge within the health care system;
- feminist theorising and feminist knowledge constructs provide useful frameworks for examining nursing questions grounded in practice;
- postmodern and radical feminist theories are useful for examining nursing projects because together they incorporate the concepts of female experience located in the every day and the power/knowledge relations that enscribe those relations; and
female experience and power/knowledge relations are integral to nursing experiences.

Given the above theoretical issues that have shaped the project, feminist research processes, combined with feminist thematic analyses, are utilised to gather the empirical evidence and analyse the data. To substantiate the particular choice of research methodology, this chapter will present arguments which support the view that, in order to explore and analyse the experiences of WHNs, and to examine their professional expertise in the context of women's health provision, an approach that offers a women-centred epistemology and a women centred methodology is a useful framework. The epistemological and methodological perspectives that have driven this phase of the project are discussed below.

Feminist research and nursing

There are many feminist connections in the social and political ways that we experience nursing, caring and life. Feminist research methodologies offer a means of analysing substantive concerns in nursing. Much of nursing 'herstory' has been defined in relation to other disciplines which, in the main, have been androcentric frameworks. Feminist theory and the derivative feminist methodological positions offer nursing an opportunity to 're-theorise' frameworks that complement the core values of nursing and assist in uncovering and developing ontological and epistemological concerns for the discipline.

Research methodologies that value other patterns of knowing (other than traditional scientific frameworks) and encompass a stronger integration of theory and practice are suited for nursing issues. Nursing has invested a substantial amount of scholarship in debating the integration of practice and theory, and theory and practice.\textsuperscript{35} A feminist framework values and connects practice (as a

\textsuperscript{35} The theory–practice debate is ongoing in nursing scholarship; the key issues debated usually centre on the vexed issue of balance and utility in theory to guide and interpret practice and the need for practice to inform theory in a practice discipline such as nursing. See discussions such as Brown (1987); Kikuchi and
form of experience) and theory as a way of interpreting practice. For, as Goldfarb (1991:1617) claims:

[...]

Feminist approaches enable us to integrate the contextual nature of the social and emotional aspects of wellness and illness and, in so doing, provides a relevant framework for nursing.

**Feminist epistemology**

There are important connections between feminist epistemology and methodology, and some will be addressed here. Hence it is appropriate to provide an overview of central questions that feminist epistemology addresses and to concentrate on the methodological underpinnings that arise from these feminist positions. Feminists have critically engaged with mainstream epistemology to deconstruct and reconstruct assumptions of who can be the knower. For example Harding (1987:3) argues:

Feminists have argued that traditional epistemologies, whether intentionally or unintentionally, systematically exclude the possibility that women could be ‘knowers’ or *agents of knowledge*; they claim that the voice is a masculine one; that history is written from only the point of view of men (of dominant class and race); that the subject of a traditional sociological sentence is always assumed to be a man. They have proposed alternative theories of knowledge that legitimate women as knowers.

Simmons (1992) and Tolley (1995). Tolley’s article provides a review of the key issues in this debate and cites many of the key nursing authors who have engaged in this discussion.
Thus, feminists have asked, can there be distinct feminist perspectives on epistemology, metaphysics and philosophy of science? These debates have generated alternative theories of knowledge that legitimate women as knowers (Harding 1987). It is also important to note that contemporary feminist debates have highlighted concerns about the 'politics of difference'. That is, having problematised the concepts of 'universal man' and 'universal truths' as having constructed universal accounts of knowledge, feminist theorising must also concern itself with the different positions of women (i.e. black, lesbian, third world) and remember that '[n]o theorists, not even feminist ones, are neutral, apolitical, ahistorical, or classless' (Gunew 1990:26). The traditional (malestream) theories of knowledge are premised on a set of dichotomies male/female, mind/body objective/subjective, public/private, theory/practice, that privileges the first category over the second. The oppositional, exclusionary, and fixed nature of these dichotomies has underpinned the social and structural oppression in the western world. These distinctions have validated certain knowledge paradigms as authoritative, and a particular case, surely, is that of the physical sciences. For, as Code (1991:31–2) claims:

Epistemologists commonly evaluate knowledge per se according to its success in approximating the methodological and epistemological criteria of the physical sciences. Implicit in the veneration of objectivity central to scientific practice is the conviction that objects of knowledge are separate from knowers and investigators and that they remain separate and unchanged throughout investigative, information-gathering, and knowledge-construction processes.

In the past, nursing has readily accepted the authority and epistemological status of science in general and medicine in particular. This has had major implications for the construction of nursing's epistemological foundations and is of interest to this project.

One particular issue that the feminist critique of knowledge has addressed is the privileging of the objective/subjective category, as it pertains to knowledge
production and women’s experience. A central feature of feminist analysis of epistemological concerns is the false nature of the dichotomy of the objective/subjective. In traditional philosophy, this distinction is rendered as an 'epistemic discrimination' (Dalmiy and Alcoff 1993:217) in which:

The ideals of rationality and objectivity that have guided and inspired theorists of knowledge throughout the history of western philosophy have been constructed through processes of excluding the attributes and experiences commonly associated with femaleness ... (Code 1993:21).

If we can refute (and I maintain there is enough scholarship to defend this position) the privileging of objective knowledge and claim that subjective knowledge should have at least equal status with objective knowledge, then analyses need to proceed that address this epistemic distinction, and highlight that the '... distinction has the effect of discrediting putative claims to knowledge that fall outside the purview of a narrowly stipulated scope of the term, for which knowledge properly so-called must transcend the particularities of experience' (Code 1991:223). The interplay of the particularities of experience or practice, and theorising from that experience, are of central importance to this project. Another dimension closely associated with subjectivity is the notion of 'context' in its broadest sense (racial, ethnic, class, age, socio-historical). How this constructs knowledge has also been addressed by feminist epistemological scholarship. Feminist postmodern scholarship has enriched the analyses by highlighting the ways in which language and the relations of power and knowledge impact on conceptualisations of subjectivities.

Feminist theorising on epistemology has raised questions about the nature of knowledge itself, epistemic agency, justification, objectivity, the politics of knowledge, and the impact on the social status and the sexed body of the knower upon the production of knowledge (Alcoff & Potter 1993:1–2). Code (1991:70) summarises such analyses in the following:
The point of the questions is to discover how subjective and objective conditions together produce knowledge, values and epistemology. It is neither to reject objectivity nor glorify subjectivity in its stead. Knowledge is neither value-free nor value-neutral; the processes that produce it are themselves value-laden; and these values are open to evaluation. The evaluative process is not a simple one, because there is no external vantage point from which to engage in it. An epistemologist has to devise ways of positioning and repositioning herself within the structures she analyzes, to untangle the values at work within them and to assess their implications. Feminists working in epistemology need to develop critical, analytical techniques that can break the thrall of an unworkable conception of objectivity, and to articulate viable, empowering epistemic imperatives and strategies.

**Feminist methodology**

Feminist methodology, drawing on feminist epistemology, is central to the methodological framework that has shaped this research. If one is operating out of a feminist consciousness, then that consciousness or world view will be reflected in the conceptualizations and implementation of one's research study (Hedin and Duffy, 1991:227).

Feminist methodology refers to a theory and analysis of how the research should proceed (see Harding 1987:3). It concerns itself with epistemology, ethics and methods in a dynamic reflexive dialectical relationship. The epistemological stances of feminisms guides the methodological stances. There are many different feminist positions and each is situated in a different theoretical analysis (equality, class, gender etc.) of the 'woman question(s)'. However, there are some shared concepts which underpin feminist research projects:

- a valuing of women and validation of women's experience, ideas and needs;
• a recognition of the existence of the ideological, structural and
interpersonal conditions that oppress women; and
• a desire to bring about social change of the oppressive constraints through
criticisms and political action (Hall and Stevens 1991:17).

What is important to remember is that there is not one or the correct feminist
methodology. The variety of feminist methodologies is reflected in the variety of
epistemic orientations in feminisms. Such positions espouse different rationales
for women's oppression; i.e. class, gender. Methods will also differ in relation to
the specific nature of the research projects undertaken (Klein 1983:89). However,
certain features appear across the methodological positions. Feminist
methodologies challenge the privileging of rationality and objectivity in
scientific research. Ramazanoglu (1992:210) states that ‘Feminist methodologies
are then new ways of knowing and of seeking 'truths', but they are also forms of
political commitment to the empowerment of women’. Feminist methodology has
a reflexive relationship with the designated epistemological positions and
provides important critiques highlighting that the very definition of a problem or
issues to be researched is shaped by 'situated' knowledges which have been (are)
predominantly androcentric. Feminist research as conceived here, considers the
research questions, the research methodologies and the methods as political and
emancipatory.

Feminist methodology is distinguished by certain features, and the following
concepts and features have been borrowed, synthesised and adapted from various
texts about feminist research scholarship\textsuperscript{36} for this research project. These are
discussed below.

\textsuperscript{36} The concepts and features of feminist research methodology for this project
have been drawn from the following scholarship: Mies (1983) & Klein (1983);
Thompson (1992); Reinhart (ed.) (1992); Stanley & Wise (1983); Hedin, & Duffy
Feminist research should be based on feminist theory
This feature draws on ontological and epistemological feminist scholarship and has been integrated throughout the whole thesis.

Women's experiences are central and contextually grounded, viewed as a starting point for knowledge production
This feature is composed from the ontological and the epistemological perspectives of feminist theory, and draws from standpoint theory. Women are the central reference point in the analysis and the research process. Women’s experience, subjectivity and contextually-grounded experience is valued as a way of producing knowledge. Theorising from experience is central to feminist projects. Goldfarb (1991:1614) states that:

These experiences are then questioned, probed, examined, explored, and analyzed, a process that produces tentative theoretical conceptions. Once formulated, these theories are continually held up to the light of new experiences for evaluation, refinement, modification, and development. In short, feminist thinkers view concrete situations as containing strong theoretical potentialities. Theory then circles back to guide future behavioural choices which, in turn, test and reshape theory.

In this way, the research process considers the socio-political position and diversity of women’s lives. This feature of feminist research (and theory) is often charged with being essentialist. This is countered in feminist scholarship by arguments documenting the exclusion of women in research and knowledge development and thus the need to hear women’s perspective to balance the omissions. Moreover, feminist research uses reflexive processes in the research methods to highlight the partiality of experience and validates the research through identifying subjectivity, the local and contextual nature of experience,

37 See Harding (1987) and Smith (1990 & 1992)
diversity and the socially constructed nature of experience (Seuffert 1994). Seuffert (1994:81), drawing on Katherine Bartlett argues that this ‘positionality’ is an epistemological stance, recognising situated knowledges. She argues the following:

Positionality recognises that experience can reveal new understandings of current perceptions from women’s positions of exclusion. It also recognises that both experiences and the resulting knowledges are situated and partial, and that the relationships of the "knower" provide the location for meaning, identity and political commitment. Experience is therefore retained as a useful category and basis for knowledge, but is coupled with the insight that the knowledge thus obtained is limited by context, and never assumed as a monolithic category.

This feature has given rise to many innovations in feminist research methods. A variety of methods are used in designing feminist research. In particular, the use of stories and narratives of women’s lives have been utilised to gather material in feminist projects. Once the experience is ‘gathered’, feminist research processes theorise on from that experience to produce knowledge. Likewise, in this research study focusing on the oral traditions of nurses, interviews were the primary source of data.

**Feminist research emphasises a non-exploitative relationship between researcher and researched, which is based on collaboration, co-operation and mutual respect**

This is a key methodological feature of feminist research and requires engagement in collaborative research strategies. Careful consideration is given to the ‘power’ in the research relationship and in the research process, strategies are employed to equalise the interactions with researcher and researched. This has given rise to
reflexive research models, checking data with participants for congruence and validation and incorporating mutual exchanges in the research relationship.\textsuperscript{38}

**Feminist research recognises the open presence of the researcher as intrinsic to the process; the research process is to be one of learning and self-reflection for all participants**

This feature is interwoven with the above and identifies the researcher within the research process. It challenges traditional methodological frameworks of objectivity and reliability. In feminist research, the notion of objectivity is displaced and rigorous attention and systematic documentation and accounting of the research ‘trail’ provides rigour and validity to the research. Thus, situating the researcher and highlighting their role in the process is implemented in feminist enquiry.\textsuperscript{39}

**Consideration about the use of data, control of, and ownership of the material and consideration of the collective interests of women and recognition of the political nature of research**

This feature requires attention to the writing, reporting, publishing, and authorship of research. A central question asked in feminist enquiry in support of the epistemological and methodological commitments is—have the voices of women been heard and does the research serve the interests of women?

**Ethics**

The ethics of the research as a whole and ethical considerations for individual participants is given careful consideration in feminist projects. This methodological premise requires not only formal institutional ethical research approval but that consideration is given to the ethics of establishing and


\textsuperscript{39} Hall & Stevens (1991) provide a detailed account of features of feminist methodological frameworks and develop concepts to demonstrate rigor in feminist studies.
maintaining the research relationships, leaving the research relationship and, finally, the outcomes of research.

Thus, the epistemological and methodological features of feminist research processes provide distinctive conceptualisations and features for feminist research. The data collection requires a constant interplay between the epistemological and the methodological issues. This section will recount the background, the principles and the approach used to collect and analyse the data in this study.

**Shaping the approach to capturing voice**

Drawing on the epistemological framework described earlier, certain values shaped the research design. Two principles in particular, drawn from the epistemological framework, informed the method of data collection. These were the notions of capturing the WHN’s 'voice', and in so doing, capturing the grounded everyday experience of the WHN participants and exchanging and responding to them (if necessary) as co-participants. To 'uphold' these principles it was decided to utilise face-to-face interviews, using a semi-structured or focused interview approach. Such an approach offered direct personal contact (important for establishing research relationships), the opportunity to focus some questions (i.e. demographic and clinical technical questions), and the scope to have open-ended questions to elicit further and full descriptions as directed by the participants. Interviews were constructed to encourage them to talk about their experiences, feelings, opinions, knowledge constructs and issues of practice related to the provision of cervical cancer screening.

The questions were devised with the methodological principles previously mentioned in mind as the guiding framework, and in light of the theoretical concerns raised in chapters 2 and 3 (These are summarised again on page 96). I set about developing the semi-structured interview questions using these principles and keeping in mind that '[a]s researchers our primary goal is to link the empirical and the theoretical—to use theory to make sense of evidence and to
use evidence to sharpen and redefine theory' (Ragin & Becker 1992:224). I reviewed my theoretical discussions and considered my 'informal' discussion with WHNs and developed a series of questions with a duration of one hour to explore practice, professional and theoretical issues with the WHN participants. During this time I applied for, and was granted, approval through the Deakin University Ethics Committee. Interviews were taped, to ensure accurate representation of the semi-structured interview questions and to provide quotes and qualitative material for data analysis, interpretation and description. Although language as a descriptor of the 'voice' of experience was central to the project, I decided not to fully transcribe each interview because I was not intending to do a conversational or a linguistic analysis. The completed interviews, supplemented by notes and tapes, form the basis for thematic analysis and theoretical interpretations.

**Voices and co-participation**

The premise of the study is located in conceptual and theoretical analyses of nursing and feminist theories of power and knowledge. Central to the epistemological focus of the project is an exploration of the voices/experiences of WHNs in the context of the provision of cervical cancer screening. The application of 'voices' in this context implies using 'voice' for more than describing a point of view; it is using the metaphor of voice to depict women's preference for speaking their epistemologies (Belenky, Clinchy, Goldberger and Tarule 1986). In addition, in keeping with feminist approaches now well documented and debated in research scholarship (see Oakley 1981; Reinharz 1992, 1990; Stanley & Wise 1983, 1993 ), I wished to put 'feminist politics into practice' and design a research interview schedule that first, allowed rich descriptions of nurses' work (women's voice) and second was able to respond in kind, and exchange 'conversation' and knowledge if required. Feminist research methodologies locate women describing their experience and theorising from that experience as a central tenet. Utilising an oral method to collect data fits well with nursing, since oral traditions are strong in the nursing community. We apply story telling/narratives/conversations in everyday practice when we hand over at clients’ bedsides, report at shift changes, reports in client care conferences, and
hand over to colleagues. We often employ talking as a way of grappling with the complexities and tensions that face us in our care giving. Tapping into the oral culture of nursing as a way of theorising about nursing is a methodology increasingly evident in health research. For example Street (1992:269) in her critical ethnography of clinical nursing practice claims:

My personal experiences of taping oral conversations with nurses for analysis and reflection demonstrated the sophistication of their skills of memory, description, and analysis. Although these women were not confident of their skills of writing about nursing practices I found that they were highly articulate concerning their views about themselves, their nursing practices, and nursing issues.

For nursing, oral traditions have been the dominant form by which our knowledge and practice issues have been transferred and offer a way of communicating and making sense of our practice world and creating and recreating meaning. Language, although shaped and mediated by social and cultural experience (Wuest 1994:579), represents our 'knowing', and shapes and creates our knowing. Moreover, as suggested by Lather (1991:111) 'language is seen both as a carrier and creator of a culture's epistemological codes'. The use of 'voices' has been the common mode of shaping, creating meaning and transferring meaning within the nursing culture. It is, as Walker (1995:160) suggests, that clinical discourses in nursing 'which shape[s] how we think into how we actually act as nurses. have remained largely untheorised until recently'. Moreover, in some nursing contexts, it has not been an authoritative voice, or a voice that others have valued when considering descriptions of nursing work or in relation to theorising about nursing. In addition, commitment to feminist methodology suggests doing research with women as opposed to on women (Klein 1983), and so I wanted to give consideration to the power in the research relationship and to locate myself in the research process.
Situating the researcher

The extent to which the researcher participates in her/his research varies in degree and to the extent that their own story is told alongside and/or affects their interpretations. In this instance I am not a practising WHN, my story as a nurse is not part of the data, but I have been involved in the WHNs’ committee activities and have been a participant in the ongoing development of inservices and professional issues forums for WHNs. However, in this research project, I committed myself to the following strategies in the research design in order to close the gap between researcher and participant:

- direct face-to-face interviews;
- full explanation prior to meeting, through phone consultation;
- utilising feminist processes at:
  - onset of interview—explanation;
  - during—engaged with, open to questions discussion; and
  - after—closure and contact after.

In addition; I made a commitment to giving each participant a summarised version of the final project with particular details related to WHNs’ work.

The interview questions

Having decided how I would go about it I developed a semi-structured interview schedule with fifty-three questions. After developing the schedule I consulted with a group of WHNs at a committee meeting of the WHNs Association. I presented the questions to this group for verification of salient issues and presented what I thought needed exploring in relation to the opening questions (see chapter 1). The group endorsed the questions. The questions covered the following concepts and theoretical issues:

- How are WHNs affected as a particular occupational group in relation to constructs such as gender, knowledge, and power in the health system?
- what are the theoretical and practice constructs utilised by women’s health nurses?
• do WHNs operate from specific knowledge and professional constructs and why?
• what are the experiences of WHNs in operationalising their professional expertise in the socio-political context of the current health care culture?
• why and how do WHNs develop specific models of care and professional practice?
• what are the major professional issues for WHNs?
• what is the relationship between the policy process and practice outcomes in the context of WHNs work?

Questions were piloted with ten WHNs chosen randomly from the list of available participants. Some clarification and relevance issues were tightened up. In addition I interviewed four people who worked for government agencies responsible for policy, program development and education provision for the Pap Test Victoria program. These interviews were conducted to provide background information and to ascertain the historical development of the nurse based programs.

From the ten pilot interviews, the interview schedule was restructured (see appendix B). This enabled responses to be coded on semi-structured questions whilst also allowing for open-ended elaboration. Sessions were taped and interviews took about one hour to each to complete.

Recruitment strategies

In the next two WHNA newsletters I provided information and requests for participation in an interview with WHN practitioners. One of the major hurdles was the lack of available information and co-ordination as to how many nurse practitioners were practising cervical cancer screening (CCS). I discovered that some who had done the training were not currently practising, and a decision was made to include those practitioners, and to ascertain why they were not practising CCS. In addition, the Anti-Cancer Council Pap Test Victoria program offered to
mail a request to participate in the research to those practitioners who had done Pap Test Victoria program training. Nurse practitioners were interviewed from three different demographic areas: rural, provincial and metropolitan. The participants were recruited through the following strategies:

- from the WHNA newsletter with some nurses contacting me directly;
- through WHNs indicating on renewal of membership of the WHNA that I could contact them;
- from a mail-out in conjunction with the ACC of Victoria to WHNs, in which I provided a self-addressed envelope requesting permission to contact them;
- presentations by me at two inservices attended by WHN practitioners, asking for participants; and
- during interviews through asking them to suggest other participants.

There is no reliable data available on how many nurse practitioners have done a Pap test provision courses and who was currently practising, during this research project. It was therefore impossible to establish the total population; it was, however, estimated that 79 nurses had been trained to do Pap tests at the time of data collection (ACC 1995). It should be noted that not all of those trained would be practicing. Through the recruitment strategies previously outlined I was able to organise 50 interviews.

**ANALYSIS**

**Method**

Three approaches to analysis and interpretation of the data were utilised. For the demographic and structured questions, Excel descriptive statistics analysis was used to organise and analyse the data after all the interviews had been completed. For the data from the open-ended responses, a form of thematic analysis was used, that I would describe as feminist thematic analysis. Designating the analysis
'feminist' is a deliberate fusing together of epistemological and methodological notions of feminist theory and the technical analytic procedures of data analysis. This approach to data analysis serves to critically reveal the meaning and ideologies under the surface of the interviews. Thematic analysis refers to a subjective and interpretive process in which themes/categories are designated from the narrative of the interview (Kellehear 1993:38–39). The process utilised in this project adapted an approach suggested by Kellehear (1993:40) drawing on Miles and Huberman (1984:215–30) in which I set about:

- counting, looking for repetition, recurring events/experiences/topics;
- noting themes, patterns—looking for underlying similarities between experiences;
- checking to see if single variables/events/experiences were really several;
- connecting particular events to general ones;
- noting differences and similarities;
- noting triggering, connecting or mediating variables;
- noting if patterns in the data resembled theories / concepts;
- noting clustered patterns and themes;
- noting compacted patterns and reviewed patterns; and
- constructing thematic categories from data.

The wider epistemological and methodological orientations which underpin the feminist analytic stance taken here will invariably shape the interpretations. Thus, the fusing of the conceptual and technical combine a systematic process within a theoretical position. It emphasises that a critical position has been taken in that this interpretation of nurses’ work highlights gender/race/class and the gendered meanings of health/power in relationships/experience as valid knowledge.
Describing and interpreting voices

The feminist/thematic analysis activity began early on in the interviewing process. The first step of the feminist/thematic analysis occurred after the pilot study in which responses were synthesised (this included checking with the participants and rechecking on the tapes that these constructs or labels represented what they said) of the first eight interviews into thematic categories. Emergent themes were identified through recurring phrases and common accounts as described by the participants and segments of these responses were summarised into smaller sets of patterns. A form of descriptive/pattern coding (see Miles and Huberman 1994:56–70) on the responses was utilised and responses were divided up into concrete patterns related to demographic data and conceptual patterns related to the more narrative responses. The interview schedule was formatted to include these categories on the hard copy and to further streamline the interviews. During and after the interviews, responses were matched with these categories. This process served to organise the material from the interviews and provided the foundation for 'deeper analysis' after the completion of all interviews.

For the rest of the interviews open ended questions were asked and an effort was made to ensure that participants responded in their own terms. During and after each interview coding was revised. Incidental categories appeared during this process, but to borrow from grounded theory, 'saturation'\textsuperscript{40} was reached early on, however I continued with the interviews in order to build a rich and 'thick' data base.

\textsuperscript{40} Grounded theory is a methodological approach to research that involves the generation of theory, and is associated with the authors Glasser and Strauss (1967). The term saturation refers to a technique during data analysis in which, through constant comparisons across the data sets, the categories or concepts inherent in the data are deemed to be offering no new information or characteristics and therefore have reached 'saturation'. See Glasser and Strauss (1967) and Field & Morse (1985) for details on grounded theory.
In addition, during the field work, after the interviews (often in the car before I set off home) I would write down ideas, interesting points or field notes in a book. In between the interviews I would write up thoughts and interpretations; sometimes these were related to the data or to the reading that I was doing or they were simply ideas that everyday living triggered off and which I thought had some connection to this work. The 'writing it down' and 'writing it up' procedure I implemented was similar to the approach described by Catherine Garret (1993:16) in her thesis. She describes 'writing it down' as the process of formulating the questions, recording taped conversations and taking field notes, and 'writing it up' as the process of analysis and interpretation.

From the data, two systems or levels emerged as the inductive analysis took place. During this phase of the analysis Patton’s (1990:390) work on indigenous and sensitizing concepts was a useful framework for organising the data. First, the categories/conceptualisations articulated by the participants are described as indigenous concepts. In this way, certain terms and concepts could be highlighted that had shared meaning for the practitioners and which emerged frequently from the participants’ interviews. Second, categories/patterns or concepts that the analyst brings to the data are described as sensitizing concepts. As I reflected on the interviews, my frame of reference and theories shaped what I saw/heard in the interviews and the notion of sensitizing concepts provided a framework for interpreting these emerging concepts from the data.

Along the way, I conferred with participants and particularly with the WHN committee, in relation to these interpretations and descriptions and this further verified and clarified the developing thematic analysis. At one of the inservices held by the WHNA, I reported on the 'state' of the projects’ analysis and some developing ideas and asked for feedback.
The final check was completed after all interviews were done and I listened to each tape and referred to the schedule and field notes to add or revise categories. During this process I took extensive notes to record key concepts that were emerging and the 'rich' descriptions from participants as they described specific issues and responses. After completing all the interviews, an Excel spreadsheet was used to systematically organise responses from each participant to indicate specific responses and complete descriptive statistics on the demographic and closed question data. The final analysis and interpretation of the more descriptive data, using an inductive feminist/thematic approach further classified the information into meaningful categories and an analysis was performed to further clarify the constructs, themes and meanings that emerged from the data.

Throughout, and at the end of the analysis phase of the research, questions of interpretation were considered, such as, whose voice is speaking here? Will I represent the data authentically? It is these questions that the next section addresses.

**Questions of interpretation**

The dilemma of any researcher who has gathered narratives through the interview process is the management of a vast quantity of rich descriptive data, and more particularly, the selection of descriptions to support discussions and theorising. The problem of decontextualising respondents' 'voices' needs to be addressed when selecting excerpts. The narratives of each respondent told interwoven, multiple, and integrated stories, in which experiences did not occur in isolation but were told as incorporating many rich layers of issues. These narratives were also shaped and mediated by the interpretations of the 'teller'. I was conscious throughout the process, when reviewing the data when listening to each tape, and then reflecting on all of the tapes, that I gathered a sense of the 'whole' picture, but that the respondents' 'quotes' that I used are only partial representations of the
full descriptions. To manage the potential decontextualisation that renders interpretations ‘false’ I have ‘conceived and authored the text itself’ with a ‘... critical eye toward ‘what is’ attending seriously to local meanings, changes over time, dominant frames, and contextual contradictions’ (Fine 1994:23). However, it should be noted that above all, this is a construction of stories that were told to me and is shaped by the ‘partiality of any one interpretative frame’ (Fine 1994:26). It is neither possible nor appropriate to include every respondent’s comments related to the particular themes. Thus I have included selected excerpts to illustrate and provide insights for the reader on the theme discussed. The overall themes were chosen on the basis of a pattern of frequency and consistency in the participants’ descriptions that gradually built a ‘picture’ of a thematic construct. To summarise, the process of analysis and interpretation utilised is represented below:

**Data collection**
- written interview schedule;
- interview tapes;
- field notes; and
- reflective notes.

**Process of analysis**
- counting, looking for repetition, recurring events/experiences/topics;
- noting themes, patterns—looking for underlying similarities between experiences;
- checking to see whether single variables/events/experiences are really several;
- connecting particular events to general ones;
- noting differences and similarities;
- noting triggering, connecting or mediating variables;
- noting whether patterns in the data resemble theories/concepts;
- clustering of patterns and themes;
- compacting patterns/themes and reviewing patterns/themes;
reflecting on data patterns and themes;
constructing themes;
utilising computer spreadsheet and descriptive statistics.

**Process of interpretation**

- reviewing thematic constructs;
- clarifying themes with participants;
- reviewing themes with data sets;
- exploring relationships with themes and theory;
- critically reviewing thematic categories and theories;
- building links with themes and theory;
- reviewing other theory;
- proposing new constructs and new theoretical propositions.

Interpretations from qualitative data require a different approach from quantitative explanation. Patton (1990:424) suggests:

> It is important to understand that the interpretive explanation of qualitative analysis does not yield knowledge in the same sense as quantitative explanation. The emphasis is on illumination, understanding, and extrapolation rather than causal determination, prediction and generalisation.

Adopting a position similar to the one described by Patton (1990:424) above, an understanding and illumination of the practice issues faced by nurses will be developed in the following chapters.

**Conclusion**

Throughout this project I have endeavoured to engage in a critical reflexive process with the theoretical material, the discussions with the participants, and my own standpoint as the researcher. The interpretive phase highlights the critical nexus of the link between the empirical 'evidence' and the interpretations of the researcher. Holland and Ramazanoglu (1994:125) remind us that:
Feminist researchers have made a major contribution to critical reflection on the research process, but deciding whether, or how, we can arrive at authoritative conclusions about the nature of other people’s experiences remains a problem.

This problem remains a tension throughout this research. Thus, to minimise queries of validity (from the participants’ point of view and from that of providing ‘good’ research methodologically), and to clarify how it is that I have come to the conclusions offered, I have endeavoured to institute a number of systematic processes that are fundamental to the interpretive process and the claims made. This chapter and the ones to follow, document explicit details of the methodological process and present the epistemological position underpinning the project as a whole. The adopted methodological and epistemological positions are constant companions to this process and were not merely engaged in at specific points in the research process. In particular, the use and stance of the legitimacy of ‘experience’ of WHNs as a basis for empirical material and theorising for research is valued in this position. The concerns with the use of experience dealt with earlier in chapter 4 (see section on radical feminism) and in this chapter, in further support of the use of experience, Stanley (1991:208) offers this astute comment:

>[P]eople theorise from their own experience—unlike, presumably, quasars and amino acids; and so researchers of the social are faced with an already ‘first order’ theorised material social reality. Thus criticism that ‘feminist methodology is atheoretical because it is concerned with experience derives from a complete misunderstanding of what is meant by the term ‘experience’ . This is not—for anyone—a morass of unformed inchoate sensation: people observe, categorise, analyze, reach conclusions—which is exactly what theory is.

However, attention must be also be given to using theories to interpret and explain experience. As Maynard (1994:23) suggests:
Although women’s experience may constitute a starting point for the production of feminist knowledge, it is not sufficient for understanding the processes and practices through which this is organised.

To be sufficient, consideration must be given to making connections between theory and experience, to ‘use theory to make sense of experience’ and ‘this is an interpretive and synthesising process which connects experience to understanding’ (Maynard 1994:24). In addition, I have engaged in reflexive and critical reflection of the interview data, in part to make explicit the distinction between the participants’ experiences and the place of interpretation made by the researcher. The distinction made in the introduction of this thesis between research with and on women is particularly relevant here, for the phase of interpretation presented in the following pages is a combination of with and on. Holland and Ramazanoglu (1994:133) provide useful comments on the ideas and processes that underpin the interpretations of the work of WHNs:

We cannot read meaning in interview texts, allowing them to pose their own meanings, without also reading into them, as we make sense of their meanings. Feminist researchers can only try to explain the grounds on which selective interpretations have been made by making explicit the process of decision-making which produces the interpretations, and the logic of method on which these decisions are based. This entails acknowledging complexity and contradiction which may be beyond the interpreter’s experience, and recognising the possibility of silences and absence in their data.

In addition, I have ‘relocated’ some of the data, disconnecting the chronological form of the interview schedule, to provide ‘hard’ data to support the thematic development. Although the themes were spawned from the data as a ‘collective narrative’, the open-ended questions (represented in questions 19–33, see appendix B) either generated, or further established, the themes in greater detail.
Furthermore, the themes are discussed in relation to discourses highlighted in chapters 2, 3 and 4 that affect the practice of WHNs. Three conceptual threads emerge throughout the discussions: one focuses on nursing practice as a distinct process, with its own distinct epistemological base rather than in relation to ‘other’ knowledge forms; another describes the medical restriction and opposition as experienced by this group of nurses, but also of their resistance to medical opposition. The third theme apparent from the interviews, was the description of the alternative discourses evident in nursing work, and focused on notions of professionalism and autonomy from the point of view of WHNs. It is upon these themes that the discussions in the following chapters is based.
CHAPTER SIX: ANALYSES AND INTERPRETATIONS

INTRODUCTION

This section will present material gathered from the 50 interviews and was organised from the conceptual categories that emerged from the interviews, or from material that was addressed by specific questions generated from the theoretical development of the study. It is presented and further analysed in the following chapters.

Once all the interviews were completed and systematically coded through the use of computer programs, the material was then reviewed as collective narratives of ‘voices’ of nurses describing their practice, and was subjected to an interpretive process in which constructs, meanings and themes were identified. (The process of analysing and interpreting this data set was described in detail in chapter 5). This chapter will present a profile of the nurses, describe the groups’ demographics, and why they are involved in women’s health practice.

The next three chapters (7, 8 and 9) will detail the three distinct thematic categories that emerged from the nurses’ discussions. The themes of Nursing Praxis, Restriction and Resistance, and Beyond Resistance: Nurses, Professionalism and Autonomy were woven throughout the rich descriptions of practice as told by the participants during the interviews. Each theme incorporates several related constructs. Chapter 10 will draw together the material presented in these three thematic chapters, reflecting on the theoretical and practice issues raised throughout the thesis.

PRESENTING THE 'VOICES'—DEscribing THE PARTICIPANTS

This chapter will present a collective ‘occupational biography’ of the participants. The profile of these women as nurses illustrates an experienced group of health practitioners, with many years grounded in clinical nursing practice, working in a
variety of settings in rural, regional and metropolitan Victoria. The participants were recruited through the various strategies, described in chapter 5. After which an interview took place. The interviews, with the field notes, provide extremely rich data on the practice and issues of Women’s Health Nurses (WHNs).

The profile of the participants, using collated information from the interviews, gives a detailed ‘picture’ of the nurse participants and their work. Using the demographic information gathered from each participant and drawing on responses from both the closed and open questions (1–19 in Appendix B), this chapter is presented as a foundation to chapters 7, 8 and 9 in which the ‘voices’ of the nurses have been organised into three thematic categories mentioned above. Capturing and analysing descriptive accounts of nursing practice is seen, in this thesis, as the basis for theorising about nursing work and health service delivery. Mapping the experiences (voices/practices) of these nurses will demonstrate the rich knowledge forms that are embedded in clinical nursing practice. Explicating, describing, analysing, and theorising from nursing practice knowledge provides one of the central theoretical themes: theorising from experience/voice and so mapping alternative discourses. Thus, one of the analytic goals is to describe nursing actions and to theorise from those descriptions. Drawing on the feminist positions that underpin this research, the methodology embraces experience as described by the voices of the WHNs as providing theoretical potentialities. In suggesting the following, Street (1992:89) articulates the use of describing nursing practice as a way of charting theoretical constructs from practice:

Nursing actions are dialectically related to nursing knowledge. This dialectic relationship represents the continual interchange between the practices engaged in by nurses and the particular forms of knowledge in which these practices are embedded and by which they are informed and transformed.

Furthermore, the methodology provides a structure whereby nurses can engage in the research through the use of the strong oral culture of nursing. Women’s use of conversation and oral recounting of their world of work or everyday lives is well
documented in feminist and nursing circles as a valuable and legitimate way of constructing and transforming knowledge (Oakley 1981; Street 1992; Klein 1983; Lather 1991; Chinn 1995). Indeed Walker (1995:157) argues that, in the ‘twilight of modernity’, nursing must be theorised as an oral culture in which narratives of nursing practice provide a technology of research as nurses are able to provide detailed descriptions and complex analysis of nursing practice in oral forms. This research embraces nurses’ ‘voices’ as a medium for articulating theoretical conceptions about health service delivery and nursing.

THE WOMEN’S HEALTH NURSES: THE SAMPLE

Age.

All 50 participants were women, with 43 (86%) aged between 30 and 49 years of age, 2 of the participants (4%) were aged between 18 and 29 years of age and 5 (10%) were aged between 50 and 59 years of age. As can be seen from figure 1, the majority of participants are between 30 to 49 years of age.

![Age groups diagram]

**Figure 1: Participants age groups**

**Years of practice**

Collectively, the nurses had many years of experience as illustrated in figure 2 below. 19 (38%) of them had been working in nursing for between 20 and 29
years; 15 (30%) of them had worked as nurses for between 15 to 19 years; 10 (20%) had worked for between 10 to 14 years as nurses. Only 3 (6%) were relatively ‘new’ practitioners, having practised between 4–9 years, and 3 (6%) were very experienced practitioners who had worked as a nurses for between 30 and 39 years.

![Years of practice chart]

**Figure 2: Years of practice**

The profile of years of practice experience has shaped the nurses’ approaches to work and their philosophy of practice. This approach will be described further during the analyses and discussion. The philosophy that underpinned the practice of many of the nurses is encapsulated by this comment by one of the participants:

*I feel as though—I’m a well prepared, highly skilled practitioner—I am valuable in the workplace, and I become very cross when people don’t recognise that—it’s not only my years of service, but also the efforts that I’ve made, to ensure that I can provide the best possible service for the community I work in. And that’s quite a conscious thing from my point of view.*
Qualifications

The depth and breath of experience of these nurses is reflected not only in their years of practice but in the formal qualifications they have gained over those years, as is demonstrated in the chart following (figure 3).

![Nurses' qualifications chart]

**Figure 3: Qualifications**

The basic qualification for all participants is Registered Nurse. In addition, 31 (62%) have a midwifery qualification. Twenty-seven (54%) also have a community health diploma or certificate and 16 (32%) had completed qualifications at graduate diploma level in either rural health/community health or maternal and child health. One had completed a masters degree in public health and all participants (100%, charted as other) had completed short courses since their base qualification as a registered nurse in a variety of courses including: HIV/Aids courses; family planning; counselling; lactation consultant; continence management; massage; infectious diseases; critical care; health education; health promotion; tropical diseases; horticulture.

Their most often cited reasons (78%) for undertaking additional qualifications was to expand their knowledge base through extending skills or because they had a commitment to and interest in being prepared for their role (64%).
Pap test training course

Of the 48 nurses who had completed a Pap test provision course in Victoria, the following chart (figure 4) demonstrates at which training institution this was undertaken. Two participants had done courses in other states.

Figure 4: Pap test training course in Victoria

Work patterns, work role and location

The work patterns of these nurses were commensurate with traditional work patterns of women and nurses\textsuperscript{41}: 23 (46\%) of the nurses worked full-time hours and 27 (54\%) worked part time, as shown in figure 5.

Figure 5: Work patterns

\textsuperscript{41} The latest information on work patterns from the Australian Bureau of Statistics (1991) for the health occupations confirms that female nurses are the largest group to work to under 40 hours.
The majority (82%) of these nurses worked in community health settings, in which their broad role was community health provision, with women’s health and cancer screening as a major component of that role. Five nurses (10%) worked in acute care agencies, in which women’s health provision was their major work role and 2 (4%) worked as independent nurse practitioners, and women’s health was their only focus. Another 2 (4%) worked in specialised care agencies, in which women’s health was not a specified role, but due to their client base being predominantly women, women’s health issues and clinical service was the major component.

![Work place of participants](image)

**Figure 6: Work place of participants**

Although all nurses stated that women’s health provision was either the main focus of their work or that it was a major component (usually nominated by hours spent) of their work role, their work titles did not reflect this.

![Focus of work](image)

**Figure 7: Focus of work**
Thirty-three (66%) of respondents had the designated title of generalist community health nurse; only 2 (4%) were specified by work title as a women’s health nurse. The 15 others (30%) had titles including health educator, nurse co-ordinator, community midwife, independent midwife, independent nurse practitioner and clinical nurse specialist.

As demonstrated in figure 8 below, just over half of the participants, 26 (52%) of the nurses worked in a rural context, 11 (22%) worked in provincial areas and 13 (26%) worked in the metropolitan context.

![Work location](image)

**Figure 8: Work location**

**Reasons for working in community health**

For the majority of the participants (88%), as shown in figure 9, working in community health was a conscious move to work in a ‘broader health model’ than the traditional hospital environment in which they had started their work life. In responding to the question of why they were a community health nurse 60% of the nurses cited autonomy of practice as a key factor in attracting them to community health work. Autonomy was described as incorporating the ability to initiate and develop health programs and a sense of control and freedom in the provision of their work. As an adjunct to this the notion of autonomous practice, 52% felt that community nursing work was less restrictive than working in acute care settings such as hospital.
Reasons for working in community health

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Health Model</td>
<td>88%</td>
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<tr>
<td>Autonomy</td>
<td>60%</td>
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<tr>
<td>Less restrictions</td>
<td>52%</td>
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</tbody>
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N=50

Figure 9: Reasons for working in community health

The following comments best capture the nurses’ reasons for moving into community health practice:

*I really do enjoy it—I like working in the community. I don’t think I could ever go back to an institution and to the formal—you know hierarchical set-up of hospitals and things like that. I really do like—to allow the consumers to have input as well—it’s really working with people.*

*Well—I consider we are the avant guard of nursing. We have a lot of freedom—a lot of autonomy. Able to move around the community—be really proactive when we want to be rather than reactive.*

*It’s the philosophy—of community health centres— it’s much more sort of consultative and you know the—community management is community elected—which has its problems, but philosophically it suits me better. You are responding to real needs, not perceived needs, as much—I mean it’s still there, and I sort of feel like the centre is set up for the community, whereas I feel the hospital is set up for the staff.*
If you think about nursing you tend think automatically about acute care, institutional type care. So if I look at as to think of why I don’t do that—it seems—well—I had some time where I worked—in the community, for a couple years—and then I actually went back to work in the hospital for a year—and that was quite clear to me why I didn’t want to work in a hospital—and it wasn’t just the organisational issues. It was the philosophy—and I didn’t realise I had such a strong philosophy, about working in the community. And it was really only brought home to me, when I was back into the hospital, that in fact it’s a whole different, its almost a different profession to me, and so I suppose, I don’t just work in the community because I don’t like working in hospitals. But there’s a much—the scope, the philosophy of health and wellness, is just so much more—the potential is so much greater, much less stifling, in terms of individuality then in hospitals.

It’s because of the broad focus in community life, the context of the people’s lives—the main part of their life is living in normal situations. So my interest is to maintain the wellbeing of people, helping them through the down times when they are ill, but I like working within that preventative illness type thing and promoting wellbeing.

In addition, as is shown in figure 10, the majority had strong reasons for focusing on women’s health care provision. The most frequently cited response to what had led to their involvement in women’s health was wishing to change women’s experience of health care and wanting better outcomes for women’s health provision (66%), followed by enjoyment in and empathy with women (42%). Forty per cent of the nurses commented that an interest in working with women developed from their midwifery training and midwifery practice and 20% saw it as a career decision.
What led to women's health practice

<table>
<thead>
<tr>
<th>Change outcomes for women</th>
<th>66%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoyment</td>
<td>42%</td>
</tr>
<tr>
<td>Midwifery</td>
<td>40%</td>
</tr>
<tr>
<td>Career decision</td>
<td>20%</td>
</tr>
<tr>
<td>Other</td>
<td>12%</td>
</tr>
</tbody>
</table>

N=50. Note: Respondents' answers are represented in more than one category

Figure 10: What led to women’s health practice

All respondents articulated a strong interest in women’s health issues and described how this led to them to specialising in working with women in some way. For some respondents, this interest stemmed from their midwifery training and was expressed in the following ways:

*An interest in midwifery—a basic interest in women’s health—I’ve been involved in setting up the women’s health service in our region. It’s been an ongoing personal interest, and with my nursing background, led me to be professionally directed that way as well. I think it’s in order to have the voice of women heard—empowerment of women—and that’s from a midwifery background, to assist women getting what they wanted—in a male dominated system—so giving a voice to women, And feeling that they had specific needs and addressing some of that or making that happen.*

*Well I suppose it started when I did midwifery—that was a conscious step to work with women. And I suppose I felt an empathy with women.*
Probably a nursing lifetime of mostly working with women—in a midwifery area and gynaecology, and an empathy I guess. Women’s role, especially in the country is probably downgraded a bit and they don’t really spend a lot of time on themselves, so in providing this service I’m able to actually give them time and give them information. I—this might sound a bit airy fairy—but I really believe if you educate the women of the world, we’ll have a lot healthier sort of world; if you can talk to them about health issues and looking after themselves, about children and things, they are the ones that bring up the next generation.

So, I really think better informed women are, the healthier society is.

Oh well, I’ve always been interested in women’s health in particular and I knew—well from virtually from beginning of my nursing training—that was the area I wanted to streamline in, so I moved as quick as I could into it, and I enjoy the work because I enjoy working in terms of health promotion and preventative health strategies, and things like that, rather than assuming that sort of sick role. I like working with well people and assisting them to remain well.

Of those who had not completed a midwifery qualification, the move towards women’s health was for similar reasons and the following responses describe the development and long term involvement in women’s health practice:

I was already interested in women and women’s health—but not as a women’s health nurse—after not nursing for a while, then doing agency work. I was already fairly interested and actively reading and discussing women’s issues and women’s health issues anyway. So when I was back in the health workforce as a community health nurse, it was just a natural thing to be moving into.
I guess I hadn’t had a lot to do with women’s health, at all really, until I was actually working in a community health centre but in more of a clinical capacity, and I was looking for something to broaden my horizons a little bit. Then the social worker there suggested that maybe I’d like to do some community management work and that sounded good, so I joined the committee of management at the women’s health service. And so that really opened my eyes as to what women’s health was, and I did develop a bit of an interest, through not so much the work there, but the networking with other workers and other community people. And also working here at this agency the majority of my clients are female, and — when you talk to them about their health—it becomes—I guess it becomes more of a focus in your own mind.

Women’s health interested me for personal reasons—because of my own health problems from the past. And then when the women’s clinic first started I always put up my hand that I was interested and so it’s been going now for 7–8 years and I really enjoy it.

In 1987 I was working with a welfare worker who was interested in women’s health issues—at that time women’s health was forefront—the National Women’s Health Policy came out, the welfare worker and I got together and decided we needed to do something about women’s health in this community. We bandied the idea around about a clinic, with a focus on and following the policies that came out at that time. Why women’s health? People were a bit dubious about it—you know—what does this mean—a radical sort of move—we thought, if we can do this cheaply as we can and just run with it—to see how it goes and see if we can do it—so the manager who was really proactive at the time said OK—so we did it. We found a venue that didn’t cost anything, the shire paid for the phone—we used the maternal and child health centre down the street. It started off slowly but it grew to a really popular service—
As discussed earlier, the unifying aspect of all of these nurses’ work was their involvement in providing Pap smears to Victorian women. This role is a new initiative in Victoria and has provided many interesting and challenging issues for the nurses involved. The opportunity to be involved in Pap test provision for many of the nurses was an extension of wanting to be actively involved in social change for women’s health care. Pap test provision has thus been the pathway to examining the practice of these nurses.

**Training in Pap test provision.**

In Victoria, three courses have provided training for nurse practitioners to deliver cervical cancer screening. Believing that there was a community need and wishing to provide women another form of service provision for Pap tests were the most frequent cited reasons why nurses underwent training in cervical cancer screening. At the time of interviewing 38 of the 50 nurses were providing a Pap screening service to women. By the 12 that were not providing Pap screening the following reasons were given: one stated that health service distribution was a factor, two were not ‘allowed’ by doctors—this is discussed later in chapter 8—five were still in the process of establishing the service and four were undergoing job restructuring, in which Pap test provision was no longer a component of their job role.

In setting up the service, 50% of the nurses were involved in lobbying and submission writing to State departments for nurses in their own agency to provide
Pap test services, or for nurses in general to be able to provide cervical cancer screening services. The other half came to already established funding and or services. The key reason the majority (88%) wanted specifically to offer a Pap test service after they had done the additional training was to provide women with choice in health service. They cited that this incorporated a model of health care featuring lengthy consultation time and opportunities for education and counselling. This is illustrated in figure 11 below.

**Figure 11: Reasons for offering Pap test services**

**Screening**

The majority of nurses surveyed were providing Pap tests at the time of the interviewing. They were able to recount that the women they screened had poor screening histories, and cited that most of the women they saw had, on average, not been screened in the last 2–5 years or had never been screened. The age group of the women screened by nurses was over fifty years. This demonstrates that nurses are able to reach women who traditionally do not access the mainstream service provided by doctors. This information is congruent with the results of the Pap test Victoria report (1995) which reviewed nurse-based services in Victoria.
Barriers to screening

From their practice experience of providing cervical cancer screening services, all 50 of the nurses posited reasons as to why women experienced difficulties in attending Pap test services and the reasons have been collated in Figure 12.

![Figure 12: Barriers for women having CCS as designated by WHNs](image)

Based on information provided by their women clients, the barriers described by nurses are consistent with other research information on barriers to Pap test provision. Male practitioners was cited by the nurses most frequently as a barrier to Pap test screening by women. Issues of embarrassment related to body image and myths associated with ageing women related to decrease in sexual activity, and having had a hysterectomy created barriers in the sense that some women saw Pap test as irrelevant to them in their older years. Language and cultural issues featured as a barrier in communities where women from non-English-speaking backgrounds prevailed. Nurses also considered that fear of outcomes and past bad experiences of health care encounters acted as barriers to women’s attendance at Pap test services. Many of the nurses mentioned that women with disabilities and geographically isolated women did not have adequate access to health services. Many also commented on the fact that illness prevention for many women was not seen as a priority for women who saw themselves as ‘well’ women, so that intersecting with health services was also not a priority.
In response to the questions of what changes the nurses would like to see in the delivery of cervical cancer screening services, the following were suggested (some nurses nominated more than one reason):

- 50% would like more funding, and more acknowledgment of the time required to establish and maintain the service;
- 38% would like to see more support by the medical profession of the nurses role in Pap test provision;
- 34% would like to see more inservices for nurses on clinical and administrative issues;
- 32% suggested more state wide co-ordination to address issues such as funding, program, outreach and ethnic client issues; and
- 6% suggested that hospitals should establish outreach programs.

Policy involvement.

A concern often raised in the literature is nurses’ lack of a role in policy development and the huge potential for nurses to contribute in this area (Miller 1990; Short, Sharman & Speedy 1993; Wass 1994). To this end, this issue was explored in the interviews and questions were put to all participants. Sixty-four per cent of the nurses had been involved in policy development at local and State levels in program and policy development of the Pap test Victoria screening program. In 1996 the Anti-Cancer Council held a State-wide forum which nurses from the Victorian Screening program attended (ACC 1996). Each of the attending nurses had consulted widely with nurses providing CSS within their regions, to ascertain critical issues for nurse-based services. The information from this forum was to be considered in the planning for the recruitment strategy plan for the next three years of the Victorian screening program by the ACC (ACC 1996). Many of the nurses who participated in this forum were respondents in this research project. This is evidence that nurses’ involvement in policy and program development can be organised and nurses in this instance were able to influence State-wide policy initiatives for public health.
Conclusion

The profile of this group of nurses gained from the data illustrates a well-qualified and experienced group of nurses committed to providing women's health care in the community setting. The responses demonstrate a deliberate move to community health practice and to working with women. In choosing to work with women, WHNs identify a wish to create social change and declare their commitment to and empathy with women. Clearly, they are experienced practitioners, and examining their models of care has the potential to provide new insights for health care. The next chapter documents further details of the model of care that WHNs practise.
CHAPTER SEVEN: NURSING PRAXIS

INTRODUCTION

The following chapter presents further data, analysis and discussion and maps the work of Women's Health Nurses (WHNs). It illustrates a proactive and developing nursing service. In keeping with the methodology that underlies this research, the discussion moves between researching with and on the WHNs. I represent their voices but also engage the data with theoretical interpretations.

The first section documents the narratives from all 50 participants, utilising Pap test provision as the starting point for discussing the work of WHNs in general. Although Pap test provision was only one component of the general job focus of women's health for each of these nurses, it did provide the starting point for beginning to explore nursing work for this research. Developing Pap test programs gave many of the nurses a focal point for further developing specific women's health programs. All of the nurses, at some time, had participated in the provision of Pap test programs. This first section also addresses the range of skills that WHNs bring to Pap test provision. WHNs identified the following key skills and principles of their practice: health assessment; counselling; access and mobility; attention to the clinical setting; and a women-centred approach which involves empathy, time, and a focus on self-determination. The second section provides additional data from 38 of the nurses who, at the time of interviews, were providing Pap tests. The criterion of Pap test provision enabled this project to have manageable boundaries; it also provided the nurses with specific projects to develop their skills and practices and to further develop women's health programs in their communities. Thus, this second section provides further details of nursing practice through cervical cancer screening, describing further details of strategies and issues of nursing practice such as 'women's talk'; gender and health care; wholism; empathy, listening; and time.
NARRATIVES OF NURSING PRAXIS

The last two decades have seen much debate, discussion and scholarly activity in nursing, considering the parameters of the discipline, to discover and uncover ways to describe what nursing is, how nurses function and how nurses should be educationally prepared (Brown 1987). Critical social science and feminist theory and their corresponding research methodologies of action research and feminist research methods have offered political and philosophical frameworks for nursing to view and review practice and theoretical development in the discipline. In particular, the commitment to integrate theory and practice and uncover social structures and processes which produce and reproduce oppression are apt frameworks for nursing’s ontological and epistemological questions.

On reflection, the interviews suggest the practices of WHNs seem to encapsulate an approach that integrates practical nursing service with action for change in women’s health services. To express this specific approach to nursing, referring to nursing practice, does not sufficiently encompass their approach to health care. To be more inclusive of the action and practice of these nurses I have chosen to use the concept of praxis. The concept of praxis—drawn from the critical paradigm and closely associated with critical social theory—is a useful concept for nursing as a research methodology, but also for describing nursing work.\(^{42}\) The concept of praxis derives from Aristotle with modern influences from Marx and Paulo Freire. Freire’s (1970) definition—action and reflection of people upon their worlds in order to change them—is widely used today (Fahy 1996:55). Fahy (1996:55) claims that:

> Praxis means purposive action, including political action, to change the material and social worlds, including self and others. The aim of praxis is to change both oppressive social structure and our own relationship to these

\(^{42}\) See the work of Fahy (1996); Street (1992); Allen (1991); Thompson (1994) for discussions on critical social theory and nursing.
structures. Praxis is essentially about living and acting in a fully aware and responsible way.

With the above in mind, the concept of praxis offers a useful way to think of nursing work. The work of the women’s health practitioners as it unfolds in the following pages is work that is underpinned by a critical, political and reflexive approach. These nurses are active managers of health promotion, health service delivery and the creation of change for women’s health and for nursing practice. What emerges from these interviews is that these nurses are active agents in the construction and reconstruction of nursing. Praxis is used to encapsulate both the notion of practice as in practical approaches to nursing services, and the assumptions, values and political action that underpin practice. Thus, praxis provides a useful concept to view and to refer to the work of the nurses who participated in this research project.

Early on in the research, it was apparent that many of the women’s health nurses, who eventually became participants, were very keen to describe the work that they did. I was often told that it was great that I was developing this project as the work of women health nurses needed to be told! A common claim by nurses is that nursing work is misunderstood, devalued, and different from mainstream health provision. Such sentiments were often echoed by the WHNs in preliminary discussions. If this is the case, what then, is this ‘difference’, what is it that these nurses ‘do’ that distinguishes them from other health service providers? These reflections led to the inclusion of questions in the interviews to explore the role of nurses in Pap test provision and what they believed they offered women by providing women’s health care. In contemporary developments in nursing in the areas of primary health care, women’s health service provision and family planning, nurses are preparing for a broader role in primary health care. This broader role is particularly evident in the area of women’s health provision, where nurses provide clinical services, breast and cervical screening, counselling, and preventative health services (Short, Sharman, Speedy 1993:198). Furthermore, Short, Sharman and Speedy (1993:198) claim that:
Women's health nurses represent a significant challenge to the medical profession's monopoly over diagnostic and curative services within a primary health-care model of service delivery that is free to consumers, community oriented and community based.

The group of WHNs who form the focus of this project demonstrate that a broader and different role for nurses is applicable in the area of women's health. This group demonstrated a powerful political and agentic approach to practice and creating change for women's health service delivery.

The following discussion was drawn from data resulting from questions on how respondents saw their role and what they believed nurses in general had to offer, and what philosophy and principles guided their practice (see appendix B for specific questions). As each nurse narrated stories about her practice world and philosophy of practice, a picture emerged of committed, experienced nurses who placed as much importance on socio-cultural contexts and issues in people lives, as they did on the clinical service that they could offer. All the nurses articulated a political focus of wishing to create change for women's health provision. They expressed ideas about change in their day-to-day work and through the activism needed to create change at a broader societal level. These nurses have clearly-defined ideas about what they do as nurses and what they offer as a distinct nursing activity. Many of the nurses made the point that they were not competing with medicine but offering a distinct, nursing-focused form of health care. This, in their view, was different from, but as legitimate as, other more traditional forms of health care services. Their narratives represent examples of nursing praxis.
SECTION 1: MAPPING WOMEN HEALTH NURSES PRAXIS

Pap test provision

The provision of cervical cancer screening was the starting point for exploring the role of this group of nurses. The majority of nurses (90%) saw their role as including a broad range of general health skills. They cited comprehensive health assessment, information, counselling and accessibility, flexibility and mobility of service as central to the health service that they offered women. Figure 13 below summarises the responses given by the WHNs to the broad question of how they saw their role in the provision of cervical cancer screening.

<table>
<thead>
<tr>
<th>Reasons given for using nurse based service</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>Female practitioner</td>
<td>95%</td>
</tr>
<tr>
<td>Time / place</td>
<td>82%</td>
</tr>
<tr>
<td>Free</td>
<td>55%</td>
</tr>
<tr>
<td>Doctor issues</td>
<td>45%</td>
</tr>
<tr>
<td>Other</td>
<td>5%</td>
</tr>
</tbody>
</table>

N=38

Figure 13: Nurses’ role in Pap test

Nearly all of the WHNs had many years of experience and believed that they were able to draw on this wealth of practice and theoretical knowledge in their interactions with women. When describing their role in relation to Pap test provision, the nurses described skills ranging from clinical skills, with a focus on female reproductive health and general health assessment, to counselling skills, welfare and financial management skills, health education and promotion, referral skills, and child and adolescent health skills related to the women’s children. In their narratives they describe their ability to provide an accessible service to women because of their flexibility regarding length and times of consultations and
their ability to offer different venues and home visits. This flexibility, mobility and their approach to consultations was, in their opinion, the key to good community women’s health work. For example, one nurse, describing how busy they were, initially, in instigating a major outreach program, and commenting on how successful the campaign was in her region, stated:

*We worked really well with the medicos and stuff—all theirs increased as well. But there’s lots of areas where doctor’s don’t even go—places out of this town that you just can’t get to, so we took caravans and used halls and a lot of those women were not just underscreened but had never been screened even.*

On further examination of what they believed they offered women through the provision of cervical cancer screening, a pattern emerged in the responses. Each nurse was asked what, specifically, she believed she had to offer women in providing cervical cancer screening services. Three key skill areas emerged in the overall responses These responses are summarised in figure 14 below.

![Key skills to offer women](image)

*Figure 14: Key skills to offer women.*

Note: Categories were designated by the respondents. Responses were collated in each category.

Being able to provide more time to women during consultation was seen as a key element in their practice. In addition, being able to offer a broad range of clinical
and support services to women was mentioned by the majority of respondents. Drawing on their vast experience and being able to connect women with other services in the community was seen as crucial to their work. Located physically and philosophically in the community, WHNs embodied the spirit of community health practice and primary health care in their approach to health care delivery. Such an approach is familiar to community health nurses, and many definitions of community health nurses encapsulating the above components can be found in texts. For example McMurray (1993:xiii & 13) states:

Community health nursing is much more than nursing practised in the community. It is a unique and continually evolving specialised area within the profession of nursing which considers the context of peoples’ lives as paramount to attaining and maintaining health.

and

Community health nursing is guided by the tenets of primary health care. In any community the nurses must assess and plan care and caring which is equitable, accessible, culturally sensitive and which empowers the community, family or individual for self determined health care.

Understanding the context and reality of women’s lives and making connections for women so that they have access to clinical, educational and support services, was fundamental to these nurses and underpinned their whole approach to practice. A concept that was continually raised and spoken of as central to their practice was the relationship they developed with women. Many felt that, as women together, there was a spirit of connection as women together experiencing life-span health and family issues. Integral to this relationship was the concept of empathy. Empathy was frequently mentioned as the nurses described what they specifically offered women. In fact 80% of respondents used this term during their narratives of nursing work, in relation to what they had to offer women. Empathy was spoken of as relating to shared understandings of womanhood, both in a physical and emotional sense. The following comments demonstrate this:

I have a feeling that in being chosen for the position my age was a relevant thing as well.
Actually I have lots of empathy with the perimenopausal women (laugh). I have had enough experience to have empathy with the different stages people go through.

I think empathy is very important, you know I understand their embarrassment. We do understand what they’re going through and why they feel the way they do.

As a woman—there’s no barriers—there at all. As a nurse it’s all that close contact that we’re used to having; intimacy comes very easily. You don’t have to have any barriers. Again—it’s that women-to-women thing—I’ve got nothing prove—I don’t need to be in a power position.

A number of health research studies and texts have examined patient—health providers interactions. Many of the studies point out the inherent imbalance between the doctors’ expertise, gender, socioeconomic status and that of patients. Patients generally do not have the expertise to assess whether it is appropriate advice they are getting and have to trust doctors. Legge (1989:460) suggests that empathy—a combination of trust and identification—seems to reduce the imbalances inherent in interactions between health professionals and patients. Legge’s (1989) premise is that the difficulties between medical practitioners and patients in what he calls the empathy gap, is related to patients coming from a range of socioeconomic and cultural backgrounds, whereas doctors tend to come from white anglo-saxon upper-middle-class backgrounds. This disparity affects communication and the development of trust as a basis for sound clinical relationships.

However, from these self reports, and from service evaluations by women clients, the ‘empathy gap’ was not an issue in these nursing encounters. The notion of

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43 For example, for discussions on nurses and patient relationships see May (1992a, 1992b); May & Purkis (1995); and specifically on the encounters between the medical practitioner and patients see Lupton (1994, 1995a 1995b); Turner (1995); Frankenberg (1992).
empathy was raised by the majority of nurses in conjunction with comments about being an equal and understanding what it is like to be woman. Many believed that they demystified health care through being a ‘non-threatening’ health professional. This was illustrated by many of the nurses describing the translating role that they have in the community. This role involves deciphering information on treatment or drugs for the women and their families following appointments with doctors. During these discussions many nurses felt that they were seen as equal members in the health encounter and that they ‘were on the same level as the women’. These notions were mentioned by the majority of nurses and are best encapsulated by these comments:

_I think it’s interesting that so many people say ‘I’ve been wanting to ask the doctor that’ or ‘I haven’t really understood about this’—it seems to be that they feel you’ll relate at a level that they will understand and that is personable and friendly. Seems to be one of the main things that—well there’s that comfort zone ... an ease of service provision for women who are generally going to be in the normal—for a preventative health check, a wellness approach and the service being easily accessible and not having to wait ages._

_It all started when I went into mid. That was a conscious step to work with women. But I always enjoyed women—I remember working in the Gyny ward and use to enjoy listening to their stories. We weren’t allowed to talk to patients in those days (laugh) but I was guilty of that and always sent to the pan room to scrub pans. But I did use to talk to women and I felt an empathy with them. And then I did midwifery._

_I worked for a while and then had children so I left nursing full time got out into the community and actually experienced women’s health first hand from having children, being very isolated, living in the outer suburbs, feeling depressed, losing my confidence, sort of not knowing what my purpose in life was any more. Then the kids started school and I got involved in school—set_
up a healthy eating program with other nurses. Met a few women interested in other things; anyway I discovered that you can actually make structural change—that if you persevere long enough you can make change in the community and I found that quite exciting.

*We have a non-threatening persona*—nurses are perceived as a accessible generally and more down to earth, more on the same level as the client, they’re not necessarily seen as the ‘Doctor’ or ‘Professora’ you’re seen as just another woman—we have that to offer and shared experience—as a women. And the ability to demystify the medical terms and be able to communicate, I suppose communications skills are the biggest.

In addition, they cited the following other areas of health care they are able to offer women through providing cervical cancer screening. These include:

- providing another choice in health care;
- education and counselling;
- translation of the big policy picture down to concrete practical assistance; and
- sexual health and family planning advice.

One of the goals of this research was to map WHNs work. Each of the nurses gave rich and detailed descriptions of their practice as they responded to the questions posed. As they described what approaches or principles they employed in their interactions with women all of the nurses identified specific approaches or a philosophy that was integral to their practice with women. As with many of the questions, a consensus across the 50 respondents began to emerge. This is summarised in figure 15 below. It was interesting to note that the philosophical tenets of the women’s health movement and the tenets of the primary health care movement were recognisable in their descriptions. This was not only rhetoric, however, as these tenets were recognisable through their vignettes or exemplars of clinical practice situations or specific stories they told to describe their practice.
All of the nurses displayed a personal and ideological commitment to women’s health. This was evident in their continued practice in women’s health service and in a variety of ways of lobbying and trying to create social change in their communities for women.

![Principles that guide practice](image)

**Figure 15: Principles of practice**

As shown in figure 15, a number of principles guide WHNs practice. These are discussed below.

**A women-centred approach**

The most often cited principle—stated by 88% of the nurses—described what they called a women-centred approach. This was often identified by the nurses as a feminist approach to women’s health, in which consideration was given to privacy, dignity and an approach that valued women and allowed them to make the decisions in their health care. As one WHN comments:

*I really believe I have to understand the importance of maintaining the dignity and privacy and to alleviated the embarrassment that essentially goes along with cervical screening. So I have a few approaches. I think the empathy is very important, you know I understand their embarrassment, we do understand what they’re going through and why they feel the way that they do. For that*
reason I make appointments every half an hour—and longer if I have some indication as to why they’re coming. You know a good Pap smear can be taken in three minutes flat so it’s really a minor part of the visit.

Self-determination and empowerment

A commitment to self-determination and empowerment in health encounters is a fundamental tenet of the women’s health movement and is central to WHNs practice. Attention to issues related to the physical and emotional comfort of women clients, to encourage women to have more autonomy and control over their bodies and lives, is a distinct feature of WHNs’ practice. In addition, a concern about the fear and embarrassment related to Pap test provision was consistently mentioned.

Time as a therapeutic strategy

Eighty-two per cent of the respondents also raised the issue of allowing a significant block of time for the consultation, and giving the women some choice over when the clinical service occurs during the consultation is central to their approach. One nurse stated:

*It’s really downgrading—the whole experience of it and getting the Pap smear done as quickly as possible and put it out of the road so we can go on to what ever else we need to talk about. I’ll do it—what ever stage in the consultation they wish—which I think is important because it gives them the control. When they walk in the door they feel they’ve lost that I think. Once you remove your knickers - they feel vulnerable. So if they like it done first we can do that, if later, its OK we’ll do that.*

The issue of duration of consultation time came up frequently during the interviews. The nurses generally felt that allowing for at least half an hour was an important therapeutic strategy for women. For most women, conversation and the
opportunity to discuss issues in a unhurried environment allowed them to open up and freely discuss health and other issues with the nurses. WHNs tapped into women’s preference for ‘talk’, and saw this as an important strategy to aid communication and develop therapeutic health relationships. Consequently they felt very strongly that consultation times should allow for women’s words to unfold, for women to tell testimonies and life histories in their ‘own good time’. Many clients reported back in the evaluations of the women’s health service that longer, unhurried consultancy time was an excellent feature of the nurse-based service. The present culture of health and the structural features of the health care system are now more than ever being driven by economic imperatives. Many of the participants raised concerns about the present funding crisis within health and the move to unit-based funding for community health centres, which may jeopardise the nurse’s ability to provide lengthy consultation times. McMurray’s (1993:105), following point is most pertinent for nursing in community settings:

> It is widely accepted by care providers that primary health care is the most effective way of securing the health of populations. However, it is financial arrangements, rather than ideology, which propel the system.

**Access and mobility**

Fifty-eight per cent of respondents considered issues related to accessibility and mobility of service as an important component of delivering women’s health care. Thus, going out to the women in the community was a key principle when providing a women’s health service. The mobility and flexibility of WHNs in providing outreach models of health care and addressing accessibility issues for women is a significant feature of these nurses’ work. This feature is particularly pertinent in today’s health care environment of changing economic and structural features. A major reassessment of acute high-cost curative services compared with care in the community, including health promotion and preventative services needs to be addressed. The potential of women’s health nurses to play an extensive role in community health care is untapped. The next decade will see
many changes in health service delivery and WHNs have proved, through the Pap test programs that they are effective health care providers to groups that do not always access mainstream health services.

The consultation setting

Attention to the physical environment was considered by 56% of the respondents as an important principle in the delivery of their service. This encompassed reducing the clinical atmosphere and giving consideration to a wellness approach for the consultations.

Many of the nurses spoke of an approach that focused on the wellness of women rather than the illness or pathological model so prevalent in other areas of the health care system. Understanding the context and reality of women's lives and providing sensitive and appropriate health care with individual women was addressed in their narratives. At a broader level, the nurses spoke of political activism—not in radical ways, but through lobbying and in community education terms, with providers and consumers, to create social change. They felt that mainstream health services were not fundamentally responsive to women's health issues in appropriate ways. As one nurse very passionately stated:

I was interested, I thought I could effect change. I felt I had something to offer. Women are disadvantaged—I wanted to effect change in a country area, conservative as anything. But the thing is there was never anything to do with women's health down here, like, women's health was women going to the local General Practitioner for a Pap smear. There was no education programs. Nothing. In the first couple of years I ran once a year a menopause workshop. Sixty women would come. Like there was a screaming need and I thought I had the skills to identify the needs and to meet or attempt to meet them.
SECTION 2: PRAXIS THROUGH WOMENS' HEALTH NURSES' CERVICAL CANCER SCREENING ROLE

Further examples of WHNs' praxis can be seen in the work of the 38 nurses who, at the time of the interviews, were practising cervical cancer screening as part of their women's health role and in the descriptions of the remaining 12 who were still involved in delivering various women's health programs.

The data set from the 38 'Pap test providers' shows that they balanced a clinical service of cervical cancer screening with a health promotion/prevention role in delivering a nursing-based primary health care service, underpinned by an ideological commitment to the women's health movement. For many of these nurses, this new role provided many challenges in developing their skills, and setting up and maintaining the service. For others, this role provided an opportunity to 'enact' a political and ideological commitment to the women's health movement in a concrete and practical manner. To recapitulate for a moment (see chapter 2), the impetus developed from the Well Women's project in 1989 and further lobbying from community health nurses in 1991 to the Anti-Cancer Council saw the setting up of a specially designed program to prepare nurses to take Pap tests. This was an unintentional offshoot of the Pap Test Victoria program and it was instigated by nurses (a very proactive and agentive activity by a group of nurses) who felt that they could extend the health promotion role of nurses beyond that usually designated in the cervical cancer screening programs. This group of nurses, who are represented in this research study, felt strongly that nurses could provide a clinical role in Pap test provision, as well as in the educational activities associated with cervical cancer screening. From their past experience and anecdotal information from women, they felt that often women were not attending Pap test services because of the gender of the practitioner and because mainstream services were not conducive to their health needs. These nurses felt that they could fill a gap in health provision by providing a distinct, women-focused health service, drawing on their extensive work experience as community health practitioners. Thus this group (inclusive of all 50 participants
but exemplified by these (38) provides examples of the reconstructions of health knowledge, and sites of contested health practice based on gender differentiated and professional models of care.

The majority of nurses (38), as shown in figure 16, were actually providing a Pap test service at the time of the field work for this research study.

![Pie chart showing 76% Yes and 24% No for nurses practising cervical screening. N=50]

**Figure 16: Number of nurses providing Pap test.**

The following discussion focuses on this ‘subgroup’ to further explore the work of women’s health nurses. During the interviews what was striking was their commitment to developing Pap test services, when it was only one component of a broader role they had in providing a health service. One nurse commented on the fact that she utilised her contact with women through her women’s health role, as a barometer to gauge the needs of the women in the community at large and this influenced her planning of health programs. She states:

> It’s a very good way of picking up on trends and issues in the community for women. So if you’re seeing a number of women who are menopausal or a number of women who have relationship problems or parenting problems that seem to be the basis of their stress, then you can pick up on that issue and deal with it another way—in a group setting or work with the other multidisciplinary team to sort of look at solutions for women. So I found it a very
good way to keep in touch with women at a grassroots level. I actually found it difficult as a community health nurse trying to tap into what the needs were—and once I started the clinic it became very easy—you saw them face to face. So it's a very good model of working from the—I'd call it developmental case work—right through to the community development type continuum—where these women can actually start controlling what's going on at the centre.

The nurses developed a combination of special one-off clinics and regular clinic times to offer Pap screening in their communities. The 'special one-off' clinics were run after the nurses had been successful in obtaining specific grants from the Health Department (now Human Services) or the Anti-Cancer Council. So not only did they have to organise training themselves (which often occurred in their own time), they had to spend time obtaining money to fund the service. They used a variety of health promotion strategies to 'attract' women to the clinics.

Strategies of nursing praxis:

The chart below (figure 17) demonstrates the most frequently-cited responses to the question of how to involve women in clinics.

**Figure 17: Health promotion strategies**
Women’s Talk

Ninety-five per cent of the respondents stated that the most popular strategy to inform women of the service was through community group talks and word-of-mouth; that is, oral traditions. Using this strategy fits well with nurses and women’s preference for oral forms of communication. Recognising and utilising women’s oral traditions as a medium represents a central focus and a connecting theme of this project, for it was written into the methodology as a crucial ‘tool’ for feminist research methods and ‘women’s talk’ unfolded in the narratives of the nurses as a central strategy in their practice in working with women and as key way for them to describe their work for this research. This ‘method’ is not without problems, as there are several ‘subjectivities’ involved—the women as clients telling their stories, the women as nurses telling their stories, and the woman, as a researcher, as a nurse and a interpreter and shaper of the final analysis and text. Thus one must ask ‘whose words are these?’ In the final analyses, they are in the main, my words, but I have endeavoured to represent the words of the nurses. Being aware of the flaws of oral inquiry should not preclude a method that has the potential to ‘... provide an invaluable means of generating new insight about women’s experience of themselves in their worlds’ (Anderson & Jack 1991:11).

Over the sample as a whole, the nurses frequently stated they were very involved within the communities in which they work. They considered outreach work as crucial to their ability to provide health care. This strategy was often devised in combination with other health promotion activities or specific health days. For example, if they were running activities for diabetes or Healthy Heart Week they would take this opportunity to organise to speak to the women about having Pap smear and explain the options available to them.

Other strategies that they utilised were: utilising media such as community newsletters, local papers and radio (89%), and printed information, usually pamphlets (84%), as well as community arts programs (8%), to encourage women to access the health services. The community arts programs were designed specifically to encourage women from non-English-speaking backgrounds to
attend the health centres. Through these more ‘social’ activities the nurses incorporate health promotion and specific clinical services.

**Gender and health care**

The nurse respondents believed (based on surveys of women clients and conversations with women, represented in figure 18 below), that the major reason women chose the nurse-based clinics was because of the gender of the service provider. Several respondents mentioned their belief that access to a female practitioner is the most crucial factor in encouraging women to attend Pap test services rather than the professional speciality, i.e. nursing or medicine. The next most often cited reason why women used nurse-based services was the convenience of the times and venues, particularly when nurses can take the Pap test services out to the communities. This reason is followed by the fact that, in most cases, a free service encouraged women to attend. Furthermore, many women stated to the nurse practitioners that they were often too embarrassed or believed that the doctors were too busy to give a Pap test service. A small percentage of women attended nurses’ clinics because they wanted this procedure done by someone they didn’t know.

<table>
<thead>
<tr>
<th>Reasons given for using nurse based service</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Female practitioner</td>
<td>95%</td>
</tr>
<tr>
<td>Time / place</td>
<td>82%</td>
</tr>
<tr>
<td>Free</td>
<td>55%</td>
</tr>
<tr>
<td>Doctor issues</td>
<td>45%</td>
</tr>
<tr>
<td>Other</td>
<td>5%</td>
</tr>
</tbody>
</table>

Figure 18: Why women use nurse-based service
Wholism

The nurses often stated that central to their philosophy and practice of health provision was the offering of a very broad health assessment and service. This is consistent with the premise they all (100%) clearly stated—that during the Pap test provision, they deal with other health care concerns with the women. The most frequent health concerns expressed by the women, as stated by the nurses, are summarised in figure 19 following.

**Most common health issues for women**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Menopause</td>
<td>89%</td>
</tr>
<tr>
<td>Social</td>
<td>87%</td>
</tr>
<tr>
<td>Sexual Health</td>
<td>84%</td>
</tr>
<tr>
<td>Incontinence</td>
<td>71%</td>
</tr>
<tr>
<td>Explanations</td>
<td>29%</td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
</tr>
</tbody>
</table>

N=38

**Figure 19: Health care concerns for women clients**

Addressing a broad range of health care concerns for women attests to the utility of having WHNs working in community settings. The wholistic approach of WHNs, who focus on the social aspects of health and illness, is often more meaningful for women than that of the mainstream service providers as it addresses the connection between health status and broader cultural, social and economic factors. The importance of attending to the social aspects of health is reinforced regularly in research on women’s health. Broom (1991) reports that women are dissatisfied with the traditional biomedical model as basis for explanation and treatment of their health and asserts:
Repeatedly, women have identified factors such as their social circumstances, economic problems, rest and recreation, safe workplaces, access to affordable child care, controls on environmental contamination, and adequate transport and housing as important to their health and well being.

As can be seen in the chart above (figure 19), the social aspects of health concerns was the second most significant issue for women clients. These incorporated issues such as weight, diet, family relationships, finances, employment, grief, abuse, and parenting issues. This approach values the multiple roles that women have in society.

**Listening to voices of women**

The most common response to how these health concerns were managed by the nurses is represented in figure 20.

<table>
<thead>
<tr>
<th>Management of health concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listening</td>
</tr>
<tr>
<td>Referral</td>
</tr>
<tr>
<td>Written material</td>
</tr>
</tbody>
</table>

88% 90% 92% 94% 96% 98% 100% 102%

N=38

**Figure 20: How nurses manage health care concerns**

As can be seen from the above chart (figure 20), the central therapeutic modality in the management of health care concerns for women was stated by the nurses to
be listening skills. Talking and listening was a constant theme in all the nurses’ narratives and was also strongly reflected by this group of thirty-eight when discussing their interactions with women. Taylor (1995:100&101) contends that:

Nursing practice has the therapeutic potential as healing work. Therapeutics and therapy are taking on new connotations in nursing. Rather than seeing therapeutics as the sole province of doctors, or regarding therapy as occurring in distanced professional relationships, nurses are claiming the worth of their presence and beginning to explore the nature and effects of therapeutic relationships in nursing.

The narratives of these nurses, describing how they ‘nurse’, reflect the therapeutic relationship with women. Women clients were able to express issues and needs to the nurses, who provided the therapeutic space for healing. As described by one nurse:

_So many women say to me that it so nice to have someone to talk to and really listen to them. I had one women tell me about her incontinence, and we discussed how she could manage it and what treatments were available, and she said ‘I’ve been living with this for years’. The doctor said it was a natural part of ageing, and she never told anyone after that, and she felt an enormous relief. That happens often; they just need the space and time to talk._

Their approach in consultations thus involves ‘active’ listening and providing education and counselling as appropriate. Giving a ‘space’ where women can talk was seen by the nurses as critical to working with women. Listening was augmented by providing written material and by referral to other health care practitioners. The participants frequently commented that their major referral source was medical practitioners. They believed that this demonstrated the complementary nature of the work of nurses, rather than a model of competition, which, in their opinion, underpinned much of the doctors’ resistance to nurses
providing such a role. Most nurses felt they were targeting groups that did not intersect well with mainstream medical services. Thus, rather than taking medicine's work away, they were often increasing medical work through additional referrals.

The respondents' comments below sum up the approach that captures the wholism, the broad nature of women's health, and the listening, talking and referral activities of WHNs:

*We can offer a broad, wholistic approach to women's health. When women come in for a Pap test I give them a sixty thousand kilometre check up! Like, I go through the whole thing and there are key things that I look for. You know if they've got children that are eight, nine, ten, or two or three kids, they are generally chronically tired—they are probably down on iron, their vitamins and minerals are probably shot to pieces. So, it gives me an ideal opportunity to look at women as a whole, and acknowledge what they are doing—mothering and raising the next generation—as it is in this community—is exhausting. And not only is it emotionally exhausting but physically draining. Its wonderful opportunity to sit and talk to women about what is going on in their lives, and I don't think there's one interview that I have that I don't refer off. Menopause is a big issue and they always want to discuss the pros and cons. So if they want HRT then I refer to medicos; to dietitian nearly always—diet is usually important—doesn't matter which end of the [age] scale they're on. They nearly always have some concerns, some social concerns. At that age they reflect on how they been parented or how they parent or if there's been any sexually abuse or anything. The number of times abuse is uncovered at the time of doing an intimate Pap test is major. Often, very often referring to a social worker for grief, unresolved grief from miscarriage, neonatal death or infertility; some of these things I deal with myself but if I feel they are locked in their grief*
pattern I’ll send them off to more qualified person to do that.

Time and health care

A common experience for most of us is to spend time in ‘waiting rooms’ for an appointment for medical treatment, whether at a doctors’ surgery or at a hospital. Thus the connection of time and the experience of medicine are inextricably tied. The theme of time was a constant companion to the narratives of nursing work. Throughout this project, this theme was raised in conjunction with reasons for their move into community health practice, and was an integral part of their descriptions of the role of nurses in Pap test provision. In addition, time was seen as an important therapeutic strategy in women’s health work. For example, for the majority of the nurses in this project moving to community health work was a conscious one away from the ‘restricted hierarchical set-up of hospitals’ where the routines and lack of time to nurse frustrated them. This was contrasted with community health nursing where they felt they were able to follow through with clients in a less restricted environment in which organisational time was flexible and client-focused.

Frankenberg (1992:1) reinforces the connections between health care and time in his discussion of time and biomedical practice, and claims that, for physicians and health workers, ‘time is not peripheral but of the essence’. He develops a commentary on the relationship between time and sickness as it is socially and culturally constructed between physicians, health workers and ‘sufferers’. He claims that, in the discourses of Western medicine, time is an essential concept with important symbolic value to medicines’ organisational and healing power. Frankenberg (1992:13) highlights the interrelations of biological, social and cultural time as a basis for power and control in biomedicine and claims ‘[t]he major mechanism of this control, so vital to the maintenance of power relations that first brings patients to the hospital and then make sure that they conform, is the control of patients’ time’. The control of time by medicine is manifested in
several ways: from medicines’ classification of illness as acute, chronic, pandemic or epidemic, to doctors receiving the longest periods of training of any profession and working longer and irregular hours than most, and to the notion of the ‘sacred’ and symbolic time of the highly qualified and revered specialist who invariably keeps patients, wards and other health professionals waiting (Frankenberg 1992). The organisation of sickness and health care in hospitals is shaped by time, as Frankenberg (1992:4) describes:

We can see that for the patients, the passage of time in hospital appears to continue inflexibly from routine with almost total disruption of the ‘normal, natural’ rhythms of bodily desires: to sleep or to go on sleeping, to eat or to refrain from eating, to evacuate waste solids and liquids, and to enjoy sexual experience.

The culture of shaping the management of sickness and health care in time frameworks is imbued in all of us and our expectations of health care services. Likewise, for the respondents and their clients in this research, time was a notable issue. In responding to why they believed women chose to use nurse-based services (see figure 18) the issues of time and place were designated as significant reasons, followed by the women clients often believing doctors were too busy for such things as Pap tests. Surveys (Pritchard 1992) and anecdotal evidence from members of the public will frequently argue that doctors are very busy people and their time should not be wasted, or that many are concerned about bothering the doctor for trivial health matters. Moreover research has claimed that consultation times are inadequate for the patients’ requirements.

Frankenberg (1992:4) proposes that nurses’ and doctors’ experiences of time are quite different. For nurses, there is scheduling of time ‘externally sanctioned and ingrained’ in which ‘clock regulated schedules’ of shifts, routines of patient care, handovers, and work time is measured in hourly pay rates (Frankenberg 1992:4). Measuring time and outputs during a nursing shift has become even more
significant with the funding formulas of today’s health system. The institutional regulation of time for nursing work and nursings’ own fixation with completing ‘tasks’ in a given time frame was often cited by the respondents as the major reason they left acute hospital settings. In Frankenberg’s (1992:4) view this reality is different for doctors; yearly paid doctors dictate times of ward rounds and particular procedures. Moreover, Frankenberg (1992:4) argues, they are forever available and for doctors there is no distinction between private time and public time, or night and day, and this creates the ‘... symbol of almost sacred power and powers’ and the revered status of doctors.

Frankenberg (1992:25) highlights how the biomedical framework has successfully created and manipulated a cultural and social context of sickness. In this way, patients’ temporalities are controlled to suit a time view of others and this ‘... produces a situation of enhanced power for the healers and reduced autonomy for the patients ...’ (Frankenberg 1992:25). Moreover, the disruption of temporalities for patients in hospital settings serves to diminish patients’ status and remove their control of their normal lives and bodily functions (Lupton 1994:95). These disruptions are often perpetuated in community health agencies such as doctors’ surgeries, health centres, and the investigative services of radiology and pathology. The relinquishing of ones temporal life is infused into our expectations of health services outside hospital settings.

**Reflecting on WHNs’ praxis and time**

Time was a significant issue for WHNs. The WHNs spoke of time from the perspectives of time as a organisational tool and as a therapeutic strategy. Reflecting on the interviews, it is clear that the interrelationship of temporality and nurses’ work is crucial to the praxis of WHNs. The issue of adequate time in health provision was raised many times by the nurses. In response to this they actively sought to structure their time to be client-focused and ensured adequate consultation lengths. Thus, they frequently cited their ability to be accessible and flexible in terms of times, venues, and the offering of outreach programs as a
distinguishing feature of WHNs service. This differentiates them from other health care providers.

As shown in Figure 21, the consultation lengths for the Pap test service as designated by the thirty-eight Pap test providers, was stated as between thirty minutes and sixty minutes, with 55% of respondents taking thirty-minute consultations, and 45% of respondents taking consultations of forty-five minutes, and 16% taking a full hour.

![Consultation length of women's health nurses](image)

**Figure 21: Consultation length**

Providing client-focused, flexible and lengthy consultations was seen as a crucial strategy for therapeutic relationships. Many nurses felt that women need ‘time’ to be able to express their health needs, both social and physiological, in the consultation. This expression was always verbal and enabled women to express ways of knowing and being through conversations with the nurses. Overall, the narratives express commitment to an unhurried consultation in which a wellness and a lifespan approach is paramount rather than the traditional episodic, decontextualised view of illness that dominates much of health.

Pritchard (1992) presents some pertinent discussion and conceptualises different types of time that impact on the patient/doctor relationship and are useful for viewing nursing and client relationships. Throughout the interviews, comments by
the nurses in relation to time are reflected in Pritchard’s (1992) descriptions of
time as ‘time empathy’; ‘time as a commodity’ and ‘time structures’.

Time empathy as described by Pritchard (1992:82) incorporates an understanding
of what an illness means to the patient and ‘... as a part of this process to
appreciate what time means for the patient. Seeing things from the patients’ view
point—‘getting in the patients shoes—’ must include a dimension of time’. All of
the WHNs spoke of empathy as a central construct to their practice, and integral
to this was structuring time to enhance interactions, and understanding time from
the woman’s perspective.

The concept of time as a commodity is not new to anyone working in health in the
1990s, with corporate catchcries of ‘quicker, smarter’, ‘improved efficiency’,
permeating everyday language. The development of Casemix funding formulas
and unit cost funding in community health has reformulated health care into
economic units. Time becomes money and money is scarce and its use has to be
prioritised. For the nurses in this project, measuring time spent with clients in
monetary terms was not a central issue; they were, however, very conscious of the
advent of unit cost funding and the consequent restructuring of their practice to
account for each client consultation. Most saw this as an opportunity to make
visible the amount of client interaction and health care they provided in a given
timeframe. Some of the respondents raised concerns that the financial pressures
facing health care may soon impinge on their ability to provide ‘quality time’
through lengthy consultations, and the potential for the introduction of a ‘fee for
service’ type model. One respondent comments thus:

_We have to argue under unit cost funding as it is at the moment that there is not enough time
for evaluation, very little time for program and planning. As far as individual consultations are
concerned, nurses are OK there because we can have short, medium, and long-term
consultations, and that can fit in to whatever you like—home based or community health
centre—so we are covered there. There also a problem [with funding] nurses are good at—
well, the intangible things—you certainly can’t_
measure it all according to the unit cost funding and put a monetary value on it. They're not interested, in that they're only interested in service provision. It's much like the AMA are with the doctors, you know, six fifteen or twenty-five minute sessions—wham, straight through. So I don't know how you measure it though it's a bit like a good practitioner and a bad practitioner, or a good medico or physio will be the one who listens and so on.

Pritchard (1992:86–9) discusses time structures related to biographical, bureaucratic, clock and calender time, and proposes that, in the main, they have served to control the time of others. In this way professions have a monopoly of manipulating time on control others. Appointment systems and waiting for doctors represents the power differential between patients and doctors (Pritchard 1992). Many of the respondents commented that women clients (see Figures 14, 15, & 18) felt doctors were too busy to offer lengthy consultations. Because of the rushed nature of doctor/client interactions, many women felt that doctors were not sympathetic to their needs and this was one of the reasons they chose nurse-based services. It seems that things have not changed much since the 1980s. After extensive national consultation (over 1 000 000 Australian women) similar client issues were documented in the National Women's Health Policy Report (1989:14). It states the following:

Many women report that the unequal power relationship between patients and health care providers can be particularly damaging and can even negate effective health care provision. Others complain of not being taken seriously when they describe their problems, having their problems trivialised by medical practitioners, not being given information so they can make informed choices and not being able to participate effectively in decision making so that systems are designed to meet their needs ...

However, for WHNs, associated with the themes of time and empathy was the theme of shared power and valuing the individual. With all the participants,
attention was given to maintaining equity and balance; to sharing power or 'expertise'. The WHNs spoke of their commitment to empowering women and giving autonomy and freedom both in individual consultations and in the group work with women.

The quotes below demonstrate their belief and practice philosophy of flexible venues and time as being a pivotal to the service that they offered:

*I think I’ve got more time—than the local G.P. for example—you can actually spend more time with the women. I think there’s a different approach—I think it’s a much more individualised approach—but I also think we’re are able to offer a far more culturally sensitive service. Because we do spend a lot more time with the clients. And you know for example, most of the client contacts I have in my case work are all home visits—virtually all. I’m not competing with the medical profession, because I’m actually going to a different type of group.*

*More time. Most women respond that it’s not rushed. At all our clinics we actually allow half hour appointments and it gives women the opportunity to discuss other things beside just their Pap smear. Which is always—100% of the time - other things come up.*

*An ease of service provision. The women are generally going to be in the normal—in for a preventative health check. A wellness approach and the service being easily accessible and not having to wait for ages or you can make appointments varied.*

*Initially we structured our appointment times for three quarters of an hour, so that we had time for women to feel comfortable, to ask whatever they wanted to talk about so that we had time—time to give them information. We could pick up on cues that they might be giving, about a problem that they didn’t really feel comfortable discussing but we’d hedge around it; we had time to explore that more with them.*
Hunt (1996) claims that the informing ideologies of the Women’s Health Movement—feminism, empowerment, and the social model of health—facilitate and shape the reconstruction of women’s health knowledge and practice. Hunt’s concept of ‘women’s health cognitive praxis’ is useful here. Hunt (1996:157 & 158) develops the concept that the ‘knowledge construction in the Women’s Health Movement is both reactive and productive’ and argues that social movements such as the Women’s Health Movement are not only ‘reactions against the status quo’ but are also visionary, and practise in the ‘hope of a new social order’. She develops this position based on a study of the Women’s Health Movement in nine Western countries (Hunt 1994). Hunt (1996:163 & 165) proposes that the ideology of the Women’s Health Movement is a significant feature of women’s health workers, who have been instrumental in constructing new modes of thinking about women and their health which give ‘voice to women’s health issues rather than professionally [read medically?] defined health outcomes’. Through the descriptions of their practice and the principles they described that underpinned that practice, WHNs in this study match Hunt’s (1996:158) propositions of a ‘proactive human agency—the cognitive praxis of women’s health activists’. Moreover, the narratives of praxis illustrate a philosophical commitment to social change through practical implementation of health service delivery. The majority of nurses spoke of practice underpinned by a women-sensitive philosophy most commonly referred to as the social model of health. Hunt (1996:167) provides a list of features of the cognitive praxis of the women’s health movement that parallels the features and principles of the work of WHNS in this study:

- an emphasis on the importance of experience;
- the creation of women’s communicative space;
- a concern to link personal issues to the sociopolitical and economic context through the strategy of ‘conscientisation’;
• a perception of women’s bodies as a resource rather than encumbrance;
• social health and action research;
• feminist constructions of knowledge as a form of resistance to patriarchal and medical constructions of women’s bodies; and
• an application of knowledge in a manner aimed at social and personal change which is useful to women.

Conclusion

This chapter has articulated the distinctive attributes of WHNs’ work related to their clinical practice. All nurses were able to describe the principles that underpinned their practice and clearly identify approaches to caring that they see as central to delivering equitable and sensitive health care. In addition, as will be discussed in the following chapters (8 & 9), they identified specific issues that impact upon their work. Overall, the interviews present a sense of enthusiasm and of the active management of the role and challenges they face in everyday practice. The following comments by WHNs illustrate this point:

Absolutely essential role. I like to think I operate on a level where I know what’s going on in the broader context as well. I’m not just burrowing down in my area—I like to have a view of the bigger picture and what’s happening everywhere else, and I’d like to think that if changes are being made in the area of women’s health, that this CHC certainly has a lot to contribute—and that we are, well, not leading the field, but we are certainly up there in helping make those changes happen. Practising health in a way that’s a little bit pioneering.

A very humanitarian, caring service, and that’s ‘it’—that’s the distinction ...

One of the important themes that emerged during these discussions about the role of women’s health nurses and the respondents’ accounts of their work, was the importance they placed on the therapeutic relationship with clients, and the view
of nursing as ‘healing work’ (Taylor 1995) with an emphasis on engaging with women within the social context of their lives. Throughout the discussions, a clear sense of a very client-focused practice emerged; the engagement and connection with clients and the development of appropriate health care for the particular clients were seen as a high priority in their nursing practice. Each nurse spoke a great deal about the importance of establishing an equal relationship with women, based on trust, information giving and empathy. Many of the nurses described the basis of the relationship as one of equal partnership in which they felt they were seen as a non-threatening health professional.

Central to the nursing work described by WHNs the ability to provide choice to women in terms of practitioner, but also by being able to give time, information and health education. As one respondent states:

I guess the big one is [what WHNs have to offer women] that we provide choice and I think that sort of stands out on its own. I have it reinforced in every clinic I run; the number of women that tell me it is so good to come and see a woman for a start, then to get the time [refers to length of consultation]

WHNs believe is it crucial for a woman to be able to make choices and decisions about her health care in ways that are often precluded in more time-bound practices such as busy medical or hospital clinics.

May (1992:474) suggests that:

Conflict and structural inequalities between medical and nursing staff—and the consequent subordination of nurses in the technical division of labour in health care—are a commonplace observation in sociological accounts of the hospital and its inhabitants. But although such inequalities form the fundamental features of relations between these occupational groups, they
should not be seen as all-embracing or absolute determinants of nurse’s work.

May’s (1992:474) point of considering other features of nursing work can be seen clearly in the nursing narratives presented in this chapter. WHNs are shaped by and are also shapers of health relations, and they are active participants in the health management of clients.

Scholarship from medical sociology presents arguments and examples of how medicine has objectified patients in which patients are identified as diagnostic categories or because of specific pathology (Edwards 1988; May 1992). May (1992:478) argues that:

... medical knowledge about the patient is constituted primarily through reference to physiology and to material practices that doctors and nurses can activate to respond to the body...

However, the nurses in this study did identify a preference for getting to know clients and indeed, as the narratives suggest, they ‘aspire to come to know the patient as more than an object of clinical attention ...’ (May 1992:483). This perspective is typified by the following comments from a respondent:

*My choice is about meeting people more in their own environment and needs rather than being focused on an illness.*

This preference has its critics. The focus on the social character and social context of clients’ lives as central to nursing work has, however, undergone scrutiny in recent debates ‘and may be seen as an elicit exposition of surveillance’ and another form of the Foucauldian clinical gaze (May 1992:484, and see Lupton 1994).
May (1992) provides a useful framework within which he conceptualises ‘foreground’ and ‘background’ nursing knowledge in connection with work and patient relationships. For May (1992) ‘foreground’ knowledge consists of knowledge about the patient based on the clinical definition of the body and mediated by the power relations inherent in hospital settings of nursing and dominant medical relationships, and the organisational features of work in a hospital. May (1992:478) contends that this shapes nurses’ work in hospitals (to ‘know’ the patient as a biological entity) to an extent, but ‘... nurses’ accounts reveal that they are at the same time involved in practices through which they come to ‘know’ the patient in ways which are more than an organic focus for work’. For the nurses in this project, the hospital context and the influence of the hierarchal power relations of hospital administration and medical power on nursing work and hence nurse/patient relations is not as dominant now that they work in the community context. This is not to say that each nurse had not previously experienced such a context and the ensuing unequal power relations. Indeed, most made references to nursing work in hospital contexts as a reason for moving to community work, because of those very power relations and the prevalence of seeing the patient simply as a biological entity. In the community context, they have left behind the biological focus and unequal power relations and are able to get to ‘know’ the client. May’s (1992:472 & 482) second category—‘background’ knowledge—moves patients beyond being the ‘objects of clinical practice and procedure’ and values ‘them as idiosyncratic subjects participating in social action’. Getting to ‘know’ the patient as a ‘social’ being is fundamental to most nursing work and is exemplified in the traditional listening and caring role. Reference to this traditional role has been both instrumental in defining nursing work and creating a problem for nursing, as the ‘social’ has traditionally not been as valued as much as scientific technical clinical (medical) knowledge.

For this group of WHNs, attention to the ‘social’ was a key feature of their work and was discussed a great deal. As May (1992: 482) suggests, developing relationships with patients and ‘knowing’ them ‘... sets out a semantic space in
which the meaning of nursing work can be located, and in which ideological notions of what nurses do can be fully enacted’. For WHNs, ‘knowing’ women not only ‘emphasised the social as a site of nurse’s work’ (May 1992:482) but emphasises the difference between nursing work and other health providers. It is in this space that ‘women’s health cognitive praxis’ occurs (Hunt 1994).

The focus on the importance of the ‘social’ by women’s health nurses is predicated on the belief that this is an empowering and less restrictive (more therapeutic) mode of health care. Others (May 1992a,b; Lupton 1994, 1995c) would argue that ‘knowing’ the patient is as problematic as viewing the body according to pathological categories, because ‘knowing’ can be open to abuse and can have as much ‘disciplinary’ intent as medical ‘imperialism’. However, WHNs actively seek to balance power relations in their interactions with women. This is demonstrated in their descriptions of the principles that underpin their work, in which women as clients are empowered and given control in the health encounter. WHNs praxis counters the negative effects of the Foucauldian ‘clinical gaze’.

Further to the illustrations of WHNs praxis, the nurses describe interactions with other health professionals. Through these they engage in a variety of mediating and contesting activities. The next chapter (8) will address data that centres on WHNs’ interface with medicine. It is here that the nurses’ narratives describe nursing work as restricted by direct activities of medical practitioners or indirectly, by the culture of medicine in society. The descriptions, however, also describe WHNs resisting such medical dominance. Furthermore frameworks from feminist and postmodern theories discussed in earlier chapters provide a lens through which to view the ever-changing power relations in any given situation and, in particular, the complex and dynamic practice world of WHNs. These theories remind us that one must be suspicious of claims to universal truths—in particular, the notion of medicine’s oppression of nursing, as if they are universal and static states for all nursing. Through the narratives they illustrate a practice world of contestation and mediation of nursing work in which WHNs are active agents. In relation to the resistance to medical dominance and the development of
their role as WHNs, they provide an approach to nursing which ‘... takes the form of counter discourses which produce new knowledge, speak new truths and so constitute new powers’ (Ramazanoglu 1993:23). Accordingly, in the next two chapters (8 & 9) based on the narratives of the nurses, discussions will centre on restriction, resistance and on conceptions of professionalism and autonomy of WHNs.
CHAPTER EIGHT: RESTRICTION AND RESISTANCE

INTRODUCTION

The group of WHNs who form the basis of this study, by virtue of providing Pap test services, provide a ‘case’ to illustrate relationships between nursing and medicine and provide ‘moments’ for theorising from the specific to the general. For this group of nurses, the sociopolitical reality of medicine which shaped their work was acknowledged as they were interviewed. Thus, medical dominance of nursing praxis developed as a common theme throughout the interviews. It is referred to here in terms of restriction and denotes medical opposition to nursing work. However, these discussions also illustrate that whilst there are indeed ‘moments’ in nursing where restriction occurs through medical opposition, there are also ‘moments’ where resistance by nurses to this opposition is managed productively, with active agency, to provide a nursing service on its own terms.

The nurses’ narratives articulated a view of the structural location of nursing in the broad context of medical dominance in health care. At the micro level, they tell specific stories of medical restriction on their practice. Significantly, there was not a sense that the medical restriction was all-encompassing or, indeed, something that circumscribed their ability to provide health care within a nursing focus. An assertion in many nursing and sociological texts is that nursing is subordinated and under the direct control of medicine. This is illustrated in recent sociology and nursing texts thus:

In the health field, medical dominance is a necessary feature of the professional power and superiority of the medical practitioner in relation to other occupations. ... Occupational subordination to medical dominance characterises both nursing and midwifery (Turner 1995:138).

While it is certainly true that nursing has a hierarchical structure and that nurses are subject to the directives of nurse superiors, ultimately it is still the doctors who have overriding
(legitimated) authority in health care contexts, and it is the medical hierarchy that reigns supreme over the nursing hierarchy (Johnstone 1994:4).44

The medical establishments’ exemplary success in constructing the subordination of nursing was due in part to its success in exploiting gender and constructing and enforcing a gender division of labour between nurses (women) and doctors (men) (Johnstone 1994:18).

The sociological and nursing literature has rightly pointed to the power of the medical profession in defining health care and the health division of labour. Medical dominance means that nursing was defined historically as subordinate part of the technical division of labour surrounding medicine with nursing knowledge and practice defined by, and in relation to, medical knowledge and practice. ... As a result, nursing knowledge and practice is still largely dependent on medical knowledge and medically defined health care needs (Forsyth 1995:165,170).

The discourse of medical dominance does not altogether fit for this group of nurses. Rather, a recognition exists that medical practitioners could and often did oppose their work but this was not seen as subordination or because they were under the direct control of medicine. It was their view that, in the context of their work as WHNs, there were moments of negotiation in which they consciously met restriction, but that they managed this as active participants in shaping their role as women’s health nurses, providing care to women in the community and in

44 Johnstone (1994) presents convincing arguments that the law has played a major role in reinforcing and maintaining the subordinated position of nursing, and consequentially nurses do not have the legal status and authority of autonomous professionals. I do not disagree totally with this position and, in general, nurses do lack legal authority. However, I raise the concern that Johnstone (1994) presents yet another totalising argument re the subordination of nurses. I contend, and this is developed in Chapter 9, that differences exist in practice and in theory to legal autonomy and the conceptions of professional autonomy.
changing the delivery of women’s health more generally in the health system. This chapter documents WHNs’ (and refers to all 50 participants) perceptions and experiences of restriction and resistance in relation to medical control of women’s health care.

NURSES’ VOICES: RESTRICTION AND RESISTANCE

Restriction

The notions of medical restriction emerged during the interviews in response to a general exploration of the role of nurses in the provision of cervical cancer screening roles. Drawing on their descriptions (the research with women aspect), and some of the statistically collated data, and incorporating further interpretations (the research on women aspect), this first part looks at the influence of medical dominance and how this impacts on the mirco-practices of nurses’ work.

The notion of restriction emerged in conjunction with the provision of Pap tests, and in relation to WHNs’ general work in the women’s health area. Prior to answering direct questions on whether medical dominance or influence impacts on their work with Pap test provision, the majority of nurses commented on the relationship between nursing work and the dominant influence of medicine on the structure of health service delivery. Responses early on in each interview to the question of why they worked in community health indicated that this form of work was measured against experiences from hospital work. All of the nurses stated that they found the hierarchical bureaucratic environment of the hospital too restrictive and this led to their move to seek different work contexts. This perspective was typified by the respondents’ comments below:

I couldn’t stand being in a hospital any longer, being task-orientated, driven by doctors.

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45 All participants except one had begun their careers in the traditional apprentice system of nurses’ training which was located in hospitals. The ‘newer’ graduate had completed a tertiary education program, however the bulk of clinical hours were conducted in an acute hospital environment.
I think there's a lot more room in community health to develop as a professional and develop other skills. Well there's a limited hierarchy—so if you have an idea, you can actually follow it through—to the end, and you can see it happen very quickly, whereas a hospital—it's a very oppressive environment.

I didn't like hospital work. I did my training in a hospital and I was very disappointed, when I finished my training with the role. I trained in a small hospital. I moved and was very overwhelmed by a big hospital system and I had a few experiences that weren't pleasant—you know—particularly in relationship to doctors.

I spent many more years in hospitals—I worked—actually my last job before community health was at hospital in charge of a ward and I found the community nursing side of it was—to empower clients, to make them have human value for their illness rather than us putting the illness as the focus. So for me it was a personal choice to get out and deal with the people in their home environments rather than staying. I guess I was very lucky at the time, because now I don't think I could work in hospitals, because of the costs and expectations of functioning—now I'm autonomous and I really dictate where I put the hours.

I didn't like working in the hospital. It was too restrictive, too confined. Basically I guess the treatment, it's too medically—has to be I suppose—its very medical—the medical model— I just find that very confining.

I enjoy working with people and to have some freedom and scope in what I'm able to do. Be more independent. I found the hospital hierarchal system very difficult to handle.

During the course of the interviews, many respondents reflected on instances when medicine affected and influenced their practice. Each participant was asked to describe major issues that existed for them in the provision of cervical cancer
screening. Responses ranged from the identification of general barriers to
descriptions of issues that they located as being related to medical influences.
These are summarised below:

- professional and clinical issues of developing sound skills to be ‘expert’
  enough to provide Pap test provision for women;
- potential legal issues;
- lack of resources and funds to provide long-term comprehensive service;
  and
- lack of support from other health professionals, in particular doctors, who
  were reluctant to support nurse-based cervical cancer services.

Notably, most had experienced no major barriers and found most non-medical
colleagues to be supportive. The majority of the nurses stated that their health
agency had been supportive of the establishment of a nurse-based service. They
identified opposition to nurse-based service as coming from the medical
profession. The support from management in training, establishing and running
the service was seen as being quite significant by the nurses, and as crucial to the
development of this nursing role.

One respondent commented:

You know other colleagues were supportive—
other nurses and allied health staff all very
supportive of it and I saw it as a really good thing
that they could refer their clients on to me.

Being able to clearly delineate support from non-medical personnel enabled them
to distinguish the effects of medical restriction on their practice.

A general question that elicited a medical focus was an examination of barriers
they had experienced in providing Pap test services. The most often-cited barrier
identified by the nurses was their perception that medical personnel in their
communities were opposed to Pap test provision by nurses. The WHNs believed
that this opposition was because doctors were (wrongly) concerned about
competition that the nurses created by delivering Pap test screening or because
doctors had actually commented to them that they believed nurses were not clinically qualified for the role. General issues cited as barriers concerned lack of time to fully develop services and the lack of ongoing professional development, and for rural practitioners, geographical distances. Matters related to broader health system issues such as lack of funding and resources and the inability of nurses to obtain a Medicare rebate number were also described as barriers to developing the service fully.

These responses are represented in figure 22 below.

![Barriers to Pap test provision as designated by nurses](image)

N=50. More than one response may have been cited by respondents

**Figure 22 Barriers to Pap test provision experienced by WHNs**

Thus, the issue of the relationship between medicine and nursing practice was raised on many occasions during the discussions with the participants. A central premise in this thesis is that medical dominance, as presently theorised in relation nursing, is an incomplete framework for analysing, assessing and critiquing substantive issues in nursing. It does however, provide *part* of the picture. It would be incorrect to deny some influence of medical dominance on nursing. Clearly, medical restriction is seen as an issue and is experienced by the nurses in this research study. What is argued here is that medical dominance is often presented as a totalising discourse in relation to nursing and, as will be presented in the following discussion, there are, in nursing, sites of resistance to the
restriction of medical dominance on WHNs' practice. Furthermore, the narratives demonstrate conceptions of nursing practice that are beyond restriction and resistance.

Drawing on postmodern and feminist perspectives, this research highlights that examining nursing work attests to the existence of counter discourses that present alternative views. As Lupton (1994:11) claims '... all knowledges are inevitably the product of social relations, and are subject to change rather than fixed' and that '[h]uman subjects are viewed as being constituted in and through discourses and social practices which have complex histories'. Likewise, nursing practice is constituted through certain discourses; but these discourses are complex, subject to change and in need of explicating to uncover the realities of nursing work.

Medical influence, referred to by the participants as restriction and opposition, was a common leitmotif throughout the interviews. In addition all participants were asked directly if they perceived that their work was organised and or affected by medical influences.

Two thirds of the nurses (60% N = 50) believed that, directly and/or indirectly, their work was restricted by medicine. One third (40% N = 50) of the respondents claimed that medicine did not influence their work.

Of the 30 nurses who thought that medicine clearly did, in some way, affect their work, three patterns emerged within the responses. In order of frequency of citation are, first, descriptions of opposition by doctors in their communities to the establishment of nurse provision of Pap tests. This is particularly relevant, as the criteria for training and funding from funding bodies includes obtaining support from local medical practitioners. These criteria are based on the necessity of ensuring referral mechanisms and protocols to facilitate communication and consultation between health providers for the consumer's benefit. The nurses believed that this mode of opposition was based on a belief by doctors that Pap test provision was not a nursing role. This is illustrated by the comments below:
From the doctors, some medical resistance; the doctors thought that it wasn’t a nurse’s role and also because of the money.

It was difficult because of the doctors—they were trying to—I guess put nurses back in their traditional boxes—and felt that it’s not an area were nurses should be involved. They thought it was taking their business away— because we weren’t getting Medicare rebates for it, so that’s money the centre was losing—when in fact our target group was unscreened and under screened women anyway, so it shouldn’t have had any bearing there—but trying to make them listen was very difficult.

Well—it was affected to start with—that at first I wasn’t sure I’d be allowed to practise. Affected greatly to start with—but after time one of the main doctors against my program was one of the female general practitioners—but eventually she became my supervising doctor and she was fantastic.

Terrible—there’s a terrible culture within the medicos that work here—very exculsionary of nurse practitioners—so that’s been the real bane of my life—I suppose—that’s still an issue—they still—I mean we’ve had plenty of meetings and we’ve had mangers, nurses and doctors that come out and speak to us as a team and say this is how we operate—but the doctors here will not participate. It’s turf—turf issues.

Many nurses expressed the view that, while many of the doctors challenged nurses on the basis of Pap tests not being a nurses role (because they did not have the appropriate medical training), the crux of their objection in their opinion was to do with market share issues and nurses taking work away from doctors. In response, the general opinion from the nurses was that most of the nurse-based programs do not constitute a threat to doctors’ ‘markets’ since they target ‘at risk’ women—older women, women from lower socioeconomic groups, women from non-English-speaking backgrounds and Aboriginal women—who would not be
accessing mainstream health services. In general, the nurses felt that they were successful in screening unscreened and underscreened women from the ‘at risk’ groups. This opinion is supported by the final report of the Pap Test Victoria program (1995:5). In relation to older women, for example, this report claims that Pap Test Victoria nurses ‘screened a higher proportion of older women compared to all service providers registered through the Victorian Cervical Cytology registry. In addition, 42 per cent of women screened by the nurses had either never had a Pap test or had not been screened within the previous five years, compared with 26 per cent of all women screened through their general practitioners’. Moreover, the report (1995:49) states that the Pap Test Victoria program demonstrated that nurses were able to reach women ‘with a different demographic and screening profile from those seen by general practitioners’.

Secondly, a pattern emerged, spoken of with great frustration by the nurses, of the constant requirement, when encountering doctors, of having to justify decisions made and to explain their knowledge base in relation to Pap test provision. This attests to the biomedical model as a dominant discourse in which only medical knowledge and expertise is seen as legitimate. Two participants commented thus:

*An ever present fear that they are going to snatch the speculum out of your hand* [laugh]—*in this setting I always seem to have to justify my professional expertise and my assessment of the situation.*

*It has been difficult the doctors are very medically orientated. They’re not interested in community health, never refer to self-help groups for example and are not supportive of prevention—and I have to justify my expertise if I do* [cervical cancer screening] *programs.*

Stemming from doctors’ belief that nurses were not qualified for this role, nurses also encountered indirect opposition from doctors. Women clients commented on being ‘sanctioned’ by doctors for attending nurse-based services. One respondent describes this aspect:
When you’re talking about small country towns—and you know—no one wants to upset the doctor—doctors are gold—and that’s the culture—so you have to work very carefully, and slowly build a support network, in terms of—well if you are going to do something like this—it’s a political activity. The doctor’s we had at the time of starting—this is changing but the doctors were really crusty old blokes who’d been there for—well—delivered three generations. And so he was everybody’s doctor and there was an other older doctor between three major towns that we were targeting—so we had to be very careful about—well we didn’t want to set the women up—you know, if there was a problem we had to refer back to these guy—which they don’t have a problem with in the event of an abnormality—but they would growl at the women for going to nurse. I suppose it also a personal one about—I really do have to stand up to these guys—in the doctor nurse relationship—it’s still scary standing up to these people—you’ve got to have your facts absolutely correct so—we had to work through all of that.

Thirdly, another feature cited as indicative of medical opposition, but perhaps attributed to the broader culture of biomedical dominance in health care, was ‘expectations’ of health encounters. Comments on clients’ responses to WHNs’ work was a constant feature of the interviews. From anecdotal feedback and from formal evaluations of the services46, the WHNs have accounts of client evaluations which contain positive comments in regard to waiting times, length of consultations, the clinical service and to the general approach of the nurse practitioners. This approach was differentiated from ‘normal’ experiences of health encounters by explanations of the clinical procedure to follow, of involvement in any decision making and the information offered during the nurses’ consultation. In addition WHNs often commented upon evaluations in

46 It is common practice to organise written evaluations on a regular basis from clients for quality/best practice reports, client numbers and for funding requirements.
which women clients noted the lack of 'power differential' between nurse and women clients.

Another form of medical opposition relates to structural limits to nursing work that prohibit a wider role, such as restrictions on pathology testing, drug prescribing, medicines' successful blocking of Medicare rebates for nursing work and a lack of formal referral mechanisms for nurses. These aspects were seen as restrictive on the scope and role of their work. These issues are structural components of the current health system, and the respondents identified them as part of a system that supported medical practice over nursing work and directly affected their capacity to provide comprehensive nursing care. For example, the following comments from nurses identified the presence of these issues:

*it creates limitations to my practic; my practice is certainly not organised by medical practitioners but the limitations on prescribing and pathology etc... I don’t think we should be treating things—I think doctors should continue to treat the abnormal. I’m very happy to stay within the well context, but I think when you have a woman on the couch taking a Pap smear and you see something that you think needs further treatment—you see a bit of pathology and you need to take a swab or something—I think we should be able to have the authority to do that without rushing off to doctors for that—and then you refer them on. But instead of referring them on so she has to have that examination again - the swab the next day. But as I said I’m very happy to refer on. I still think we should be practising within the realms of well women. Look, you also get the hostility from general practitioners all the time.*

Yes, absolutely, oh yeah a lot of influence—from the medical profession—the fact that we can't get Medicare provider numbers. The fact that we are doing a Pap test and a vaginal examination but we are not allowed to take swabs—and do pathology. All the opposition and barriers that doctors put up in various places—the whole way the practice of nursing is
seen sort of as a bit of a subset of medicine, it's not like a profession on its own. I saw a really good quote from Bob Brown—he said—he was doing an interview for the ANJ and he summed it up pretty well—the power difference between nurses and doctors, it's not because doctors have done a six-year degree and nurses have only done three years—it's not because your dumber—it's because doctors have got the power over the means of production—you know it all gets back to income and money and how much control you've got there.

One of the barriers to the nursing role when I do Pap smears and there is an abnormality I then have to refer them to their general practitioners, who then has to refer them on and it seems an unnecessary step.

Of the twelve nurses who did not provide Pap test services at the time of the interviews, only two attributed this to direct medical restriction of nursing practice. In both of these instances the nurses were unable to practise Pap test provision as a result of direct intervention by medical practitioners lobbying the management of the health agencies and the community to prevent the establishment of nurse-based services. Another was unable to provide the clinical service, but did not attribute this to medical influence. Rather, the reason was perceived as a health service distribution issue, as Pap test services were run by a female doctor and the nurse decided to focus her work on health promotion and health education. Of the other nine not currently practising, five were just establishing services and were either 'buddying up' with other nurse-service providers or had only done supervised Pap test provision. Another four had been practising but through restructuring, funding or job changes, were not practising at the time of the interviews.

Whilst this group of WHNs clearly identified medical dominance as a dimension of the context within they worked, they also indicated that they negotiated around this or claimed that this was not a dimension of their practice world. Only two
WHNs claimed direct restriction on their cervical cancer screening practice; twenty eight identified medical restriction as existing in relation to their work but all had provided a service anyway. Twenty perceived that their work was not organised or influenced by medical dominance. This latter group did not identify subordination, exclusion or limitation in the delivery of their nursing service.

The dominance of medicine in health care has been a common topic in health and sociological discourses in contemporary western society. Adamson, Kenny & Wilson Barnett (1995:173) claim that ‘medical dominance of health care, in most English-speaking countries, has traditionally been the organising principle in health care delivery’. Nursing has a long and chequered history in challenging (and critiquing) the traditional power of medicine (Witz 1994:23) and in contemporary nursing scholarship and practice, the realities of medical dominance are continually felt and analysed.

Willis (1989) has identified factors that, in his opinion, sustain medical dominance in Australia: the ability of medicine to exercise autonomy and authority over its own work and the work of others and the ability of the medical profession to control activities in the wider health system. A common proposition applied to nursing and other health occupations in Australia, drawn from Willis’ (1989) thesis, is the exercise of authority by the medical profession, shaped by a framework of subordination, limitation and exclusion of other health occupations.

Willis (1989:6 & 92-124) describes doctors’ direct control over midwifery, as illustrative of subordination. Moreover, he claims the subordination of midwifery is related to the sexual division of labour and occupational divisions in labour in the health system. Limitation is another mode of domination described by Willis (1989), characterised by legal restriction of occupational territory, and optometry is cited as a case in point. The final category developed by Willis (1989:6) is exclusion. Chiropractic is proposed as an example of an occupation in which exclusion occurs. Exclusionary tactics are noted through the denial of official legitimacy in the form of licensing and Medicare rebates. Willis (1989) provides
an important framework for understanding the relationships between health occupations and medicine. But for women’s health nursing, this examination needs to go further if we are to analyse the features of this domination and assess its utility for other groups in nursing in the contemporary context. For example, Wicks (1993:4) contends that Willis’ (1989) influential account of medical dominance over nursing is ‘... so taken as a ‘given’ and no further explanation is given ...’ Her concern is that he ‘acknowledges that nursing is structurally subordinate, but makes no attempt to theorise or document the process of (in his terms) the production or reproduction of this structural location or relationship’.

Another unfortunate element of much of the theorisation on the subordination of nursing is that conclusions drawn from midwifery and hospital nursing are extrapolated to all nursing groups. Moreover, as Walby and Greenwell (1994) argue, medicine and nursing operate from different conceptual frameworks and thus conceptualising medical dominance and the subordination of nursing only through sociology of the professions gives a partial picture. Theorising the subordination of nursing also needs to consider different contexts in which nurse–doctor interactions take place. Contemporary nursing practice takes place in varied environments and this gives rise to different dynamics in the knowledge/power relations of health care.

Reflecting on this, and noting that medical dominance was not a totalising force but subject to resistance, and that for some in the group it was not perceived as a relevant force at all, suggests mapping a different concept to analyse these aspects of WHNs practice. Rudge (1996:147) claims that many of the theories that inform the ... ‘unpacking’ [of] nursing practice’ are ‘... overwhelmingly pessimistic about nursing future and promise’. She argues that:

In opening spaces, in questioning the power relationships and in attempting to re-shape nursing practice, sometimes these analyses can seem to come up against the hard wall of continuing effects of medical/scientific discourses and other dominant frames such as gender. Rather than the reader express the feeling, ‘oh no! not another look at the
dominance of medical/scientific knowledge’, I want to suggest that reflection, reflexivity and (re)visioning are positions which continually challenge nursing.

Moreover, this author proposes that using ‘... postructural and praxis-orientated analyses exposes differences in the ways that nurses talk about, think and practise nursing’ (Rudge 1996:147). My aim is to expose the differences that exist in the practice narratives of WHNs and so articulate not only the alternative ways that nurses practise, but challenge the ways that nursing is understood and analysed. Thus, the following discussion will consider resistance to medical dominance in WHNs’ work.

Resistance

In theorising the relationship of knowledge and practice dimensions in WHNs’ work, power/knowledge theorisation has offered a conceptual tool. I have grounded the approach to power within Foucauldian and feminist frameworks to view the varied and alternative voices that exist in nursing practice. Inherent within Foucauldian and feminist conceptualisations is the notion of resistance. Foucault (1978:95) connects power/knowledge and resistance, and argues the following: ‘[w]here there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power’.

Clearly, WHNs resist medical restriction of their work and have a distinct approach in delivering women-centred health care. It seems that they negotiate around or do not perceive that they encounter restriction to their practice. Thirty participants identified medical opposition and restriction within their practice context. Within this group, only two identified that doctors had prevented them from offering the service. Another respondent was unable to practise cervical cancer screening due to other issues, not to medical opposition. In total forty seven of the participants developed and practiced cervical screening, even when
some perceived that they encountered medical opposition and restriction. This service, along with the general activities of women’s health service provision, as described in chapter seven, demonstrates nursing practice in which WHNs both mediate and contest their role within a milieu of medically driven health care services. In theorising from the narratives of WHNs on this issue, one can see the development of a nursing role that suggests both restriction and resistance takes place in the every day practices of these nurses.

This research has focused on the content of nursing work and as Witz (1994:24) argues:

> It is the new focus on the content of nursing work which more directly challenges the traditional doctor led model of health care. It does so through an increasing emphasis on a patient-centred, care-driven model of nurses’ practice, underpinned by a holistic model of health and elaborated by means of a discursive reworking of the centrality of caring activity as a skilled and indeterminate, theoretically informed activity at the core of the new nursing role.

Through unpacking ‘resistance’ and focussing on the content of nursing work, we can (re)formulate theories that best describe what actually happens in nursing. Drawing on conceptualisations from Foucault and other authors (Cooper 1995; Faith 1994; Lupton 1995; and Sawicki 1991) who contend that there is ‘power in struggle’, we are able to capture the different dimensions in which dominant forms of power also create spaces where resistance, activism and change occurs. In this way we can build more appropriately-nuanced versions of the reality of nursing, that move on from repressed and submissive views of nurses, to seeing nurses and nursing as proactive, agentive, and, I would advocate, as activists for social change and reform in health care.

Lupton (1995:132) argues that there is central paradox in Foucauldian theory: she claims that ‘one confusing and ambiguous aspect of Foucault’s writing about power is the dialectic between power as simultaneously productive and as
repressive’. It is precisely this paradox that I utilise for this research. For there is evidence from WHNs (and possibly from many nursing groups) that, whilst on one hand they are located within an oppressive and restrictive environment of medical dominance (and more recently the new managerialist activities) in the health care system, they are able to ‘resist’ this dominance or work through and around it. Importantly, and what is less articulated about nursing, is the actuality of empowered nursing practice and the use of power as a productive force. In this conceptualisation nurses challenge dominant discourses and, as the next chapter will illustrate, embedded in nursing practice there are ‘new’ discourses to be found, if one explores how nurses conceptualise their work. Here however, I return to medical opposition and resistance by nurses.

In chapter 7 the data shows that all of the respondents identified particular approaches to practice, underpinned by certain philosophical principles, described as based on women’s health movement philosophy and principles. This approach is an alternative discourse and praxis to mainstream medical health provision. It represents a challenge, and can be conceptualised as resistance to the dominant discourse of medicine and, at the local level, medical practice. This group of nurses not only articulates a distinct knowledge base, but through practising from this base, presents a strategic and proactive approach to the many challenges they face in providing a women’s health service. Foucault (1978:95–6) maintains that in understanding power relationships one must consider resistance and argues, rather poetically the following:

Their existence depends on a multiplicity of points of resistance: these play the role of adversary, target, support, or handle in power relations. These points of resistance are present everywhere in the power network. Hence there is no single locus of great refusal, no soul of revolt, source of all rebellions, or pure law of the revolutionary. Instead there is a plurality of resistances, each of them a special case: resistances that are possible, necessary, improbable; others that are spontaneous, savage, solitary, concerted, rampant, or violent; still others that are quick to compromise, interested,
or sacrificial; by definition, they can only exist in
the strategic field of power relations.

Each nurse in this study told stories that display a strategic approach to providing
and developing a nurse-based women’s health service in their communities. As
stated, all but three had been or were practising cervical cancer screening at the
time of the field work and had managed to contest medical opposition, negotiate
around it or claim that it was not an issue in their work. Many of the nurses were
quite strategic in responding and negotiating around medical opposition. One
respondent’s comments indicate this, when she states:

I would say my work is affected by them
[doctors] but not organised by them. Basically—
I do a clinic—and probably a lot of people have
forgotten about this now—in the sense that I
went around to all the doctors and sent them
information about the program. It’s not until
one of their clients sees me and asks me to pass
on their results to the doctor that they are
reminded that I’m still doing it after three years.
So I don’t think my work is organised by them;
basically I organise my work myself; it’s
affected by medical influences in the sense that
I keep an ongoing link with a gynaecologist,
also so that I get appropriate feedback, and
have somebody that I can check with. And from
the negative aspects of you know, of criticism—
it’s negativity toward a nurse practitioner doing
it, so from that point its affected by it I suppose,
the service isn’t affected by it. But the
attitudes—I don’t think we are getting far you
know. What they say to you privately is different
to what they say publicly. I never had any en-
masse saying I don’t want you doing that by a
group of doctors or anything; like its more
personal comments.

Foucault’s notions of resistance provide a framework for viewing productive
patterns of nursing work. In this view nurses are both shaped by and ‘shapers’ of
their environments. Drawing on Foucault, Sawicki (1991:23) contends:
That the practical implication of his model is that resistance must be carried out in local struggles against the many forms of power exercised at the everyday level of social relations.

It is at the everyday level of social relations that WHNs operate. In utilising Foucault’s reconceptualising of power, that is, power as productive and as a ‘generation of effects’ (Cooper 1995), it is also important to conceive power effects as multiple and fragmented. This view allows for the contradictory nature of the practice world of WHNs, in which ‘individuals are neither totally powerless nor powerful, but continually positioned and repositioned in relation to power’ (Lupton 1995:133). WHNs move between dominant discourses and discourses created by a woman-centred praxis, in which subjects exercise power/knowledge as well as experience the repressive nature of power relations.

Further to the concept of resistance in relation to medical control of health care, WHNs continue to develop a women-centered analysis of women’s health care and maintain activism in order to create change. As can be seen in the narratives (presented in this chapter and chapter 7) a continued commitment exists to further develop the role of women’s health practitioners and to provide women sensitive health care services. This highlights another dimension of resistance—activism. This praxis and alternative discourse of WHNs is reflected in radical feminist positions on women’s health care.\textsuperscript{47} The concept of ‘women’s health cognitive praxis’ (Hunt 1996) cited earlier, in chapter 7, can claim to be a form of resistance through reconstructing women’s health knowledge and practice. Faith (1994:37) argues, drawing on Foucault’s notions of resistance and radical feminism ‘... resistance to invisibility and silencing’ and ‘[f]eminist resistance is articulated through women’s movements and through individual actions, including refusals and separations’. She further argues that:

\textsuperscript{47} See Rowland and Klein (1996). These authors argue that central to women’s liberation is women’s ability to control bodily integrity and autonomy in health care and the way that radical feminism has addressed this is through analysis of
Feminist resistances challenge patriarchal power/knowledges and challenge institutionalized silencing of alternative discourses. Feminist resistances are community-based, from the grassroots, and are grounded in diverse women’s beliefs in their rights, but even more in their needs, to transform the society in which they live, to change their relationships, home life and/or workplaces.

In mapping the practice of WHNs, various elements of resistance can be noted. Firstly, WHNs mediate and contest their practice within the context of medical dominance. Secondly, through providing a distinct women-centred clinical practice, and through being involved in political activism, WHNs maintain resistance and work toward social change. In addition to the praxis identified in the narratives, WHNs are on committees, in action groups, lobby government and respond to letters, policy papers and attend forums related to women’s health nurses’ roles and broader issues related to the provision of women’s health care. These activities are well documented in a publication produced by the Women’s Health Nurse Association. The Women’s Health Nurse Association of Victoria produces a publication three times a year, in which they document activities of the Association and Women’s Health Nurse Practitioners from around Victoria. This publication attests to the active role these nurses play in social change and political action for women health. In 1997 the publication recorded various inservices run by the organisation for clinical and professional updates. It documented the lobbying by WHNs at a forum, convened by the ANF Victoria branch and attended by the State health minister, on the role of and development issues for Nurse Practitioners (NP) in Victoria. The minister is proposing to establish a steering committee or advisory working groups to review NP issues and is intending to establish pilot projects to consider the roles and responsibilities of NPs. It states in the publication that WHNs intend to be involved in these activities to further represent nurses’ and women’s issues. In addition, WHNs are

the body as a site of oppression and through the activism of the women’s health movement.
involved on the advisory committee and as participants in a state-wide research project on professional credentialling for nurse Pap test providers, which will be part of national system called Certificate of Continuing Competence. The document also publishes responses to any reports, policy documents and articles that are related to WHNs. For example, the Summer 1997 edition reports on an inaccurate article in the Medical Observer in relation to nurses and Pap smears and reprints the response to the Observer addressing this misinformation.

Reflecting on the positioning and repositioning of the power relations inherent in the practice settings, it is clear that WHNs move between discourses of medical dominance (translated in practice to opposition/restriction of WHNs’ work) and resistance translated in practice to women-centred praxis health care. This moving in between discourses can be interpreted using postmodern conceptualisations of the fragmentary and contradictory nature of knowledge/power relations and radical feminist conceptualisations of uncovering subjugated knowledges and the inherent activism of women’s health praxis. Extending the conceptualisation of fluidity—of WHNs moving in and out of dominant discourses—locates them on the margins and at the centre of dominant discourses. Viewing the praxis of WHNs on the margins of discourses offers a space to further theorise nurses’ work.

The concept of marginality is most often referred to in relation to disenfranchised groups as client/receivers of health care in the community (see Stevens 1993). However, nursing is beginning to address marginality as a positive proposition in some situations for clients and nurses (Hall, Stevens & Meleis 1994; Pilhammar Andersson, 1995). Hall, Stevens & Meleis (1994:36) examine the possibilities of nurses gaining knowledge about clients on the margins and claim ‘... experiences at the margins hold promise of capturing the specificity, scope and variability of health ...’ and thus refute the universalising empirical and clinical approaches often used in relation to client groups. Pilhammar Andersson (1995) claims that the marginality of nurses related to educational issues for student nurses can be both positive and negative as they intersect in different cultures; they can be
restricted and/or can be freer to practise. However, I will place another focus on the concept and use marginality to view the work of WHNs in the context of theorising nursing work from the outside and from within dominant discourses. Thus, I propose that in reflecting on WHNs and their location on the margins, marginality can offer a conceptual structure to view the fluidity of the opposition, resistance and agency in the nurses’ work.

The concept of marginalisation, as it refers to people, locates people on the periphery or on the border of society, and sees them as disenfranchised in terms of identities, environments, gender, race, sexual preference, political, economic and cultural specificities. For bell hooks, marginalisation is a central concept in her analysis for a more inclusive feminism. She reframed marginalisation as more than a site of deprivation; in fact as oppositional, and claims that:

[I]t is also the site of radical possibilities, a space of resistance. It was this marginality that I was naming as a central location for the production of a counter hegemonic discourse that is not just found in words but in habits of being and the way one lives. As such, I was not speaking of a marginality one wishes to lose, to give up, or surrender as part of moving into the centre, but rather as a site one stays in, clings to even, because it nourishes one’s capacity to resist. It offers the possibility of radical perspectives from which to see and create, to imagine alternative worlds (hooks 1990:341).

Viewing the concept in this way is illuminating for understanding the work of WHNs, for this small group is working on the margins of health care in the community, providing health care to diverse groups of women. They practise a model of care built on experience, different from mainstream conceptualisations of health, offering care that meets the needs of women in their communities. Marginalisation is often associated with oppression, but marginalisation is not the same as oppression. Hall, Stevens and Meleis (1994) claim that:

[Al]though marginalisation and oppression are frequently concurrent processes, marginalisation
can be viewed as inclusive of oppression, incorporating aspects of experience beyond power imbalances. (Hall, Stevens and Meleis 1994:25)

I am interested in going beyond the power imbalances and viewing marginalisation as a concept that incorporates fluidity, agency and difference. If we view marginalisation through this lens, then reconceptualisations of nursing work can occur. It is an approach to understanding nursing practice that ‘... is an intervention. A message from that space in the margin that is a site of creativity and power ...’ (hooks 1990:343). In this way it is possible to extend and highlight the dynamics of marginalisation as an empowering concept, recognising diversity and difference in delivery of health care. bell hooks (1984 preface) suggests:

We looked both from the outside in and from the inside out. We focused our attention on the centre as well as on the margin. We understood both. This mode of seeing reminded us of the existence of a whole universe, a main body made up of both margin and centre. Our survival depended on an ongoing public awareness of the separation between margin and centre and an ongoing private acknowledgment that we were a necessary, a vital part of that whole.

WHNs are well situated to illustrate hooks’ (1984) statement above; her conceptualisation is apt in relation to WHNs’ praxis. WHNs come from a background of traditional (acute care) training and work experience; they have (and do) intersect with the mainstream and they operate on the ‘outside’. They have developed expertise in which they traverse between the two domains to offer women’s health care in partnership with women in the community.

Another analysis that conceptualises marginality and which I wish to draw on is Pettman’s (1992) text, in which she examines living on the margins as an Aboriginal or non-English-speaking women. This author develops an analysis of representations of difference and contested identities, based on normalising
categories which deny indigenous or non-English speaking women agency, visibility and praxis. Her analysis offers some important insights for this project. Theorising on race, ethnicity, class and gender, Pettman (1992:106) maintains that dominant discourses constitute certain social forms in which the powerful become the norm. This, she proposes, serves both to universalise and individualise subjects, and so renders ‘difference’ invisible. The notion of invisibility, and the way difference is managed within dominant discourses in relation to WHNs’ work, is pertinent to this analysis. Nursing models of care have largely remained invisible within the dominant discourses of health care. Likewise, the nature and legitimacy of models of women’s health care practised by nurses are invisible within the dominant discourses of medicine. Pettman (1992:106) constructs an analysis in which ‘[s]ites of difference are sites of power’. Moreover she claims:

But identity and difference are not only imposed. Identities are also sources of opposition and resistance, mobilised in the name of different political projects. Groups constituted as Other organise in resistance in different ways. They may deny the validity of boundaries or of categories that entrap them.

WHNs narratives demonstrate that these nurses ‘deny the validity of boundaries or categories’ of the subordination of nursing to medical dominance. WHNs are not entrapped by the dominant discourses of health and health care as they move between the margins and the centre to deliver a visible nursing focused model of health care.

**Conclusion**

The data presented in this chapter illuminated the themes of restriction, resistance and agency. These themes were discussed in relation to theoretical propositions from postmodern and radical feminist theory. In addition, the constructs of *marginality* and *difference* were incorporated into the theorising on WHNs’ praxis. These constructs further illustrate the fluidity and contradictory nature of WHNs’ mediation and contestation within their praxis. The data demonstrate the
activism and agency of WHNs' praxis in the context of the dominant discourses of health care.

In conjunction with the themes of opposition and resistance, agency and activism, WHNs identified issues related to professionalism and autonomy. Emerging from the interviews these themes represent a discourse that characterises the unique nature of WHNs' praxis. An important thread in radical feminist theorisation is the notion of uncovering subjugated knowledges and hearing previously silenced voices. In critiquing dominant patriarchal knowledge forms, radical feminism has raised questions about women's knowledge forms, and central to this critique has been making women's knowledge visible. In the next chapter (9) the voices of WHNs on professionalism and autonomy are uncovered. Data from the interviews attests to a position which is beyond opposition and resistance and which identifies WHNs' discourses on professionalism and autonomy as alternative or counter discourse to the traditional discourses on nursing professionalism and autonomy.
CHAPTER NINE: BEYOND RESISTANCE: NURSES, PROFESSIONALISM AND AUTONOMY

INTRODUCTION

This chapter examines the third thematic grouping of the narratives by the women’s health nurses (WHNs). It focuses on WHNs’ conceptions of professionalism and autonomy. Clear voices of distinct formulations on professionalism and autonomy emerge from the narratives.

In the preliminary stages of this study (through discussions with the members of the WHNA at inservices with large group of WHNs), WHNs frequently incorporated the term ‘professionalism’ in discussions of their role. When I was preparing the semi-structured interview questions and developing the pilot questionnaire, professionalism emerged as a key concept in need of further exploration. Debates on professionalism in nursing—particularly on the professional status of nursing—have been a central feature of nursing scholarship for more than a century (Turkoski 1995). Thus, to examine this concept for the group, a specific question was included on what ‘professional’ meant to them. It was also notable that, when the nurses raised the concept of professionalism during the interviews, the notion of autonomy was integral to their notions of professionalism. Thus, a specific question on the meaning of autonomy for this group was also included.

So central were these two concepts that they became recurring themes throughout the interviews in general. During the interviews, the participants frequently situated themselves thus: ‘as a professional I believe I needed to build on my initial qualifications’, or ‘as an autonomous professional I need to have a strong knowledge base’. Their narratives on professionalism and autonomy repeatedly focused on the content of their work and their particular expertise. In addition, they voiced their commitment to a client centred model of practice. It is these themes that the discussion addresses.
Nursing and professionalism revisited

All respondents identified themselves as ‘professionals’. Only four respondents declined to describe specifically what being ‘a professional’ meant to them. These four felt they were unsure what being a professional meant because it didn’t ‘fit’ with their concept of other professional groups or because they didn’t like labels; for example, two nurses stated:

I really don’t give much time to thinking about whether you’re a professional or what ever else you are not—I mean this is the work I do, I enjoy it and they are really sort of fairly arbitrary labels that are slapped upon categories of workers.

I really hate that word—but I suppose it depends on what it means. There’s the traditional sense, but I don’t know what it means for me.

However, the majority, of the respondents (92%), articulated their concept of being ‘a professional’. The following comments demonstrate a focus on developing and maintaining a knowledge base, with a commitment to client service and a responsibility to clients.

I do see myself as being a professional. It means having—well it’s on many different levels—it’s not in any order of priority—but more of a conglomeration of these things—things like having a specialised area of knowledge, which I’m able to call upon in the day-to-day things that I do; that I can also call upon in terms of looking at broader health policies and what the influences are, so its not just the day-to-day stuff that defines me as a professional, its my broader understandings in terms of at a policy level or at a political level; having that awareness and how that impacts on the women and their health issues. It is also maintaining a profile in this organisation—maintaining a profile of women’s health here. Keeping the profile high, having a commitment to what it is
that I actually do, and a belief in what I do, and keeping really up to date.

I determine what I do. It’s being responsible to ensure that your knowledge and expertise is kept up to date. I’m responsible for my own work practice and providing a quality service to women.

It’s about providing a confidential, quality service, that meets the guideline or protocols of what’s been designed, and having a knowledge base is certainly very important.

Being expert at what I do and provide a service to the whole community.

Being respected for my decisions and the knowledge base I have developed.

It means being accountable, being responsible for my actions, and offering a confidential service, but more for me, it is about having skills and being an ordinary everyday person, just like the person next door who’s easy to relate to, and is flexible, non judgmental.

Professional—I don’t particularly like that word. I suppose that brings up ideas of elitism and being up on a pedestal—that’s probably just my background, my working-class background, so I don’t like that so much, that word - but in another sense I can see that it’s really important for nurses to see themselves as professionals and I suppose that means we have expertise in an area, and we’ve studied, we are qualified to practise in that area—and there’s legal requirements around that, and that the community see that it’s a valid point of service. And working that way – it’s not a masculine model though - not that every nurse works from a feminist model, but I think it’s really important that the Well Women’s Services—the nurse practitioners, the lot of them, are really
For many decades the debate around the professional status of nursing has been occupied with the questions of whether nursing is or is not a profession or how it attained this status. The attainment of professional status, centring on the dominant paradigm of professionalism of the time, which incorporated the criteria or traits model, preoccupied nursing debates in the United Kingdom, America and Australia from the 1960s through to the 1980s. The driving force behind the goal to achieve professional status in nursing came from the belief that this strategy would legitimate status, gain control over education and practice and give rise to more autonomous nursing practice. Drawing on Freidson's (1970; 1973) analysis, contemporary sociologists have criticised the focus on traits of professionalism and have extended analysis to include the control of knowledge, giving rise to power and autonomy over others (Willis 1984; Daniel 1990). These authors focus on power, control and exclusion of others as the means of securing professional status and monopolistic practices. In many of these analyses, sociologists have claimed that nursing has not/will not achieve professional status because of the subordinated position of nursing; that is lacking the authority and autonomy necessary for professional status (see Daniel 1990; Willis 1989). Ann Daniel (1990: 34–65) presents a synthesis of the debates on what constitutes a profession and comments on the significance of these for nursing, claiming that the authority, autonomy and status of a profession is is unlikely to be realised for nursing. The problem with such analyses is that hospital-based nursing is the

48 Lists of professional characteristics described by the likes of Talcott Parsons (1976) were very influential and were utilised as the measurement for occupations wishing to prove/attain professional status. In addition see Hunt and Wainwright (1994) who provide a review of the arguments associated with nursing and the professionalism debate.
49 See chapter 3, sections on nursing and professionalism and medical dominance, for more detail on the dominant model of professionalism.
focus for making generalisations about nursing’s professional status. In many of these analyses, autonomy becomes the key attribute for professional status. For Daniel (1990) a group’s ability to gain autonomous control over a knowledge base, training and practice becomes the defining feature of professional practice and provides both social and legislative authority and power. As Daniel (1990:62) states:

Autonomy, based on knowledge claims, definitively expresses the power of a profession to control its field of work and its own reproduction. Professions control the criteria for entry, the lengthy educational training, registration, and standards of practice and conduct within the profession.

Johnstone (1994) relates nurses’ lack of autonomy to lack of legal authority and hence lack of professional status. She claims:

Nurses still lack legitimated authority as autonomous health professionals and still do not have ultimate control over their own affairs—including education, practice, research and education (Johnstone 1994:24).

Here, autonomy is tied to legal status and legal recognition. For Johnstone (1994) this is centred on a gender analysis of law as a ‘master discourse’ in which nurses have no legal authority to match their responsibilities in the health care system, coupled with the master discourse of medicine as a dominant force in shaping and restricting nursing work. However, the nurses in this study clearly define themselves as professional and consider themselves autonomous. They feel they can direct practice and have authority to manage health care in their practice environment. This is not to dispute Johnstone’s (1994) analysis—that, in legal terms, nursing lacks substantive legal authority or sovereignty over its own realm of practice. Ultimately the law, usually through the requirement of medical approval and written orders for treatments, obstructs nurses’ ability to practise as independent autonomous professionals. There is substantial evidence to support
this argument in many nursing contexts. The concern raised by Johnstone (1994:xiii) and the stark reality is that for nursing, this presents an unsatisfactory, if not dangerous, impediment to ‘practise their profession in a safe, effective and morally responsible manner’. Johnstone’s (1994:8) position is demonstrated through the analysis of litigation involving nurses; ‘... nurses still lack the legitimated authority to exercise independent (medically unauthorised) professional judgement ...’. This lack of legal status represents a ‘catch twenty-two’ situation for nurses. On one hand it requires nurses to be beholden to doctors, employers and hospital administrators for actions and instructions. However, if a nurse contests, refuses or even carries out an order/treatment that subsequently turns out to be detrimental to a patient, she is held legally accountable—often dismissed, sued or deregistered. It is on this basis that Johnston (1994) argues that nurses do not have legitimate professional autonomy and status.

Medical authority over patient management in acute illness settings has obvious merit where sophisticated ‘high tech’ medical treatments are the locus of the health care (Walby & Greenwell 1994). However, the justification for medical authority and control in the management of community health care, focused on primary health care principles, and in this case women’s health, is less persuasive. This apparent contradiction emphasises the complexities and inherent contradictions in health care practice. WHNs are providing women’s health ‘care’, which is often very broadly socially based, rather than being focused on medical treatments. The model of health care practised by WHNs is illustrated in chapter 7. This distinction is significant, as it places WHNs differently when considering arguments and issues of professional and autonomous practice.

The boundaries of treatment (medical) and care (nursing) are often contested in practice settings and are frequently analysed by researchers as significant to the complex interprofessional relations between medicine and nursing. The relations are complex as they are mediated by gender, the traditional hierarchal structures
of health care, the professional monopoly of medicine in defining and giving
health care and increasingly, financial considerations.

The care versus cure/treatment debate is significant in nursing scholarship. The
claim to nursing care as distinctive, or nursing as a healing therapy that
distinguishes the nursing role from other health professions, is currently
undergoing further debate and development. Walby and Greenwell (1994:40)
claim that, for some nurses, the distinctive boundary between nurses caring for
patients and doctors treating patients, ‘helps to define what constitutes nursing as
a distinctive process, so that determining the location of the boundary and
defending it has symbolic importance’. However, they caution the appropriation
of caring as an exclusive domain of nurses, as medicine and other health care
professionals perform care functions as well. In addition, these authors remind us
that debates about the distinctive nature of nurse caring are of little significance
unless nurses can show outcomes that influence health and the contribution nurses
makes to the treatment and recovery of patients in cost-effective ways. Although
many studies overseas have demonstrated clearly that nurse practitioners can
reduce health care costs (Coxhead 1992) very little research in Australia has been
conducted to assess the potential cost-effectiveness of nurse-based health care. An
extensive study in the United States of America claims that nurse practitioners
and midwives, despite barriers raised by legislation and medicine are, ‘... truly
cost-effective health providers. This cost-effectiveness, combined with their
proven ability to provide quality care to a large number of people, suggests that
they should play a central role in the solutions currently being developed for our

WHNs’ narratives reflect a distinct concept of professional and autonomous
practice. These nurses claim a distinct approach to health care that is not
subordinate to medicine or trying to compete with that discipline; they offer a
nursing-focused health care in which they have strong conceptions of professional
identity and autonomy. The majority of nurses stated that their practices, focused
on women, do not compete with mainstream services. As one participant states:
I'm not competing with the medical profession because I'm actually going to a different group.

It is clear from this research that aspects of the traditional concepts of professional frameworks and autonomy for nursing need to be reworked to encompass more nuanced and diverse conceptions of nursing professionalism and autonomy which are sensitive to and draw on the diverse range of nursing work environments. Contemporary debates in sociology and nursing are beginning to address this issue. The professional 'quest' has been criticised for being a misplaced project based on a patriarchal model of professionalism (Turkoski 1995; Witz 1992). Turkoski (1995:89) claims:

[A] commitment to the ideology of professionalism has often focused on the strategies of power that seem incompatible with the nursing ethic of caring, but rather, support elitism, disenfranchisement, subordination, issues of class, race and gender, as well as destructive approaches to service and altruism.

Others have questioned 'professional ideologies and activities, particularly in respect of issues of gender, power and class' (Kermode 1993:103) and argue that the 'elitism inherent in professionalisation 'does not necessarily best serve the community' (Keleher 1994:369; Kermode 1994:114). Feminist critiques have highlighted gender and power abuses as central to the analysis and have exposed the inherent problems in male models of professional practice for women as health care consumers and practitioners. Short, Sharman, and Speedy (1993:198) maintain that women's health nurses in Australia are:

... responsive to women consumers and women's health movement issues. Thus, rather than trying to emulate a masculine entrepreneurial model of professionalism, which is arguably inappropriate for nursing, their practice is informed by feminist values and based on primary health-care principles that challenge medical control of health care and women. ... Quite clearly this is a women-centred approach, which aims to cater to
women’s differing needs and to enable women to have more autonomy or control over their bodies and lives.

The characteristics of power, status and authority over others were not the focus of the professional model that was described by Short et al. (1993), nor are they evident in the narratives of WHNs.

Because of the necessarily close alignment between doctors and nurses in health work, comparisons between these two groups are inevitable, and have been the mainstay of debates in sociology of the professions. Nursing, likewise, has attracted debates on the professional project for nursing in relation to medicine. In Walby and Greenwell’s (1994:56) extensive study of interprofessional relations of medical and nursing staff, they assert that the dominant themes in contemporary sociological discussions on professions have focused on the monopolistic practice to gain/maintain power and positions over other occupational groups. Medicine, in these analyses, is taken as the archetypical successful profession, whereas nursing has not yet reached that status. However, these authors claim:

Theories of professions and occupational closure which focus on a struggle for power against adjacent occupations are not adequate for an analysis of the contemporary interprofessional relations of medicine and nursing (Walby & Greenwell 1994:88).

Their research demonstrated, as does this study, that nursing and medicine draw on different notions of professionalism (Walby & Greenwell 1994). Walby & Greenwell’s (1994:52–3) analysis describes nursing and medical realms of practice as, at times, complementary and, at other times, heavily contested. They concede that different work contexts create different levels of autonomous management of health care. This highlights that conceptual frameworks of professionalism and autonomy hold different meanings for nurses and doctors. Moreover, they raise the issue that this is often a point of conflict between the groups, without them realising that they are operating from different conceptual
frameworks. Walby & Greenwell (1994:52–61) explain the difference between medicine’s and nursing’s notions of a profession in this way: one is based on individuals who make decisions and act on their independent judgment and one derives from a group who constantly monitor their practice and standards. They assert that:

The medical notion of a profession was one where an educated person was able to respond to individual problems in undetermined, innovative yet trustworthy ways. The nursing notion was one of technicality, of pinning down exactly what was to be done and the training and staff needed to do it to agreed standards.

The nurses in this study articulated a position different from medical frameworks and traditional models of nursing professional status and autonomy. Drawing on the descriptions given by WHNs throughout the interviews, it is apparent that they focus on the content of their work to define being a ‘professional’. This model of professionalism is based in the following constructs:

- client focus;
- nursing health knowledge and expertise;
- no power differential in client–provider relationship;
- information sharing;
- accessibility/mobility/geographically;
- distinct boundaries to expertise;
- collaboration, referral and interdependence with other health providers

Overall, the respondents describe a collaborative model of professionalism and autonomy centred in women’s health care principles. Many debates on nursing’s professional project, both from sociology and nursing, operate on the basis that the conceptual frameworks of nursing and medicine are similar, and thus do not address the differences. Further to the descriptions of what ‘professional’ means for these nurses, autonomy was inextricably linked to their perceptions of professional nursing practice.
A women's health nurse concept of autonomy

Of central significance to the descriptions of the autonomy of WHNs is that it is not based on the traditional characteristics of professional autonomy associated with independent practitioners. The traditional model of professional practice is commonly associated with doctors, lawyers, accountants, and engineers. The model of professional autonomous nursing practice espoused by this group described an interdependent, collaborative model of practice. Central to this view of autonomy was a model of client-focused, preventative health care.

The majority—forty-four of the respondents (88%)—stated during the interviews that they wanted to stay working in women’s health in community health agency settings; that is, as salaried members of a health agency. Of the rest, one wished to move from nursing into the health policy area, two were currently independent nurse practitioners,\(^{50}\) and another three thought they would eventually move into independent practice. Wishing to stay within a health agency is significant because it illustrates that the model of professional practice and the conceptualisation of autonomy is not based in the taken-for-granted framework of working as an independent health practitioner, but includes having autonomy of practice as a salaried employee within a community health setting.

Nurses and autonomy

The concept of autonomy was first raised in reference to the nurses’ experience of hospital work and interactions with medicine. It was examined in greater detail during the specific questions on autonomy related to their current practice.

The majority of the nurses perceived that they have greater autonomy in community health settings than in hospitals. This autonomy was associated with being ‘freer’ and less restricted to develop work programs and deliver the required

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\(^{50}\) These two ‘independent nurses practitioners’ had developed consultancy businesses and work as clinical practitioners in women’s health.
health service.\textsuperscript{51} Autonomy was again raised during discussions about the role of a women’s health nurse and what they believe they have to offer women in the provision of community health care. Autonomy was frequently raised as an important strategy with clients and was often discussed in relation to enabling clients’ autonomy in decisions about their health management.

Theoretical discussions on autonomy present it as a ‘principle’ connected to self-governance and the individual’s ability to make or exercise choice (Hayes 1995:172). Mitchinson (1996:34) describes autonomy for nurses as a concept that incorporates the following attributes:

> Professional practice which is defined, negotiated and developed by individual practitioners who are solely responsible and accountable to the patient and to their professional body for their actions and omissions.

Being able to make and exercise choice was a key construct for all the nurses in their own practice and in their interactions with clients about their health care. As I listened and relisteden to the taped interviews I was struck by the different understandings of autonomy. Interpretation of this collective voice suggested a sense of autonomy that spoke of a sense of choice and self-governance in the delivery of their expertise and skills as nurses in conjunction with women clients. In addition, they stressed that accountability and responsibility to clients and the agencies was integral to their autonomous practice.

Connected to autonomy as they conceive it in their own practice, was a strong sense of clients’ rights to autonomy in health care. Hence, the following discussions will advance arguments to support the view that there is a further conception of autonomy in relation to women’s health nursing. The position will be developed that the literature on nursing in general supports a conception of

\textsuperscript{51} A finding consistent with other research on nurses’ perceptions of autonomy in hospital settings compared with other work contexts; see Adamson & Harris (1996) who also cites other research substantiating this point.
autonomy that only encompasses professional autonomy and self-governance of a professional body, the drive to gain legislative control and status as a legitimate profession, and the securing of professional autonomy through exclusionary tactics and occupational closure. The conception developed here, based on this group of WHNs, centres on autonomy constructed on knowledge, practice and skills for clients not on a need or drive to gain legislative differentiated independent ‘professional’ autonomy or on selective membership criteria. To ground this discussion I will present the collated responses on WHNs’ notions of autonomy, and from those descriptions present critical reflections in relation to the literature on autonomy.

In response to the question of whether they see themselves as autonomous practitioners, the majority of nurses commented that, for them, the concept of autonomy is connected to their skills, independent practice and expertise and in the delivery of their work. For these nurses autonomy is defined in the way they practise, not, to the sense of being fully independent workers. These nurses share their status as employees with nurses in general, with only two exceptions who work as independent nurse practitioners.

Thirty-five of the fifty stated a clear preference for being described as autonomous. They described this autonomy as being able to design, implement and structure their own programs based on nursing knowledge and expertise, and related to collaboration, referral and interdependence with other health professionals. Twelve argued that autonomy was not a useful concept for them. While they were perceived themselves as autonomous, they made the distinction that they saw themselves very much as a part of a health team, and at times had varying degrees of autonomy. Identifying autonomy as variable confounds the usual view of autonomy as an absolute. Any restrictions on autonomy were described as related to dependence on the ‘system’ for medical referrals for women or because they had to refer to medical practitioners for medications. Three nurses felt very restricted and did not describe themselves as autonomous. Overall, a sense of autonomy existed for these nursing practitioners.
Nurses' descriptions of autonomy began early on in the interviews, when they outlined their reasons for working in community health settings. For example, one respondent cites:

*I didn’t go into community health because it was community health. I went because I wanted to leave the hospital system. I was fairly disillusioned about what really happened in hospitals in terms of nursing and caring, and hated being—I suppose—subject to the whims of people who had more decision making power. I had no autonomy. I was a very small cog in large wheel—which doesn’t worry me—which hasn’t really changed in some ways—except I do have a lot of decisions—I can make—I can work in my own way. I felt that me and my client or me and my patient in the hospital weren’t really—well didn’t really have much of a fair go. I was pretty disillusioned.*

Her response to whether she sees herself as autonomous and how that is enacted is as follows:

*I am autonomous. It means that I can identify—I don’t have somebody else, saying ‘well you must work in this particular way’. It means I can go and identify the need. I can set up the program in the way I like—providing there’s funds—and execute that in the way I like. And the way I like to do it is that some people come to me with a problem—of some sort or another—so I’d say let’s get together and we’d white board what the major issues are. I’ll say what are we going to do about it and what’s the plan of action and we do it.*

Another respondent raises autonomy as a factor explaining why she entered community health practice and says:

*Particularly in this centre I’m allowed to be creative and autonomous and use my range of skills and experiences, which is broader than being clinically focused.*
Notably, this respondent, who had been working as a nurse for over thirty years, believed that in some ways she was less autonomous in areas such as health education and health promotion in the present funding climate than she had been in the past in community health. This respondent demonstrates that autonomy was a concept which varied over the range of areas in which WHNs work. In this view, autonomy is conceived as fluctuating, and dependent on a range of conditions. This view recognises the plurality and shifting conditions within which they work.

She claims:

*It's becoming much less* [of being autonomous with the new funding arrangements] — *it's becoming now to the point where the planning of health programs, the running of health programs, is becoming a great challenge with unit cost funding. That I can only have half an hour to plan a sunsmart program, in which, over a month period, I reach some four to five thousand children is ridiculous — the same if I'm planning a big drive for the Pap test program. That needs a component to educate women to run a newspaper article and woo women along with morning, afternoon teas or whatever. That's all part of the preparation. The incentive to do it is a one-to-one statistic and that's how you are counted these days. So my health education sessions and sort of all of that, seems to be not as valued at the moment.*

However, for direct service provision in the individual Pap test, the funding formula is perceived as better, for it measures one-to-one health service provision.

The same respondent makes the following comment:

*In fact that side of it is better for me to be a nurse practitioner—because I have legitimate statistics, that a certain time, a certain date, I did this. But if I do a community health women's education program and I'm only allocated a certain amount of hours to do that, in actual fact though it is more beneficial for me to do a session for fifty women in one go than do one-to-one.*
Her concern was that with the new funding formulas, health education and promotion was less valued and this restricted her practice. Her major concern stemmed from her belief that health promotion was crucial to encourage women to attend screening programs. Thus, for this respondent, the concept of autonomy was directly related to the ability to deliver health services.

Another respondent felt that her qualifications and the idea of autonomy of community health practice led her to being a community health nurse. She says:

*The community* [health practice] *is nicely autonomous and certainly without my qualifications I wouldn’t have this position. I’m probably over-qualified for it but it provides me with the autonomy that I need.*

Later in the interview, autonomy for the above respondent is described as encapsulating the following:

*In this role I have autonomy—well it’s my discretion, which centres I go to, how I run them, the numbers of people I see. I have the scope to organise tests and all things like that—I don’t need anybody’s permission to do that. I treat clients as I personally see fit—within the guidelines. If I run two hours late for some reason I’m at liberty to come in two hours late tomorrow. I don’t need to fill out time in-lieu-forms—you know—not necessary. I have a boss who said to me will you just get on and do the work. If I have a really big problem that you need to talk to me about the doors always open, but don’t come to me with all the other ones. You know you’re employed get on, do the job and let me know if you want my help. I think all that’s autonomous.*

Many of the respondents, as evidenced by the comments above and this one below, conceptualised autonomy as the freedom to design and implement programs without having to be supervised or to have their work sanctioned by anyone.
I'm able to make decisions within the limits of my knowledge, I'm not supervised directly by anybody, but I don't want that to sound like I think I can do it all on my own.

In the main, their descriptions of autonomy were conceptualised against their previous experiences of working in the traditional hierarchal hospital system in which clinical nurses often have very little autonomy over the management and development of health care for patients. Moreover, alongside raising autonomy in their discussions about their own practice, they also focused on clients' involvement in health care decisions and clients' autonomy in health management. For example, one respondent who works in both settings (hospital and community health), illustrates that the concept of autonomy is a central thread in her conceptions of nursing practice. She says:

*I like the idea of autonomy in care, and clients' right to their knowledge, and self-care has to reflect back on them, the way the hospitals are moving. Giving more knowledge and information, I'm right into the education side of things—to be able to provide that from my perspective and also help the clients become more autonomous in their delivery and self-care. I suppose in this day and age it's not as restricted in the hospital as it used to be.*

And later when asked if she saw herself as an autonomous practitioner and to describe what makes her feel autonomous, she adds:

*I do now—yeah—working in community health and family planning, in different light. Working in both those areas have helped me and made me feel autonomous. I suppose you know—being 'protected' as such—in inverted commas—in an institution like a hospital for so long, those were my big steps towards getting out of an institution, even though I love nursing when I do nurse in the hospital. Because I like the high powered stuff anyway and I think both complement each other. But—I can see how closed or claustrophobic I am still in the*
hospital, even though I feel confident to go out deliver information to people to answer their questions. And I'm honest if I don't know and I find out and come back and I'm the same in the hospital but I can't always just keep going in the hospital. There's too many medical boundaries and administration boundaries. And when I first started here I'd ask the coordinator—like when I'm running workshops / talks—I'd write up something and ask her to check and read this and she'd say 'no I don't have to read that, don't worry'—I'd think good grief—it was scary—because I'm used to people being on your back all the time but now it's given me—well—I've grown with it—I suppose autonomy—I'm now 'allowed' to do things—make decisions—even though I'd been able to in the past I've had to acknowledge it from somewhere. Also your input is worth something your not boo hoo-ed like you have got something to say.

For the women’s health nurse practitioners autonomy included many components; for example, many described enabling client autonomy and being part of a health team, thus having shared autonomy, was part of the concept for them. This respondent describes her commitment to autonomy for clients thus:

*It was years ago when I first looked at community health. It was a very exciting era and I felt philosophically committed to the principles and the way you were to practice in community health. It made eminent common sense, to look actually look at prevention and I liked the idea of empowering people to take care of themselves and to take control of their own health status. And also the wholistic approach, that it isn't just—you're not just focusing on illness/well model—that it's actually bringing in all aspects of a person's well being together.*

And later on in the interview she describes autonomy as incorporating the following aspects:
I think we have a large degree of autonomy to practise here; it suits my personality [laugh]. What I mean by that is that I don’t mean you have a free hand to do whatever you like. Professionally you have a responsibility to yourself, to your clients, to your community, to your employing body, to your professional organisations, and registering bodies, and so forth, to abide by all the normal ethical principles and practices and so forth. The autonomy comes in, in that you chose to work in this field, or chose to not work in this field—that we are very flexible here in regarding the hours that we work, our appointments—how many people we have to see—were not told we have to see ten people per hour. We’ve got our autonomy to structure our work routines to suit what we are doing for clients.

Many described aspects of autonomy as being associated with their ability to determine what and how they delivered as far as health care is concerned in a client-centred model. The narratives also suggest the varied nature of autonomy as it is experienced as a WHN. Some of the participants found the concept of autonomy confounding as they conceived themselves to be part of a health team. These narratives described their expertise and skills as nurses as being autonomous but as dependent in positive and negative ways with other health professionals. One respondent comments thus:

In the context of my work I see myself as autonomous to a certain degree. I guess the only way we would be totally autonomous would be to be in practice solely by ourselves. So while I am working and employed within the service then there is limitations to my autonomy, I’m part of a health team. I choose to be like that.

I work within a health team in that sense, but I have autonomy with women and how I work with them.
Reconstructing autonomy

The above narratives raise the point that what is missing in many of the theoretical discussions of autonomy is not only the different conceptions of autonomy for different workers in different contexts, but also the possibility of different levels or distinctions within the concept of autonomy itself. The majority of WHNs felt very autonomous: this may point to a distinctive form—a WHNs’ autonomy. This description of autonomy contains aspects of traditional conceptions of autonomy—a distinct body of knowledge, responsibility, ethical codes governing practice and culture (the professional and union bodies of nursing have codes governing practice), specific periods of training, self governance, independence and at times, dependence, and interdependence with other health professionals. This contradictory and flexible view of autonomy does not reduce the WHNs’ ability to practise autonomously. This group felt they were autonomous professionals who had expertise, accountability and responsibility for working in conjunction with women to best assess and manage their health care needs.

Autonomy in health care delivery is most often discussed in relation to the concept of professional identity and the ability of a profession to control independently, in a variety of ways, its field of practice and the delivery of the profession’s ‘expert’ knowledge to the public. The history of the professionalisation of occupations is synonymous with the concept of autonomy, defined as the right to self-governance and control. This concept of autonomy is frequently discussed and theorised in relation to nursing practice. For example, a common statement in regard to nursing and autonomy is: ‘[a]lthough autonomy is the hallmark of professions, nursing has traditionally been less autonomous than other professions’ (Collins and Henderson 1991:24).

It is the contention of the findings of this study that comparisons between the traditional notions and criteria of professions and autonomy are inappropriate for nursing groups such as WHNs. A recent Australian study by Adamson and Harris (1996), using various scales and statistical analyses, compared the perceptions of
status, professional issues and professional relationships of health personnel (hospital nurses, community health nurses, occupational therapists, physiotherapists, and speech therapists), within their own groups and with medicine. Of relevance to this study was that hospital nurses were least satisfied with their professional standing when compared to all other groups and they felt restrictions on their professional autonomy and ability to contribute to decisions about patient care. The study concludes that ‘... even within one professional group important differences have emerged, dependent on work setting’ (Adamson and Harris 1996:78). This point is of relevance to this study as WHNs provide a distinct form of autonomous nursing practice in the context of women’s health care in the community.

During the interviews the WHNs discussed notions of professionalism and autonomy but did not view control, ownership of expertise, clients or the exclusion of other health professionals as necessary to their practice. Walby and Greenwell (1994:60) claim that

> Distinctions within the notion of autonomy itself may be useful; for instance, between the autonomy of individuals by virtue of membership of a profession and the autonomy vested in a profession as a corporate body. Autonomy may be separated into economic autonomy, the right to determine levels and forms of remuneration; political autonomy, the right to be considered experts in policy matters related to their field; technical autonomy, the right to determine standards of performance; autonomy over recruitment and training; autonomy in disciplinary practices.

Likewise, consideration needs to be given to the concept of autonomy that has evolved from the development of WHNs’ work. This research refutes the universalising notion that nurses do not have professional status, independence and responsibility and consequently, they cannot be considered autonomous professionals. It is time to review notions of professional characteristics and autonomy for nursing to allow for diversity, in relation to WHNs and perhaps to
other groups in nursing such as midwives, general community nurses, district nurses and nurses in case management roles.

Conclusion

Different contexts offer nurses varying ‘freedoms’ to practise as autonomous professionals. Paying attention to difference and conceptualising divergent approaches to the dominant notions of what constitutes professions and autonomy give voice to a WHN perspective. Alternative notions of professional status and autonomy might encompass a transitory, participatory, collaborative model that focuses on an equitable encounter between a health practitioner and a client. WHNs acknowledge a level of expertise and skill, but utilise this in a collaborative exchange to assist individuals to make health treatment choices. They do not see it as power and authority over an area of knowledge, or over people to control and determine the direction of health care encounters or take ownership of the clients’ body and health care. WHNs actively seek to equalise the ‘power differential’ and the ‘competence gap’ (Lupton, 1994:105) with women clients.

A theoretical anchor throughout this thesis is the connection between power and knowledge, and the notion of power as a positive force. Reflecting on the theme ‘beyond resistance: professionalism and autonomy’, examined in this chapter, power and knowledge underlie this aspect of WHNs’ praxis. Cox (1996:33) encapsulates an approach utilised by WHNs in their interactions with women and with other allied health workers in her redefinition of power and authority:

This is power as mutuality, sharing of obligations and responsibilities. It presumes the capacity, where necessary, to call on each other’s knowledge and skills and to separate out parts of the leadership role for solo action and others for joint action.

Power and authority in these conceptualisations are more akin to postmodern notions of power as a productive and positive force. As Foucault (1980:98) states:
Power must be analysed as something which circulates, or rather as something which only functions in the form of a chain. It is never localised here or there, never in anybody’s hands, never appropriated as a commodity or piece of wealth. Power is employed and exercised through a net-like organisation. And not only do individuals circulate through its threads; they are always in the position of simultaneously undergoing and exercising this power. They are not only its inert or consenting target; they are always also the elements of its articulation. In other words, individuals are vehicles of power, not its points of application.

The corollary is not that in other nursing contexts power over and power as a repressive force doesn’t exist; indeed the structures of class, gender and the power of medicine have limited and shaped nursing (Wicks 1994). The point is, rather, that there exists (to borrow another postmodern concept) a plurality of experience, meaning and actions in the human–nursing condition. Throughout the interviews, WHNs articulated an approach to the development of women’s health practice that identified a proactive stance to create social change and influence practice and policy for women’s health. In the context of WHNs’ work, acting to create change is a powerful stance involving resistance and action. It is not a powerless subordinated position. It is a position on power and action that needs redefinition and further analysis to capture the reality of nursing work. It calls for a refocus or rethinking of what it means to be professional or to conceive of oneself as an autonomous practitioner in the context of WHNs’ work. It offers the potential to construct and extend both the analysis and future directions of nursing work. The evidence from this study supports Wicks’ (1994:382) claim that we need to go beyond analyses from patriarchy, medical dominance, voluntarism, and functionalist assumptions and ‘incorporate the active role of nurses in constituting their occupation’ and view how ‘the agency of individuals and groups worked to extend and reshape those limits in ways that made future power relationships and structures unstable and contingent’.
In this chapter the voices of the fifty WHNs offer alternative discourses on what it means to be professional and autonomous. If we listen closely to WHNs' voices, we hear different versions of traditions that have become the 'truth'. Giving consideration to other 'truths' opens the way to question taken-for-granted views on professionalism, autonomy and nursing.

Engaging the narratives with theoretical propositions from feminist and postmodern scholarship highlights not only the power embedded in dominant discourses but the power in alternative discourses. Moreover, theorising from these perspectives shows the contradictory, fragmentary and pluralistic nature of social relations (Lupton 1995). Mapping this conception of professionalism and autonomy illustrates Rudges' (1996:147) argument for 'unpacking nursing', in which she claims the following:

Using poststructural or praxis-oriented analyses exposes differences in the ways that nurses talk about, think and practise nursing. Such analyses show nurses are differently affected by current practices. It suggests that these alternative forms of practice already exist, and are only awaiting their time and their political moment when they will be recognised and valued.

One way to begin the process of recognition and valuing of nursing work is to document clinical nursing praxis; to open it up for examination and review so others can view its potential. To this end, the next and final chapter will draw together the empirical and theoretical discussions presented thus far.
CHAPTER TEN: CONCLUDING REMARKS: REFLECTIONS AND (RE) VISIONING NURSING

INTRODUCTION

This chapter will draw together the material presented in the four thematic chapters (6, 7, 8, & 9) and provide concluding remarks in relation to the whole research project. The purpose of this study is to generate a detailed analysis of Women’s Health Nurse’s (WHNs’) work within the socio-political context of the health system. The methodology focuses on capturing and analysing descriptive accounts of nursing praxis and is perceived as providing a way to theorise about nursing work. The study specifically aimed to explore the practice issues and experience of women’s health service provision by WHNs.

Reflecting on the three major themes generated from the data and considering the theoretical discussion throughout the thesis, the following final comments will argue that this study has exposed aspects of nursing praxis—WHNs’ praxis—that allows for new theoretical insights. These insights have implications for epistemological developments in nursing and about nursing. WHNs’ praxis does challenge the subordination/oppressed group notions of nursing. WHNs provide a women-centred and distinctly nursing-focused approach to health care. Moreover, the narratives of the nurses reveal different conceptions of autonomy and of attributes associated with the professions, thus offering alternative discourses about nursing.

Overall, the narratives illustrate that WHNs occupy a number of positions as they deliver health care. First, they are shaped by and are themselves shapers of discourses of health. Second, they have agency as they travel between the centre and the margins of mainstream and dominant discourses and practices in health care.
Women's Health Nurses' praxis: Practice and experience

Chapters 6 and 7 present narratives and collated responses from the participants, and map the model of praxis of WHNs through their practical/clinical work. The components of this model contrast with traditional models of health care that focus on disease. Traditionally, medical discourses identify patients as organic objects and focus on the physiological perspectives of illness and treatment. Critical sociology drawing on Foucauldian scholarship and feminist analysis, has exposed the powerful nature of this discourse and provides alternative views on illness and health care. Turner (1995:11) argues that ‘[a] disease entity is the product of medical discourses which in turn reflect the dominant mode of thinking within society’ and ‘[i]f we adopt this theory of knowledge, then disease is not a pathological entity in nature, but the outcome of socio-historical processes’. Viewing disease entities in this way provides space to challenge these 'official histories' (Turner 1995:12) and uncover other ways of conceptualising and practising health care. Research has demonstrated that women generally favour the social health perspective because it links health status with range of social, economic and cultural factors (National Women's Health Policy 1989; Broom 1990,1991).

WHNs clearly identified a distinct model of health care in which the core values centre on the therapeutic relationship between the nurse and client. This model of health care fills a gap in the current system. WHNs offer nursing care not medical care. Principally, the model of health care practised by WHNs is wholistic in its approach and has a social and wellness focus. This is evident in their descriptions of the broad socio-economic and cultural issues that are addressed in client consultations along with the clinical service provision. There are a number of strategies that WHNs nominate as being crucial to the caring relationships they have with women. Listening, talking and giving extra time in consultations are cited as primary aspects of this model of care. These strategies are orientated to the social and contextual aspects of women's lives. This aspect of WHNs' praxis highlights women's (as clients and as providers of health care) disposition for
talking/listening as the prime modality of identifying, seeking assistance and treating health and family issues. Moreover, it reinforces, as does other research,\textsuperscript{52} that women have a preference for talking/listening to convey their experiences and knowledge forms.

Integral to this model of praxis is the feeling of shared womanhood and partnership in health care. The concept of empathy was proposed by the nurses as essential to this partnership. Empathy was a constant theme throughout all the interviews. The importance of the emotional and caring aspects of health care are stressed in many studies on patient–practitioner interactions (Nettleton 1995). Moreover, Nettleton (1995:151) argues that studies have identified caring and emotional labour as central to health care, but lay people and academic research has found that it was sometimes excluded or devalued in favour of technological skills in medical consultations.

Interrelated with empathy was the issue of the gender of the health care provider. Significantly, this study, demonstrates, that in cervical cancer screening, there is a preference for a female service provider and this is often the case for other forms of health care (See also National Women’s Health Policy 1989). Gender issues related to client–practitioner relationships in health care have important implications for social policy planning. All participants raised the themes of choice, equity and empowerment in their interactions with women clients, as important elements of the distinct model of health care provided by them. The concept of choice involved not only the view that women should have choice of a female practitioner and type (i.e nurse/doctor), but also about specific aspects of the consultation. WHNs felt that choice in time (length of and appointment time), venue, how the actual clinical procedure was organised, and follow-up care, were

\textsuperscript{52} There are a number of texts that discuss the use of ‘voice’—talking/listening—as a methodological tool for research and viewing ‘voice’ as denoting women’s experience as a key to seeing women as agents of knowledge and therefore identifying alternative epistemologies. See in particular Belenky, Clinchy, Goldberger, & Tarule (1986); Harding (1987); Nielson McCarl (1990); and Reinhartz (1992).
all crucial to giving women choice. Giving consideration to equity and empowerment, expertise and exchange of information were also nominated as fundamental to the WHNs’ model of care.

All of the above strategies are aimed at equalising the power differential between provider and client, thus creating a ‘partnership of care’, and this is seen as different from the traditional form of power and domination in the medical encounter (Lupton 1995b). Nevertheless the claim of nursing–client encounters as participatory and focused on equalising the power differential is not without criticism. Lupton (1995b:160) argues that this is an ‘idealised vision’ of nurse–patient relationships, as ‘... there is never an absence of power from any social relationship, given the ubiquitous, capillary and constitutive nature of power relations’. However, the WHNs in this study clearly stated that there is an awareness of this potential power disparity and that strategies are actively sought to disperse any abusive power in the health provider–client relationship (See chapters 6, 7 & 8).

In addition to this model of praxis, the WHNs saw social activism as important in creating change for the delivery of women’s health care. Through activities at local and state levels, WHNs participate in social actions in order to influence the broader health system. They are on committees that address cervical cancer screening issues, women’s health generally and professional issues in nursing. Through these activities they are able to influence policy initiatives and shape nursing practice and women’s health issues.

WHNs praxis illustrates a combination of clinical service provision and action on the broader social and political issues for women in health care. This approach supports the dual strategy underpinning the National Women’s Health Policy (1989)—the combination of reform of the mainstream health services and the establishment of special health services for women (National Women’s Health Policy 1989).
In summary, this thesis demonstrates that WHNs’ praxis provides a differentiated model of health care. It is socially oriented and activist in intent. It is constituted of the following core elements:

- wellness;
- listening;
- talking;
- time;
- empathy;
- choice;
- equity;
- empowerment;
- expertise;
- exchange; and
- activism.

Mapping this model of health care identifies that there are alternative patterns of health care practised by nurses. WHNs have reconstructed dominant forms of health care through their praxis of a women-centred social model of care. Significantly, it illustrates the agency and the transformative nature of nursing work.

Women’s Health Nurses’ praxis: Resistance and beyond resistance

The second theme in the WHNs’ narratives was the relationship between nursing and medicine. During the interviews WHNs acknowledged the influence of the discourses of medical dominance on their praxis. However, they also acknowledged their own resistance to this dominant discourse. The view that nurses are subordinated and oppressed by is a common leitmotif in sociological and nursing texts, and is framed in relation to theories of medical dominance. Such discourse positions nursing as universally trapped, and theorises nursing work as always in relation to dominant knowledge forms. This study argues that
this represents a totalising discourse in relation to *all of* nursing: an inadequate framework for some groups in contemporary nursing, such as WHNs. Medical dominance is a feature of the sociopolitical context in which WHNs work. Indeed, at the level of ‘micropolitics of power’ the WHNs in this study relate local stories of opposition by medical practitioners to Pap test provision by nurses. Notably, they also describe how they resist, negotiate and work around this opposition. Postmodern and feminist theorising on power and resistance provides an analytical framework that highlights the varied nature of power relations. In these conceptualisations, power is viewed as a continually shifting force in which it can be oppressive and productive. As demonstrated in this study, WHNs are powerless *and* powerful, as they continually position and reposition themselves in relation to medicine. Through their praxis, WHNs move between dominant discourses and women-centred discourses of health care.

In describing this continual positioning and repositioning of their praxis, the WHNs made continual references to notions of autonomy and professional practice. Further examination identified WHNs’ conceptualisations of autonomy, and their views on being a professional.

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In describing their conception of being a professional and of autonomy they outlined the following constructs:

- client focus;
- nursing health knowledge and expertise;
- equalising of the power differential in client–provider relationships;
- information sharing;
- geographical accessibility and mobility;
- distinct boundaries to expertise; and
• collaboration, referral and interdependence with other health care providers.

WHNs claim a distinct, nursing-focused model of professional practice which is not subordinate to, or trying to compete with, medicine. This model is constructed upon a strong conception of professional identity and autonomy in nursing-focused women’s health praxis. Autonomy for this group involved freedom, self-direction, expertise, accountability, responsibility and interdependence with other health care providers. In their view, working as salaried members of health agencies and working closely with health personnel does not diminish their autonomy. Autonomy; in this conception, is defined by the way WHNs practise and their relationship with women; not by state or other forms of sanctioned independence.

Reflecting on the narratives in chapters 8 and 9 has uncovered different and alternative epistemological positions on medical dominance of a specific group of nurses, and on conceptions of autonomy and professional status of this group. It identifies points of resistance and praxis beyond resistance, from the local level of nursing work, that can challenge traditional assumptions about nursing subordination to dominant discourses of medicine and professionalisation. Furthermore, the narratives demonstrate that a rich knowledge base is embedded in the activity of nursing, and further that uncovering these epistemological insights can construct and reconstruct what is ‘known’ by nurses and what is ‘known’ about nursing.

**Women’s Health Nurses’ praxis and the nursing profession**

In the introduction to this study I raise the problem of using the experience/knowledge of a specific group of nurses as a base for theorising about nursing in general, in order to contribute to nursing knowledge in a broader context, without slipping into the essentialising and totalising positions so commonly presented about women and nursing. This tension exists throughout
the whole study. I argue that many analyses of nursing work tend to universalise the structural and social subordination of all nurses and nursing knowledge. These analyses view nursing as a dependent occupation with little agency, and position it as always in relation to medicine, to hospitals and to other knowledge forms. This study has demonstrated that we need not accept these totalising discourses, because if we examine nursing work closely through the ‘voices’ of practitioners, we uncover other ways of seeing nursing work. The ‘other’ ways of conceptualising nursing work are framed with theoretical propositions from postmodern and radical feminist theorising. In particular, the theoretical framework I argued that viewing power as multi-sited, as circulating and productive, provides a way of locating and understanding varieties of nursing work and epistemological positions in nursing. Reflecting on the empirical part of the study I assert attention to the plurality of experience is critical to building more appropriately-nuanced versions of the reality of nursing. In addition, I argue that the following theoretical propositions are useful for interpreting and explaining these ‘other’ ways of seeing nursing work:

- nursing takes place in a socio-political health care system which generates and reproduces particular structures and meanings;
- these structures and meanings are gendered and imbued with knowledge and power relations that create and recreate those structures and meanings;
- WHNs posses a unique body of practical knowledge and clinical wisdom that has not been documented or explored in relation to dominant relations of power/knowledge within the health care system;
- feminist theorising and feminist knowledge constructs provide useful frameworks for examining nursing questions grounded in practice.
- postmodern and radical feminist theories are useful for examining nursing projects because together they incorporate the concepts of female experience located in the everyday and the power/knowledge relations that enscribe those relations; and
- female experience and power/knowledge relations are integral to nursing experiences.
This research has illustrated that WHNs approaches to health care differ from those of the traditional biomedical model. The analysis of the `voices’ of WHNs attests to a distinctive knowledge base. Central to this model of nursing was WHNs’ defining themselves in relation to the content of their work and their approaches to health care rather than in relation to other dominant knowledge forms. Moreover, the study demonstrates that nursing can be an empowered and transformative activity, and it illustrates that WHNs can shed the shackles of history and challenge the view of the subordination of nurses within the health care system.

What does mapping these ‘other’ ways of seeing nursing mean for nursing more generally? In chapters 3, 8 and 9 I critiqued the application of theorising from specific nursing roles, most often from the acute settings and midwifery, to all of nursing. This is an important critique for contemporary nursing. However, to borrow from radical feminist theorising, it is important to clarify the distinction between universalising concepts of nursing, and the use of the category ‘nursing’ as a unitary, absolutist category which denies difference (Richardson 1996) and to attend to the general commonalities that exist in, or add to further understandings of the discipline. The position adopted here, is that this research holds insights for nursing in general and thus it is important to consider the relationship of this study to other forms of nursing. In so doing I am not attempting to extrapolate results from this study to claim the findings can be applied to all other nursing groups.

To reiterate a postmodern position introduced in the beginning of this thesis: the point is to explicate nursing ‘truths’ of a given specificity that extend and challenge previous analyses of nursing work.

**Implications for nursing**

There are a number of implications for nursing which support the ongoing mapping of nursing work. Identifying what it is that nurses do is a prerequisite for arguing that nurse led-care is cost effective and necessary to the health and wellbeing of communities. To view the work of WHNs in a broader context,
comparisons with nurse practitioners (NP) internationally is useful. The role of WHNs is similar to that of NPs from around the world, except in the ability to prescribe drugs and order pathology and radiological tests. The nurse practitioner movement is just emerging in Australia, with some states piloting research projects involving nurses taking on the roles of NPs, to examine the scope and desirability of the role in the Australian context.

For some time there has been global concern about managing the growing demands on health services. Witz (1994:24) claims that; [m]odes of funding, organising, and delivering health care in Britain are being radically overhauled'. Likewise, in other countries, health services are in a state of great change and turmoil in the quest to find more effective ways of managing the limited resources for health care (Safriet 1992; Duffield and Lumby 1994; Southon 1996). Witz (1994:24) argues that in Britain there are three major elements to these health reforms: the introduction of general management, the introduction of market principles and an increasing emphasis on health promotion and disease prevention, and suggests that nurses are, potentially, in a better position to respond to and capitalise upon, the restructuring of health care in Britain. This, she claims, requires nurses to redefine the core of nursing work. Across the world, other groups in nursing such as nurse practitioners (NPs) in the United States of America, and those closely aligned to nursing, such as independent or community midwives, are staking claims to a unique and cost-effective role in health care. Numerous studies internationally and in Australia have demonstrated that nurse practitioners can reduce health care costs and bring about positive outcomes for patients (Coxhead 1992; Safriet 1992). The final report of the Nurse Practitioner Project (1995:ii) in New South Wales claims that evidence from a series of pilot projects supports the view that ‘... nurse practitioners are feasible, safe, and effective in their roles and provide quality health services in the range of settings researched'. In relation to midwifery in New Zealand, Guilliland and Pairman (1995) claim the emergence of a unique body of knowledge from medicine and nursing, asserting that midwifery is a distinct discipline, and in developing its' own theories challenges the dominant ideology of the medicalisation of childbirth.
The same authors argue that midwives were given a social mandate through the ‘... political partnership between women and midwives which brought about the 1990 Nurses Amendment Act whereby the State granted midwives legitimate organised autonomy in their professional practice’ (1995:19). In Australia, the nurse practitioner movement is relatively new. The Australian state of New South Wales has been the most active, releasing a discussion paper on the role and function of nurse practitioners in 1992. More recently, other states have begun to examine the possibilities of nurse practitioners. The movement in Australia is also based on the premise that many preventative and restorative aspects of health care can be delivered by nurses (Coxhead 1992). For over thirty years, nurse practitioners in the United States have had an important role in primary health care, based on a differentiated model of care from doctors (Safriet 1992). In America, nurse practitioners evolved as a result of the shortage of medical services in rural areas and some concern has been raised that they are little more than doctor substitutes. However, this is refuted by a NP who states:

Conceptually the roots of NP were in professional nursing. For some while, some NPs seemed to have lost sight of that and followed a medical model, but today it is obvious that the NP is firmly rooted in professional nursing NP (Ford 1990)

In 1997 American nurses saw President Clinton sign the Reconciliation Bill, providing direct Medicare reimbursement payments to all NPs and clinical nurse specialists (CNS). This was heralded as ‘a major legislative accomplishment for organised nursing and a true example of how grass roots legislative action can work’ (Haber 1998:11).

In Britain, under the National Health Service reforms, career restructuring and nursing reforms such as the Project 2000, the term ‘new nursing’ has been coined to denote the redefining of nursing work, the ‘new politics of health’ and a ‘new nursing philosophy’ (Witz 1994). Under this ‘new nursing’, roles that extend nursing functions into primary and specialist areas of care for nurses have been
created, such as practice nurses, nurse practitioners, and nurse specialists (Lorentzon and Hooker 1996). Witz (1994:29) argues that under this ‘new nursing’ ‘... the delineation of a new specialist practitioner role is a vision of an enlarged practitioner role for nurses, which turns upon two pivotal issues: the core tasks of nursing and the degree of autonomy to be enjoyed by the nurses’. In addition she claims that the new nursing advocates an enhanced nursing role which is ‘... distinct from an extended role, which enlarges the sphere of competence by incorporating specialist medically derived tasks, devolved on to nurses by doctors’ (Witz 1994:31). This distinction is of significance to this study, since WHNs, and potentially, many other nursing groups, are developing ‘enhanced roles’. Models of care such as the one illustrated in this study have nursing strategies at the centre and offer alternative models of health care. The nursing groups cited above are also redefining and revisioning nursing and health care provision. This calls for national and international support for further research to examine issues of nurse-led care to ascertain efficacy and develop models of health care to bring about the most positive results for health service users.

Another important implication of mapping nursing is to extend the potential for change inherent in nursing-led care and thus effect change in health policy. However, it is crucial, as Duffield and Lumby (1994:79) suggest, ‘... in today’s economic climate to somehow quantify caring in order to ensure it is valued by those who allocate the resources’. In the move to develop enhanced roles in nursing and provide health care to communities, the nursing profession needs to influence health policy planning and resource allocation. It needs to be able to demonstrate and defend the contribution that nursing-led care can offer to communities. Moreover, as Keyzer (1995:31) argues, nurses must:

[A]dress the issues surrounding the outcomes of nursing interventions before others do it for them. This in turn demands our proper use of information technology to collect, collate and analyse the data we require, to provide cost-effective nursing services to meet a population’s expressed demands for nursing care.
To this end he argues for the establishment of a nursing policy unit, to guide the development of "... new practitioner roles; to rethink our career structure and its appropriateness to the service required by populations and to renegotiate our boundaries with other health and social service occupational groups" (Keyzer 1995:34). WHNs in this study are involved in influencing policy at local and state levels. Hadley (1996:9) points out that American nurses have two notable strengths in the political area: large numbers and a positive public image. This is also the case in Australia. Nurses need to harness their political force to influence health care. Importantly, this must not only address the efficacy of outcomes related to cost-effective health care, but must also provide a balance to the economic rationalist market principles with the socially focused model of health care that nurses such as WHNs provide. Duffield and Lumby (1994:80) make strong claims for the role of nurses in the policy arena when they argue the following:

It is time that nurses established their position in the policy arena by speaking out on behalf of their clients for whom they provide a 24-hour service. Nurses must value their caring so that others will do so. Nurses must be resolute and united as to what is essential in nursing and what makes a difference to patient outcomes. This can be achieved by more Australian research, into many practices, which identifies the impact of our actions on quality and cost. More attention must be directed to applying research findings to the industrial and professional issues associated with health care. This includes moving the focus to community care where nurses may have the time to 'be with' rather than merely 'doing for' a person as is now evident in our short-stay, high-dependency hospitals. All nurses, whether clinicians, managers or academics, need to come together with policy-makers, the medical profession and others involved in health care for this to occur. It is up to this profession to articulate publicly, within multidisciplinary environments, how we have made, and can continue to make, a difference to the cost and quality of health from the patient's perspective.
Examining the work of WHNs attests to redefinitions of nursing roles, that illustrate *the difference* that can inform both practice and theoretical development in nursing and provide empowering health care for clients.

Moreover, examination of core theoretical and practice principles of WHNs has important implications for resourcing and measuring the quality of nurse-provided women's health services. This is particularly crucial in the present funding climate as part of the broader soci-political context of current managerialist and economic rationalist led policy changes may have the potential to squeeze out valued aspects of WHNs work. For example in a recent study of community health nurses Smith (1998:12) claims that under the current National and Victorian health policies there is concern amongst community health nurses that there is:

A persistent devaluing of generalist community nursing practice by managerialist and economic rationalist health policies. An emphasis on outputs rather than outcomes, the valuing of administrative efficiency over professional effectiveness and the increasing medicalisation of community health are significant factors that coalesce to 'silence' the work of the nurses.

In addition under the proposed Commonwealth/State broadbanded funding agreements and the acute care sector led changes to community health may serve to weaken the legitimacy of specific health services and programs for women (Hancock 1998). It is particularly important for WHNs to be vigilant under the current reform agendas for as Hancock (1998:6) asks 'will these funding and structural changes do anything to address women's traditional lack of power within health systems-despite their numerical dominance as workers within the health sector'. Thus in the current funding climate WHNs, and nurses in general, need to be strategic and voice the significant contribution that they can make to health care.
Conclusion

This study identifies three important propositions for nursing:

- nursing praxis can reconstructs traditional models of health care;
- nursing praxis is powerful and able to ‘resist’ dominant discourses; and
- nursing praxis can be transformative.

In summary, chapter 1 introduced the topic for study and the various issues related to using postmodern and feminist theories in research. It highlighted the tensions in critical research of travelling from the specific to the general and raised the concern that many previous analyses of nursing work tend to universalise the subordination of nurses and nursing knowledge. The study specifically aimed at exploring the practice issues and experience of women’s health service provision by women’s health nurses (WHNs). In mapping this particular group of nurses’ practice, it set out to examine the professional and theoretical issues in contemporary nursing and women’s health care. Thus the purpose of the study was to generate a detailed analysis of WHNs work within the socio-political context of the health system related to the provision of cervical cancer screening and women’s health services. Central to the study was an assessment of whether the social and structural subordination of nursing, as so often documented about nurses and nursing, was apparent within this group. To this end, the study problematised the view that all of nursing is universally constrained and subordinated to dominant discourses of biomedical knowledge. Rather than confirming these totalising discourses, the study showed that there were examples within nursing of resistance—both ideologically and in practice—to these dominant discourses.

Chapter 2 described the public health context of WHNs work. Although WHNs work in generalist community health centres, they have developed their praxis within the philosophy and policies of the broader women’s health movement and from primary health care principles in Australia. This chapter reviewed these policy initiatives, the current funding climate and specifically women’s health
policy and concluded that these initiatives impact significantly on the work practices of WHNs. This chapter also identified that WHNs are very proactive in developing nurse-led screening. In addition this chapter proposed that the discourses of biomedical science and professionalisation of nursing have greatly influenced nursing work.

Further examination of these dominant discourses and the impact they have on nursing more broadly was taken up in the third chapter. This chapter concluded that denoting certain discourses as dominant proposes a relationship of power and knowledge. Specifically, chapter 3 argued that work relations and practices in health are structured by certain power/knowledge relations. Moreover, this analysis revealed that there are many competing and complementary power/knowledge relations that structure nursing, but that nursing, and in particular WHNs, also challenge the power/knowledge relations around them. Chapter 4 developed this analysis further through examining theories of power and knowledge, and proposed that theoretical eclecticism is necessary to address the complex and varied nature of nursing work. In particular, this chapter identified that postmodern and radical feminist theorising provided the most appropriate framework to further analyse and interpret the work of WHNs.

Fundamental to the position argued in this thesis is a feminist perspective. This position creates important theoretical and methodological links throughout the whole study. Feminist methodology was employed to guide the design, the collection and the analysis. Intrinsic to this process was the use of the ‘voices’ of WHNs as the basis for theorising. A constant companion along the way in examining WHNs’ work, was reflexivity between feminist research processes, the theoretical discussions and the ‘voices’ of WHNs. Capturing and analysing descriptive accounts of nursing praxis is seen in this thesis as providing a way to theorise about nursing work. This methodology is able to demonstrate the rich knowledge forms embedded in clinical nursing praxis.
The final section of the thesis, presented over four chapters (6, 7, 8, & 9) introduced and discussed the narratives of the WHNs. Chapter 6 presented a profile of the participants and illustrated the high level of experience and creativity that the 50 nurses brought to their work as WHNs. Chapters 7, 8, and 9 presented the narratives of the WHNs and discussed the findings with the additional theoretical propositions and those highlighted in previous chapters. Three conceptual threads emerged throughout these discussions: one focused on nursing praxis as a distinct process, with its own distinct epistemological base rather than in relation to ‘other’ knowledge forms; another described the medical restriction and opposition as experienced by this group of nurses, but also their resistance to medical opposition. The third theme apparent from the interviews, and which was conceptualised as beyond resistance, was the description of the alternative discourses evident in nursing work, and this focused on notions of being a professional and on autonomous nursing praxis.

The narratives of WHNs expose the difference that exists in nursing praxis, and in doing so, articulates the alternative ways that nurses practise. It challenges the ways in which nursing is understood and analysed. Overall, joining feminist perspectives and postmodern analyses of power provides a pluralistic and emancipatory politics for viewing, describing and analysing ‘other’ nursing work. At the micro sites of power and knowledge relations—in the everyday practice worlds of nurses, of negotiation and renegotiation, of work on the margins and at the centre—WHNs nursing praxis operates as a positive, productive and reconstructive force in health care.
APPENDIX A

DEAKIN UNIVERSITY
ETHICS COMMITTEE

PLAIN LANGUAGE STATEMENT

My name is Sarah Leach and I am a Registered Nurse currently working toward the requirements of a Doctor of Philosophy Degree.

During 1995 I will be preparing to collect information from Registered Nurses about their practices and experiences related to providing cervical cancer screening (Pap smears) programs. I would like interview nurses who are currently providing this service and those who are not for various reasons able to offer this service.

I am interested in what you believe are the important components of your practice, and what you think are the major issues for you and the women you see in cervical cancer screening. I am seeking assistance from nurses who are willing to participate in interviews with me to explore this area of their practice.

I would like to arrange an interview with you for approximately one hour, at a time and place of your choosing, so that I can ask you some questions and tape record our discussion. I wish to emphasise that the interviews will be treated with total confidentiality and no identifying information will be used in the research thesis. You are under no obligation to participate in this project and you are able to withdraw at any stage.

If you would like further information about the study please do not hesitate to contact me ...............or Deakin University Faculty of Arts........................

Thank you

Sarah Leach
APPENDIX A

DEAKIN UNIVERSITY
ETHICS COMMITTEE
CONSENT FORM

I, ________________________________, of ________________________________

Hereby consent to be a subject of a human research study to be undertaken

by SARAH LEACH

and I understand that the purpose of the research is TO EXAMINE MY
EXPERIENCES AS A NURSE RELATED TO CERVICAL CANCER
SCREENING PROGRAMS.

I acknowledge that

1. That the aims, methods, and anticipated benefits, and possible hazards of the
research study, have been explained to me.

2. Upon receipt, my interview will be coded and my name and address kept separately
from it.

3. That I voluntarily and freely give my consent to my participation in such research
study.

4. Any information that I provide will not be made public in any form that could
reveal my identity to an outside party ie. that I will remain fully anonymous.

5. I understand that aggregated results of the whole study only will be used for
research purposes and may be reported in scientific journals.

6. Individual results will not be released to any person except at my request and on
my authorisation.

7. That I am free to withdraw my consent at any time, in which event my participation
in the research study will immediately cease and any information obtained destroyed
if requested by me.

Signature: ________________________________ Date: ________________________________
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<td>7. DO YOU WORK IN</td>
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<td>3 OTHER</td>
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<td>B. WELL WOMENS HEALTH NURSE</td>
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<td>C. WELL WOMENS RESOURCE MIDWIFE</td>
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<tr>
<td>D. HEALTH ED AND PROMOTION</td>
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9). WHAT IS THE MAJOR FOCUS OF YOUR WORK

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<td>3 OTHER</td>
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<td>B. MCHN</td>
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<td>C. HEALTH EDUCATION AND PROMOTION</td>
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10. WHY ARE YOU A COMMUNITY HEALTH NURSE:

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<td>3. WORK IN COMMUNITY SETTING / LESS RESTRICTIVE</td>
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<td>4. WITH INCREASED QUALIFICATIONS NEEDED FURTHER CAREER PATHWAYS</td>
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<td>5. OTHER</td>
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11. WHY DID YOU DO ADDITIONAL TRAINING FOR COMMUNITY HEALTH:

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<td>3. DEVELOP FURTHER SKILLS</td>
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<td>5. OTHER</td>
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12). WHAT HAS LED TO YOUR PRACTICE IN THE WOMEN'S HEALTH AREA.

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<td>3. ENJOYMENT AND EMPATHY WORKING WITH WOMEN</td>
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<tr>
<td>4. SAW IT AS A CAREER OPPORTUNITY / FUNDING AVAILABLE AND UTILISE FOR CAREER ADVANCEMENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. OTHER</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13). DID YOU DO ADDITIONAL TRAINING FOR CERVICAL CANCER

<table>
<thead>
<tr>
<th>Q13</th>
<th>YES (1)</th>
<th>NO (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14). IN WHAT YEAR DID YOU DO THIS TRAINING

<table>
<thead>
<tr>
<th>Q14</th>
<th>YES(1)</th>
<th>NO(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 1991</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. 1992</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. 1993</td>
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<td></td>
</tr>
<tr>
<td>4. 1994</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. 1995</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
15). WHICH TRAINING COURSE DID YOU UNDERTAKE:

<table>
<thead>
<tr>
<th>Q15</th>
<th>YES(1)</th>
<th>NO(2)</th>
</tr>
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<tbody>
<tr>
<td>41</td>
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<td>43</td>
<td></td>
<td></td>
</tr>
<tr>
<td>44</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 1. LA TOBE UNIVERSITY DEPARTMENT OF NURSING WOMEN'S HEALTH: ASSESSMENT, SCREENING AN THERAPIES |
| 2. PAP TEST VICTORIA / ACCV |
| 3. FAMILY PLANNING VICTORIA |
| 4. OTHER |

16). WHY DID YOU DO THIS ADDITIONAL TRAINING

<table>
<thead>
<tr>
<th>Q16</th>
<th>YES(1)</th>
<th>NO(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
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<tr>
<td>46</td>
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<tr>
<td>47</td>
<td></td>
<td></td>
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<td>48</td>
<td></td>
<td></td>
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<tr>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 1. TO PROVIDE WOMEN WITH ANOTHER OPTION |
| 2. BELIEVED THERE WAS A COMMUNITY NEED |
| 3. CAREER ADVANCEMENT |
| 4. TO FURTHER DEVELOP SKILLS |
| 5. JOB CRITERIA |
| 6. OTHER |
17). WHERE YOU INVOLVED IN LOBBYING OR SUBMISSION WRITING FOR NURSES TO DO CCS, EITHER IN YOUR CENTRE OR FOR ANY ORGANISATION

<table>
<thead>
<tr>
<th></th>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q17</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>YES, SPECIFICALLY FOR OUR AGENCY TO GAIN FUNDING FOR PROVISION OF NURSED BASED SERVICE</td>
<td></td>
<td>51</td>
</tr>
<tr>
<td>2.</td>
<td>YES, FOR NURSES IN GENERAL TO COMMENCE CCS TO H&amp;CS/ACC/RFP, VIC.</td>
<td></td>
<td>52</td>
</tr>
<tr>
<td>3.</td>
<td>NO</td>
<td></td>
<td>53</td>
</tr>
<tr>
<td>4.</td>
<td>OTHER</td>
<td></td>
<td>54</td>
</tr>
</tbody>
</table>

18). WHY DID YOU WANT TO BE ABLE TO OFFER THIS SERVICE.

<table>
<thead>
<tr>
<th></th>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q18</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>TO PROVIDE WOMEN WITH ANOTHER OPTION / MODEL OF CARE WITH FEMALE PRACTITIONER / MORE TIME/ INFORMATION/ COUNSELLING</td>
<td></td>
<td>55</td>
</tr>
<tr>
<td>2.</td>
<td>BELIEVED THERE WAS A COMMUNITY NEED / TO ACCESS UN/ UNDER SCREENED WOMEN</td>
<td></td>
<td>56</td>
</tr>
<tr>
<td>3.</td>
<td>TO ADVANCE SKILLS AND EXPERTISE</td>
<td></td>
<td>57</td>
</tr>
<tr>
<td>4.</td>
<td>TO CREATE A CAREER DEFINITION AS A WOMEN'S HEALTH NURSE</td>
<td></td>
<td>58</td>
</tr>
<tr>
<td>5.</td>
<td>BELIEF THAT WOMEN DISADVANTAGED WITH SERVICE ACCESSIBILITY EITHER GEOGRAPHICALLY / CULTURALLY / GENDER OF PRACTITIONER</td>
<td></td>
<td>59</td>
</tr>
<tr>
<td>6.</td>
<td>OTHER</td>
<td></td>
<td>60</td>
</tr>
</tbody>
</table>
19). HOW DO YOU SEE YOUR ROLE IN THE PROVISION OF CERVICAL CANCER SCREENING.

<table>
<thead>
<tr>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q19</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. TO PROVIDE WOMEN INFORMATION / COUNSELLING /</td>
<td></td>
<td>61</td>
</tr>
<tr>
<td>2. BEING ABLE TO PROVIDE A BROAD RANGE OF SERVICES / COMPREHENSIVE HEALTH ASSESSMENT / FOLLOW UP</td>
<td></td>
<td>62</td>
</tr>
<tr>
<td>3. ACCESSIBILITY AND FLEXIBILITY BECAUSE OF MOBILITY OFFERING SERVICE AT A CHOICE OF VENUES</td>
<td></td>
<td>63</td>
</tr>
<tr>
<td>4. OTHER</td>
<td></td>
<td>64</td>
</tr>
</tbody>
</table>

20). WHAT DO YOU BELIEVE YOU OR NURSES IN GENERAL HAVE TO OFFER WOMEN IN PROVIDING CCS

<table>
<thead>
<tr>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q20</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. SHARED EMPATHY AS A WOMEN / ABLE TO DEMYSTIFY HEALTH CARE / NON THREATENING HEALTH PROFESSIONAL /</td>
<td></td>
<td>65</td>
</tr>
<tr>
<td>2. BEING ABLE TO PROVIDE A BROAD RANGE OF SERVICES / COMPREHENSIVE HEALTH ASSESSMENT / BEING ABLE TO FOLLOW UP</td>
<td></td>
<td>66</td>
</tr>
<tr>
<td>3. MORE TIME IN CONSULTATION</td>
<td></td>
<td>67</td>
</tr>
<tr>
<td>4. OTHER</td>
<td></td>
<td>68</td>
</tr>
</tbody>
</table>
21). WHAT SPECIFIC APPROACHES OR PRINCIPLES DO YOU EMPLOY IN YOUR NURSING PRACTICE IN YOUR INTERACTIONS WITH WOMEN CLIENTS

<table>
<thead>
<tr>
<th></th>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q21</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. WOMEN CENTRED / FEMINIST / APPROACH CONSIDER ISSUES OF PRIVACY / DIGNITY / FEAR / EMBARRASSMENT / WOMEN MAKE THE DECISIONS</td>
<td></td>
<td></td>
<td>69</td>
</tr>
<tr>
<td>2. TIME / ALLOW WOMEN WHEN READY FOR Pap TEST</td>
<td></td>
<td></td>
<td>70</td>
</tr>
<tr>
<td>3. CONSIDER PHYSICAL ENVIRONMENT REDUCE CLINICAL ATMOSPHERE</td>
<td></td>
<td></td>
<td>71</td>
</tr>
<tr>
<td>4. CONSIDER ISSUES OF ACCESSIBILITY / 'GO TO THEM'</td>
<td></td>
<td></td>
<td>72</td>
</tr>
<tr>
<td>5. OTHER</td>
<td></td>
<td></td>
<td>73</td>
</tr>
</tbody>
</table>

22). WHAT HAVE BEEN \ ARE THE MAJOR ISSUES FOR YOU IN DELIVERING CCS

<table>
<thead>
<tr>
<th></th>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q22</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CLINICAL / THAT I AM CLINICALLY COMPETENT / TRUSTING MY OWN CLINICAL SKILLS / 'ON MY OWN NOW'</td>
<td></td>
<td></td>
<td>74</td>
</tr>
<tr>
<td>2. PROFESSIONAL / WITH OTHER HEALTH PROFESSIONALS NO PEER SUPPORT OR NO PROFESSIONAL EXCHANGE / OR KNOWLEDGE SHARING, ESPECIALLY DR'S</td>
<td></td>
<td></td>
<td>75</td>
</tr>
<tr>
<td>3. NO MAJOR ISSUES / MOST COLLEAGUES SUPPORTIVE</td>
<td></td>
<td></td>
<td>76</td>
</tr>
<tr>
<td>4. HEALTH AGENCY BEEN SUPPORTIVE / OR NON SUPPORTIVE</td>
<td></td>
<td></td>
<td>77</td>
</tr>
<tr>
<td>5. OTHER</td>
<td></td>
<td></td>
<td>78</td>
</tr>
</tbody>
</table>
23). WHAT BARRIERS HAVE YOU EXPERIENCED IN PROVIDING THIS SERVICE

<table>
<thead>
<tr>
<th></th>
<th>YES(1)</th>
<th>NO(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. LACK OF FUNDING / RESOURCES FOR SERVICE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. LACK OF TIME AVAILABLE TO ADDRESS ALL ISSUES AS USUALLY ONLY A COMPONENT OF JOB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. FOR RURAL PRACTITIONERS DISTANCE / GEOGRAPHICAL ISSUES MADE LIMITATIONS TO SE REDUCED ABILITY TO OFFER SERVICE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. MEDICAL RESISTANCE * TAKING MARKET SHARE AWAY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. MEDICAL RESISTANCE * NURSES NOT CLINICALLY EXPERT FOR ROLE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. NO MEDICARE REBATE FOR NURSE PRACTICE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. LACK OF PROFESSIONAL DEVELOPMENT AVAILABLE LACK OF PROTOCOLS / LITTLE CLINICAL SUPPORT / LACK OF PROFESSIONAL SUPPORT FOR ESTABLISHING AND MAINTAINING SERVICE.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. OTHER</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q23

79

80

81

82

83

84

85

86
### 24). WHAT DO YOU BELIEVE ARE THE BARRIERS FOR WOMEN IN HAVING CCS

<table>
<thead>
<tr>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q. 24</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. LANGUAGE / CULTURAL ISSUES</td>
<td></td>
<td>87</td>
</tr>
<tr>
<td>2. USUALLY MALE PRACTITIONERS</td>
<td></td>
<td>88</td>
</tr>
<tr>
<td>3. FOR OLDER WOMEN / MANY NOT OFFERED SERVICE OR COMMON BELIEFS NOT NEEDED AFTER HYSTERECTOMY OR NOT SEXUALLY ACTIVE</td>
<td></td>
<td>89</td>
</tr>
<tr>
<td>4. GENERAL EMBARRASSMENT / BODY IMAGE ISSUES / WOMEN UNKNOWLEDGEABLE ABOUT BODIES</td>
<td></td>
<td>90</td>
</tr>
<tr>
<td>5. PAST EXPERIENCE OF HEALTH CARE BAD REDUCE LIKELY CONTACT</td>
<td></td>
<td>91</td>
</tr>
<tr>
<td>6. FEAR OF OUTCOMES</td>
<td></td>
<td>92</td>
</tr>
<tr>
<td>7. OTHER</td>
<td></td>
<td>93</td>
</tr>
</tbody>
</table>

### 25). WHAT CHANGES IF ANY WOULD YOU LIKE TO SEE IN THE SERVICE DELIVERY OF CCS PROGRAMS

<table>
<thead>
<tr>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q25</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MAJOR STATE WIDE CO-ORDINATION / TO ADDRESS PROGRAM TRAINING / OUTREACH / ETHNIC ISSUES</td>
<td></td>
<td>94</td>
</tr>
<tr>
<td>2. MORE TIME / FUNDING / MORE ACKNOWLEDGMENT OF TIME REQUIRED TO ESTABLISH AND MAINTAIN SERVICE</td>
<td></td>
<td>95</td>
</tr>
<tr>
<td>3. ACKNOWLEDGEMENT / LEGITIMACY AND SUPPORT BY MEDICAL PROFESSION OF NURSE ROLE IN CCS</td>
<td></td>
<td>96</td>
</tr>
<tr>
<td>4. INSERVICE PROGRAM FOR NURSES</td>
<td></td>
<td>97</td>
</tr>
<tr>
<td>5. OTHER</td>
<td></td>
<td>98</td>
</tr>
</tbody>
</table>
26). DO YOU PERCEIVE YOUR WORK IS ORGANISED AND / OR AFFECTED BY MEDICAL INFLUENCES

<table>
<thead>
<tr>
<th>Q. 26</th>
<th>YES(1)</th>
<th>NO(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. DO YOU PERCEIVE YOUR WORK IS ORGANISED AND / OR AFFECTED BY MEDICAL INFLUENCES</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AND IF SO IN WHAT WAYS.

<table>
<thead>
<tr>
<th>Q. 26</th>
<th>YES(1)</th>
<th>NO(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. OFTEN HAVE TO JUSTIFY DECISIONS / KNOWLEDGE AND / OR EXPERTISE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. WOMEN'S EXPECTATIONS OF SERVICE VERY MEDICAL MODEL ORIENTATED ESPECIALLY IN REGARD TO TIME ALLOCATED AND THE EXPERIENCE OF THE SERVICE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. RESISTANCE TO ESTABLISHING / MAINTAINING THE SERVICE AS DR'S BELIEVE NOT A ROLE FOR NURSES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. OTHER</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

27). WHAT HAVE BEEN THE BENEFITS FOR YOUR PRACTICE RELATED TO THIS ROLE

<table>
<thead>
<tr>
<th>Q27</th>
<th>YES(1)</th>
<th>NO(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ADVANCED SKILLS IN WOMEN HEALTH / EXTENDED ME CLINICALLY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. ACKNOWLEDGEMENT OF EXPERTISE AND DEVELOPMENT OF PROFESSIONAL CREDIBILITY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. ABLE TO EXPAND ROLE AND GIVE BENEFITS TO THE COMMUNITY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. DEVELOP NETWORKS WITH OTHER WHN'S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. LEGITIMATED FOCUS ON WOMEN'S HEALTH ROLE / CONCRETE SKILL / ABLE TO DOCUMENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. DEVELOP FURTHER COMMUNICATION AND COUNSELLING SKILLS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. EXPAND COMMUNITY DEVELOPMENT ROLE WITH ACCESS MORE WOMEN IN THE COMMUNITY AND ASCERTAIN WOMEN HEALTH NEEDS IN COMMUNITY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. OTHER</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
28). DO YOU SEE YOURSELF AS AN AUTONOMOUS PRACTITIONER
PLEASE DESCRIBE WHAT MAKES YOU AUTONOMOUS

<table>
<thead>
<tr>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q28</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. NO / RESTRICTED AND WORK DESIGNATED BY OTHERS</td>
<td>112</td>
<td></td>
</tr>
<tr>
<td>2. NO PART OF A HEALTH TEAM</td>
<td>113</td>
<td></td>
</tr>
<tr>
<td>3. YES AS I AM ABLE TO DEVELOPMENT OWN WORK PROGRAM AND DECIDE OWN PROGRAMS ALLOWED TO MAKE MY OWN DECISION AND DO NOT REQUIRE 'PERMISSION FROM OTHERS</td>
<td>114</td>
<td></td>
</tr>
<tr>
<td>4. OTHER</td>
<td>115</td>
<td></td>
</tr>
</tbody>
</table>

29). HOW DO YOU SEE YOURSELF IN THE HEALTH SYSTEM

<table>
<thead>
<tr>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q29</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PIVOTAL ROLE AND ESSENTIAL ROLE ABLE TO HAVE WIDE ACCESS IN THE COMMUNITY FOR HEALTH ED / PROMOTION / CARE</td>
<td>116</td>
<td></td>
</tr>
<tr>
<td>2. BEING ABLE TO OFFER WOMEN ANOTHER CHOICE IN HEALTH PROVISION</td>
<td>117</td>
<td></td>
</tr>
<tr>
<td>3. UNRECOGNISED</td>
<td>118</td>
<td></td>
</tr>
<tr>
<td>4. OTHER</td>
<td>119</td>
<td></td>
</tr>
</tbody>
</table>
30). TO WHAT EXTENT HAVE YOU BEEN INVOLVED IN PROGRAM AND POLICY DEVELOPMENT OF CCS

<table>
<thead>
<tr>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q30</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. AT LOCAL LEVEL / AT OWN AGENCY DEVELOPING PROTOCOLS AND ESTABLISHING SERVICE</td>
<td></td>
<td>120</td>
</tr>
<tr>
<td>2. AT A BROADER LEVEL WITH STATE WIDE PROGRAM DEVELOPING COMPETENCIES / INPUT TO SCREENING FOR NURSES</td>
<td></td>
<td>121</td>
</tr>
<tr>
<td>3. NO</td>
<td></td>
<td>122</td>
</tr>
<tr>
<td>4. OTHER</td>
<td></td>
<td>123</td>
</tr>
</tbody>
</table>

31). ARE YOU AWARE OF ANY OF THE POLICY ISSUES RELATED TO CCS PROGRAMS

<table>
<thead>
<tr>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q31</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. NO</td>
<td></td>
<td>124</td>
</tr>
<tr>
<td>2. YES / PAP TEST VIC SPECIFICALLY COMPETENCY / STANDARDS PROTOCOLS</td>
<td></td>
<td>125</td>
</tr>
<tr>
<td>3. OTHER</td>
<td></td>
<td>126</td>
</tr>
</tbody>
</table>

32). HOW DO YOU SEE YOUR ROLE AS A NURSE DEVELOPING AND WHERE WOULD YOU LIKE TO GO PROFESSIONALLY

<table>
<thead>
<tr>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q32</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CONTINUE TO DEVELOP AND WORK WITH WOMEN IN COMMUNITY HEALTH SETTING HEALTH PROMOTION / PRIMARY HEALTH CARE</td>
<td></td>
<td>127</td>
</tr>
<tr>
<td>2. PURSUE FURTHER QUALIFICATIONS</td>
<td></td>
<td>128</td>
</tr>
<tr>
<td>3. MOVE TO INDEPENDENT PRACTICE</td>
<td></td>
<td>129</td>
</tr>
</tbody>
</table>
33) WHAT DOES BEING A PROFESSIONAL MEAN TO YOU

<table>
<thead>
<tr>
<th>Q32</th>
<th>YES(1)</th>
<th>NO(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>130</td>
<td></td>
<td></td>
</tr>
<tr>
<td>131</td>
<td></td>
<td></td>
</tr>
<tr>
<td>132</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. BEING RECOGNISED, RESPECTED AND LEGITIMATED AS HAVING KNOWLEDGE BASE AND EXPERTISE/ AND DECISION RECOGNISED

2. BEING ABLE TO DETERMINE OWN WORK ROLE

3. OTHER

34) DO YOU DO CERVICAL CANCER SCREENING (CCS)

<table>
<thead>
<tr>
<th>Q34</th>
<th>YES(1)</th>
<th>NO(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>133</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1

35) COULD YOU TELL ME HOW YOU ORGANISED A CC SERVICE.

<table>
<thead>
<tr>
<th>Q35</th>
<th>YES(1)</th>
<th>NO(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>134</td>
<td></td>
<td></td>
</tr>
<tr>
<td>135</td>
<td></td>
<td></td>
</tr>
<tr>
<td>136</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. SUBMISSION WRITING TO OBTAIN FUNDING

2. SPECIAL ONCE OFF PROJECTS AND OTHER REGULAR CLINIC TIMES

3. OTHER
36). HOW DO YOU ATTRACT WOMEN TO YOUR SERVICE:

<table>
<thead>
<tr>
<th></th>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q36</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MEDIA / PAPER / RADIO / COMMUNITY NEWSLETTER</td>
<td></td>
<td></td>
<td>137</td>
</tr>
<tr>
<td>2. PAMPHLETS</td>
<td></td>
<td></td>
<td>138</td>
</tr>
<tr>
<td>3. WORD OF MOUTH / COMMUNITY GROUP TALKS</td>
<td></td>
<td></td>
<td>139</td>
</tr>
<tr>
<td>4. COMMUNITY ARTS PROGRAM</td>
<td></td>
<td></td>
<td>140</td>
</tr>
<tr>
<td>5. OTHER</td>
<td></td>
<td></td>
<td>141</td>
</tr>
</tbody>
</table>

37). DO THE WOMEN WHO USE YOUR SERVICE INDICATE WHY THEY CHOSE NURSES BASED CCS:

<table>
<thead>
<tr>
<th></th>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q37</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. FEMALE PRACTITIONER</td>
<td></td>
<td></td>
<td>142</td>
</tr>
<tr>
<td>2. FREE SERVICE</td>
<td></td>
<td></td>
<td>143</td>
</tr>
<tr>
<td>3. CONVENIENT PLACE / TIME</td>
<td></td>
<td></td>
<td>144</td>
</tr>
<tr>
<td>4. DR TO BUSY OR TO EMBARRASSED TO ASK DR</td>
<td></td>
<td></td>
<td>145</td>
</tr>
<tr>
<td>5. OTHER</td>
<td></td>
<td></td>
<td>146</td>
</tr>
</tbody>
</table>

38). DID YOU OFFER SPECIFIC CCS PROGRAMS: (PLEASE SPECIFY) WOMEN'S HEALTH WELL WOMEN'S CLINICS

<table>
<thead>
<tr>
<th></th>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q38</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>147</td>
</tr>
</tbody>
</table>
39). WAS THE MAJOR REASON WOMEN CAME TO YOU FOR:
PAP SMEAR
IF, OTHER PLEASE DESCRIBE 'OTHER'

<table>
<thead>
<tr>
<th></th>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q39</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PAP SMEAR</td>
<td></td>
<td></td>
<td>148</td>
</tr>
<tr>
<td>2. PAP SMEAR AS ENTRY POINT BUT WANTED TO DISCUSS OTHER THINGS</td>
<td></td>
<td></td>
<td>149</td>
</tr>
<tr>
<td>3. OTHER</td>
<td></td>
<td></td>
<td>150</td>
</tr>
</tbody>
</table>

40). DURING THE WOMEN'S VISIT DO YOU PICK UP ON OTHER HEALTH OR GENERAL CONCERNS

<table>
<thead>
<tr>
<th></th>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q40</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. OTHER HEALTH CARE CONCERNS</td>
<td></td>
<td></td>
<td>151</td>
</tr>
</tbody>
</table>

41). CAN YOU DESCRIBE WHAT THESE OTHER HEALTH OR GENERAL CONCERNS ARE:

<table>
<thead>
<tr>
<th></th>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q41</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MENOPAUSE</td>
<td></td>
<td></td>
<td>152</td>
</tr>
<tr>
<td>2. SOCIAL ISSUES / FAMILY / DEPRESSION</td>
<td></td>
<td></td>
<td>153</td>
</tr>
<tr>
<td>3. INCONTINENCE</td>
<td></td>
<td></td>
<td>154</td>
</tr>
<tr>
<td>4. SEXUAL HEALTH</td>
<td></td>
<td></td>
<td>155</td>
</tr>
<tr>
<td>5. EXPLANATIONS FROM MEDICAL INTERACTIONS</td>
<td></td>
<td></td>
<td>156</td>
</tr>
<tr>
<td>6. OTHER</td>
<td></td>
<td></td>
<td>157</td>
</tr>
</tbody>
</table>
42). IN WHAT WAYS DO YOU RESPOND TO THE OTHER HEALTH CARE CONCERNS

<table>
<thead>
<tr>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q42</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>158</td>
</tr>
<tr>
<td>1. LISTENING AND PROVIDE EDUCATION AND COUNSELLING IF REQUIRED</td>
<td></td>
<td>159</td>
</tr>
<tr>
<td>2. PROVIDE APPROPRIATE WRITTEN MATERIAL</td>
<td></td>
<td>160</td>
</tr>
<tr>
<td>3. REFERRAL TO DR AND OTHER SERVICES AT CHC</td>
<td></td>
<td>161</td>
</tr>
<tr>
<td>4. OTHER</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

43). HOW LONG IS YOUR AVERAGE CONSULTATION FOR CCS:

<table>
<thead>
<tr>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q43</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>162</td>
</tr>
<tr>
<td>1. 15. MINUTES (1)</td>
<td></td>
<td>163</td>
</tr>
<tr>
<td>2. 30. MINUTES</td>
<td></td>
<td>164</td>
</tr>
<tr>
<td>3. 45. MINUTES</td>
<td></td>
<td>165</td>
</tr>
<tr>
<td>4. 60. MINUTES</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

44) DO YOU NOTIFY THEM OF NORMAL CCS RESULTS

<table>
<thead>
<tr>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q44</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>166</td>
</tr>
<tr>
<td>1. DO YOU NOTIFY THEM OF NORMAL CCS RESULTS</td>
<td></td>
<td>167</td>
</tr>
<tr>
<td>2. BY LETTER</td>
<td></td>
<td>168</td>
</tr>
<tr>
<td>3. OTHER</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

45). HOW LONG IS YOUR AVERAGE CONSULTATION FOR ABNORMAL CCS RESULTS:

<table>
<thead>
<tr>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q45</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>169</td>
</tr>
<tr>
<td>1. 15. MINUTES.</td>
<td></td>
<td>170</td>
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<td>2. 30. MINUTES</td>
<td></td>
<td>171</td>
</tr>
<tr>
<td>3. 45. MINUTES</td>
<td></td>
<td>172</td>
</tr>
<tr>
<td>4. 60. MINUTES</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

46) HOW DO YOU NOTIFY THEM OF ABNORMAL CCS RESULTS

<table>
<thead>
<tr>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q46</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>173</td>
</tr>
<tr>
<td>1. PHONE</td>
<td></td>
<td>174</td>
</tr>
<tr>
<td>2. BY LETTER</td>
<td></td>
<td>175</td>
</tr>
<tr>
<td>3. APPOINTMENT AND THEN REFERRAL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
47). DO YOU CHARGE FOR YOUR CONSULTATION:  

<table>
<thead>
<tr>
<th>YES(1)</th>
<th>NO(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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</table>

48). IF SO HOW MUCH:  

<table>
<thead>
<tr>
<th>YES(1)</th>
<th>NO(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. $5.00</td>
<td></td>
</tr>
<tr>
<td>2. $10.00</td>
<td></td>
</tr>
<tr>
<td>3. $15.00</td>
<td></td>
</tr>
<tr>
<td>4. OTHER</td>
<td></td>
</tr>
</tbody>
</table>

49). HOW MANY PAP SMEARS DID YOU DO IN THE LAST 12 MONTHS  

<table>
<thead>
<tr>
<th>YES(1)</th>
<th>NO(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. LESS THAN 20</td>
<td></td>
</tr>
<tr>
<td>2. 20</td>
<td></td>
</tr>
<tr>
<td>3. 30</td>
<td></td>
</tr>
<tr>
<td>4. 40</td>
<td></td>
</tr>
<tr>
<td>5. 50</td>
<td></td>
</tr>
<tr>
<td>6. 60</td>
<td></td>
</tr>
<tr>
<td>7. OTHER</td>
<td></td>
</tr>
</tbody>
</table>

PLEASE WRITE HOW MANY

IF YOU HAVE DEMOGRAPHIC INFORMATION ABOUT THE WOMEN WHO HAVE USED THE NURSE BASED SERVICE DURING THE LAST 12 MONTHS COULD YOU TELL ME THE FOLLOWING

50). ON AVERAGE OF THE WOMEN YOU HAVE SEEN WHAT HAS BEEN THEIR SCREENING HISTORY  

<table>
<thead>
<tr>
<th>YES(1)</th>
<th>NO(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. LESS THAN 2YRS</td>
<td></td>
</tr>
<tr>
<td>2. BETWEEN 2-5YRS</td>
<td></td>
</tr>
<tr>
<td>3. MORE THAN 5YRS</td>
<td></td>
</tr>
<tr>
<td>4. NEVER SCREENED</td>
<td></td>
</tr>
<tr>
<td>5. OTHER</td>
<td></td>
</tr>
</tbody>
</table>
51). WHAT AGE GROUPS HAVE THE WOMEN COME FROM

<table>
<thead>
<tr>
<th>Age Group</th>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q51</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 25-35 YRS</td>
<td></td>
<td></td>
<td>193</td>
</tr>
<tr>
<td>2. 35-45 YRS</td>
<td></td>
<td></td>
<td>194</td>
</tr>
<tr>
<td>3. 45-55 YRS</td>
<td></td>
<td></td>
<td>195</td>
</tr>
<tr>
<td>4. 55-65 YRS</td>
<td></td>
<td></td>
<td>196</td>
</tr>
<tr>
<td>5. 65-75 YRS</td>
<td></td>
<td></td>
<td>197</td>
</tr>
</tbody>
</table>

52). WHAT WAS THE WOMEN'S COUNTRY OF BIRTH

<table>
<thead>
<tr>
<th>Country Type</th>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q52</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. AUSTRALIAN</td>
<td></td>
<td></td>
<td>198</td>
</tr>
<tr>
<td>2. BORN OVERSEAS</td>
<td></td>
<td></td>
<td>199</td>
</tr>
</tbody>
</table>

53). WHAT AREAS DO THE WOMEN COME FROM

<table>
<thead>
<tr>
<th>Area Type</th>
<th>YES(1)</th>
<th>NO(2)</th>
<th>Q53</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. RURAL</td>
<td></td>
<td></td>
<td>200</td>
</tr>
<tr>
<td>2. PROVINCIAL</td>
<td></td>
<td></td>
<td>201</td>
</tr>
<tr>
<td>3. METROPOLITAN</td>
<td></td>
<td></td>
<td>202</td>
</tr>
</tbody>
</table>

ANY OTHER ISSUES YOU WOULD LIKE TO COMMENT ON

THANK YOU.
REFERENCES


Australian Government Publishing Service.


Coxhead, J., (1992), United We Stand - Divided We Fall. The Australian Journal of Rural Health. 1, (2) 13-18.


End Press.


New York: Routledge.


Women’s Health Nurse Association of Victoria. Melbourne. No Date Given


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<table>
<thead>
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<th>Signature</th>
<th>Date</th>
</tr>
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<tr>
<td>Fionachilds</td>
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<td>9-4-99</td>
</tr>
<tr>
<td>Catherine Stoddart</td>
<td></td>
<td>7/4/00</td>
</tr>
<tr>
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<td>1/8/03</td>
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