FROM THE EDITORS - Margaret McMillan and Jane Conway

MAINTAINING ETHICAL PRACTICE: THE CHALLENGES FOR CLINICIANS, SCHOLARS, REVIEWERS AND EDITORS

In the days following the recent inaugural Australian National Health and Medical Research Council's (NHMRC) conference on 'Ethics in Human Research', we were caused to think about our roles as editors in ensuring the process of research and subsequent publication is ethical.

We acknowledge the advances made in nursing knowledge as a result of research, and recognise that dissemination of knowledge through journals such as *AJAN* underpins the professional imperative that the nursing community values research based practice. However, we also experience occasional disquiet about whose needs are served through publication in a professional environment in which the 'publish or perish mentality' is increasingly pervasive.

In an attempt to understand how nurses might improve practice and align the professional ideal of caring with the demands of clinical practice, some nurses engage in research or reflect on their practice through scholarly writing. However, we are aware that beginning researchers frequently see ethics clearance as an obstacle to overcome in the research journey and may struggle with demands for compliance with guidelines.

The NHMRC National Statement on Ethical Conduct in Research[1] is a critical mechanism to identify essential matters of research ethics. It provides us with a way to examine matters of conscience, particularly if human subjects are involved. In general, these focus on individual studies in relation to questions such as:

- How well do nurses articulate those aspects of a situation that pose a moral dilemma for them?;
- Is the research involving health personnel and consumers consistent with elements of quality in ethical decision making?;
- Is the research undertaken ethical and scientifically robust?;
- Were the processes of obtaining ethics clearance efficient and reflective of the maintenance of the rights of the participants?;
- Does the design of the nursing research accommodate the need to treat all potential participants in a just manner?;
- Are there any unfair burdens placed on those who are approached to participate?;
- Are their risks to participants and if so how have these been minimised?;
- Are these risks balanced by the likely benefits?; and,
- Is there regard for the welfare, rights, beliefs, perceptions, customs and heritage of the persons on whom the research focuses?

Perhaps the superordinate question should be: How is the research that nurses sometimes see as easy to undertake relevant to the needs of the community?

To begin, we need to ask 'What justifies this research involving humans?' People need to have control over their lives and any level of interference needs to be justified. In order to do this, we need to be sure that the outcomes of the research add value to professional practice, increase knowledge or provide benefit to society. There needs to be guarantees that in their enthusiasm to research and publish, nurses do not violate human rights and that the benefits of the research outweighs any risk for those involved.

As editors and reviewers, we also need to ask 'What justifies publication of this article?' We need to ensure that the claims made about the adequacy of, and need for, any study we publish are based on a thorough analysis of any prior work undertaken in the area of concern. We rely heavily on the integrity of the authors to present papers for publication that meet ethics criteria.

There are a number of issues pertinent to questions about ethics in reports of research and philosophical commentary in the scholarly papers in this journal. In particular, there is a need to address the issues that arise from the potential to exploit easily accessible or vulnerable groups. A number of these are identified in Tuttle and Siebold's paper that explores the conduct of research with vulnerable groups, the gay and lesbian population, those dependent on alcohol and other substances, and clientele with learning disabilities.

Other papers use a number of research methods to examine student nurse perceptions. In selecting these papers for publication we examined the benefits of the knowledge generated by these as we are conscious that student nurses themselves may well be a vulnerable population and that, as a profession, nursing needs to be vigilant against exploiting students as a research population.

All of the papers highlight key issues that need to be addressed in order to meet the community need for, and expectation of, nurses.

The study by Ward et al centres on the critical issue of what attracts people to enter nursing and stay within the workforce. The study is significant to society, they argue, because of the shortage of nurses.

When examining ageism in nursing students, de la Rue uses participatory action research. This method poses particular challenges to managing participant consent in a study setting that seeks to be inclusive and democratic, and relies on a high level of ongoing commitment to achieve change in the culture across contexts of practice. Moyle's study required consent from students enrolled in a nursing program. This paper explores the views of nursing students towards older people and ageing and suggests a number of strategies to enhance students' perceptions of older people.

For those in practice, the present world of health care often appears messy and complex. This messiness and complexity arises because of inherent tensions and competing demands that arise from the heightened awareness of stakeholder needs. For example, it can be difficult for nurses to make sense of their contexts of practice when they have a commitment to a culture of client focused care (whatever the meaning they attach to that concept), and are faced with the daily challenges of managing care within resource constraints. The situations nurses need to contend with or attempt to manage inevitably have an ethical dimension.

Working in complex situations may result in the need for interventions that support nurses more effectively. Two of the articles in this *AJAN* highlight the need for nurses themselves to have their rights in the workplace respected and their needs met. Patterson and McMurray examine the changing scope of professional practice and the expectations of consumers and practice nurses (PNs) about the nature and extent of care provided by a PN in an expanded role. This topic raises issues about the complexity of practice and the difficulties in maintaining ethical relationships in such an environment. On the other hand, the work presents a model of collaborative practice rather than the traditional hierarchical approach. Such a change in models of practice may well have the potential to foster more ethical professional interactions.

Jeavons and O'Connor examine an area of great sensitivity - stress debriefing. There is particular need in this type of research to ensure that participants in the research project are not exposed to further distress or harm as a result of participation in the study.

While individual nurses aspire to ethical practice in their daily lives, the profession's collective commitment to ethical practice is also evident when one takes a 'big picture' view and examines the work of clinicians, researchers, reviewers and editors as scholars.

Dr Mary Chiarella, the recently appointed Chief Nurse in New South Wales, has to take a big picture view. In her role she has to deal with a range of health service personnel and represent the interests of nurses. She too would be cognisant of the need to embrace a set of sound principles of ethical conduct in every facet of her role.

REFERENCE

1 The NHMRC Statement on Ethical Conduct in Research. www.health.gov.au/nhmrc/publications/synopses/e35syn.htm

CALL FOR REVIEWERS

GUEST EDITORIAL - Professor Mary Chiarella, Chief Nursing Officer, NSW Health, RN, LLB(Hons), PhD(UNSW)

SIX WEEKS IN....

Margaret McMillan asked me if I would put fingers to keyboard to provide my first impressions of the role of New South Wales Chief Nurse. I am not sure whether or not such an endeavour takes me where angels fear to tread, but I had promised (rashly) beforehand and Margaret is holding to it.

I took up the post when the NSW Government had gone into caretaker mode, three weeks out from the election. This is a relatively quiet time in terms of Government activity, but is obviously busy as requests for information come from the Government, the Opposition and the media. Fortunately the office staff and the Acting Chief Nursing Officer (who nobly remained in post for two weeks to overlap with me) were extremely skilful and guided me through that time.

My immediate orientation was concerned with meeting key people within the Department and learning the ropes. A number of early pieces of advice were fairly sobering, especially for an academic who is used to being argumentative, sometimes just for the sake of it! Let me share them with you:

- 'Whatever you say, expect to be quoted'
- 'It is your responsibility to provide the Minister with frank and fearless advice'
- 'Rapid turnaround of information is essential'

Notwithstanding the sombreness of such advice, I am grateful for it, and am learning to understand the nature of life as a public servant quite quickly. There is a great deal of protocol to be observed, particularly in the preparation of briefing documents (only one page - dot points on each topic), but it is a stimulating intellectual exercise to condense a complex issue into a one-page document - quite the reverse of my previous work.

If there is one phenomenon that has struck me more than any other since I have been in the NSW Health Department, it is the presence of nurses. So often when I have met a senior bureaucrat they have told me with considerable pride, 'of course, I'm a nurse, you know'. A significant number of the senior bureaucrats in the Department are nurses. They may not be working in nursing positions any more, but they certainly identify with nurses and they are interested in and supportive of us and our endeavours. They are working in a range of settings and are tackling diverse issues which include development and maintenance of the Clinical Information Access Project (CIAP), the management of the NSW Private Hospitals and Day Procedures legislation and major portfolios in quality, primary healthcare and mental health, to name but a few.

It has long been my view that the skills we develop during our education and clinical practice are extremely valuable commodities. In addition to our clinical skills, we have a range of finely developed interpersonal skills, which stem from the fact that we deal with people in extreme situations and under significant stress. We also learn to stay calm in emergencies, to multitask and to triage, clinically and managerially, from a very early stage. These skills have long been recognised by other industries as being highly desirable and it is heartening to see that nursing skills are able to be used within health to influence the wider health care agenda. What we are now starting to see are nurses as leaders in the wider health arena, and this development means that many nurses are moving through nursing to use their nursing skills in a diverse range of senior positions in health. Until recently, nurses seeking advancement have rarely considered this a possibility, because nursing affairs have been managed within an internal nursing structure, and such affairs have consumed all nurses' efforts and energy. In the past, nurses who moved to non-nursing appointments (even within health) would have been regarded as having 'left' nursing, and indeed many of the nurses who did so would also have considered this to be the case. Often it was simpler to leave health altogether, rather than to take up such roles.

But this was because there was no prevailing philosophy that, in moving to non-nursing positions, nurses might have been manoeuvring into other key influential positions in health care, which could help those left practising nursing to have their voices heard and their contribution recognised.

Today that cannot be the case. We must celebrate and embrace those nurses who work in these diverse roles because they still celebrate the fact they are nurses and feel able to contribute to the profession in many different ways. While I do not wish to encourage nurses to leave the bedside, it appears to me that it is preferable to provide 'time out' for nurses within the health system rather than to lose them to other careers completely. Furthermore, if we allow them to take time out with a good grace, rather than making them feel guilty, the probability of their returning to clinical practice is greater. There is no doubt that the nurses I have met in the Department identify themselves as such with pride and confidence, and I have been delighted to encounter them.

PREVENTING AGEISM IN NURSING STUDENTS: AN ACTION THEORY APPROACH

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ABSTRACT

Australia has an ageing population and increased longevity has resulted in a larger proportion of the older population surviving to be 75 years and older. As a result of demographic trends, nurses are more likely to come into contact with older people. Ageism exists in Australian society and can unfortunately be found in some practicing nurses. 'Ageism' is a term used to describe a process of systematic stereotyping and discrimination against older people because they are very old, in a similar vein as racism and sexism accomplish this with skin colour and gender.

The aim of this study was to explore final year Bachelor of Nursing (BN) students' attitudes toward ageism and emancipate them to come to terms with these issues to prevent replication of ageism in their future practice as registered nurses (RNs).

Critical social theory (Fay 1987) combined with Stringer's (1996) model of Participatory Action Research (PAR) provided the theoretical directions for this study. Nine final year BN students at the University of Southern Queensland (USQ) volunteered to participate. Data were collected by focus group meetings and clinical diaries over a duration of six months.

Findings of this study revealed an acute self-awareness of what ageism was and a personal fear of the ageing process itself. Identified issues are discussed and re-framed in the form of recommendations so they can offer potential for renewed critical conscious raising to prevent ageism.

INTRODUCTION AND LITERATURE REVIEW

Populations across the world are ageing, a trend that is expected to continue for at least the next few decades. For example, if an older population is defined as people aged 65 years and over, projections indicate a growth in the proportion of this age group to 11.9% of Australia's population by 2001, 16.38% by 2021, and to 20.08% by 2031. Furthermore, by 2036 it is estimated there will be 5.2 million Australians aged over 65 (Commonwealth Department of Health and Family Services 1998).

An older population will comprise a greater number of people seeking health care. Given that RNs comprise the greater number of health care professionals, it is likely the older person will be cared for by RNs more than by any other health care professional. For example, according to the Australian Institute of Health and Welfare (AIHW 1996), there are at least 184,761 people working as RNs in Australia of whom 14.6% or 22,663 work directly in aged care.

The term 'ageism' refers to attitudes and stereotypes and is a generalisation made about people who fall into a similar age bracket. The potentially damaging implication it has is that ageism can be negative in regard to older people (Picton 1991). Hoyer (1997) and Smith (1997) have argued that ageism is reflected in the view that older people are a burden, and that the process of growing older is widely viewed as being associated with the loss of independence, loss of self-control, social isolation and disengagement from life.

Prevailing attitudes in Western countries are argued to influence the quality of services offered and the treatment to older individuals (Koenig 1995), and to affect the behaviour of policy makers, health and community care agencies and service providers (Sherman 1993). Reports in the literature have focused upon aspects of ageism among health professionals, such as medical practitioners, psychologists and nurses (Gething et al 2001; Gatz and

Pearson 1988; Gattuso and Saw 1998; Minichiello et al 1998; Le Couteur et al 1997; Haug 1994; Gething 1994). Some studies indicate that attitudes toward ageism both commence and already exist, in health professionals, during their preparation for a career in health and human services (Gattuso and Saw 1998; Le Couteur et al 1997; Braithwaite et al 1993).

However, the fact that no attempt has been made to eradicate these ageist attitudes during the preparation of health professionals before their graduation raises issues for concern for their future aged care practices. The literature has drawn attention to attitudes among nurses and questions whether such attitudes could have a detrimental effect on the care provided to older people. The discussion has not been directed to nursing practice in aged care contexts alone, but is extended to all areas of nursing practice. For example, Donahue and Alligood (1995) argue that nurses are in a pre-eminent position to address the health care needs of the 'greying' society, but that negative attitudes toward older people are often incorporated into the beliefs of health care providers and influence behaviour toward and care given to older people. Gibb and O'Brien's (1990) and Gibb's (1990a, 1990b) studies found that an ageist attitude held by some nurses could be related to the managerial hierarchical position they held in an aged care agency and the role they had to fulfill. These studies showed that RNs, who were the most senior professionals in the nursing home, were often quite distant and cold to the older person, often because of time pressures and because they had to deal with issues directly concerned with, for example, medication. In contrast, people in a lower hierarchical position, for example, the enrolled nurses, had a much kinder approach. This could be attributed to the fact that they interacted with older people much more than the RNs by attending to their personal care such as taking them to the shower.

Hence, there was much more opportunity for social interactions which reflected equality in the relationship, as opposed to the RNs who tended to quickly wash someone in their bed, because of time pressures to administer the more complex nursing care. The author also concluded that if there is a dominant philosophy that does not respect and value older people coming from management then all nurses will adopt the same attitudes.

Stevens and Herbert (1997) strongly attest that ageism has many expressions in the health care industry in Australia where its effects are systemic. For example, they argue that the priorities of the health care industry are predicted on the value of obtaining a 'cure' and on the high status of working with 'high tech' equipment. Similar findings have emerged in the United States, Canada and United Kingdom (McMinn 1996; Lookinland and Anson 1995). In this same vein, studies by Stevens and Crouch (1997; 1995) show, despite the best intentions of many institutions that prepare nursing students for practice as RNs and promote aged care as a dynamic professional domain for nurses, students tend to devalue aged care

from a time somewhere between the start and completion of their course. Hence, a profile seems to emerge that technical nursing, such as in intensive care units, is perceived as high-status, whilst the more basic areas such as mental health and aged care, are regarded as having low status (Stevens and Crouch 1997; Lawler 1991). According to these studies, this perception is most likely to be held by students and new graduates. This raises an area for concern, as this particular cohort is either just beginning or preparing for a career in the health care industry, and if they already possess ageist beliefs and behaviours, the negative implications can be perpetuated as they further their practice. In addition, the ageist attitudes and behaviour can affect the way older people view themselves. For example, negative messages in relation to ageism received from others can create a 'self-fulfilling' prophesy that the older individual comes to believe and acts accordingly. The results reflect limited horizons or opportunities, lowered self-esteem, and limited freedom of choice (Gething 1999).

In summary, while the findings of the above studies have determined that an ageist attitude does exist within nursing and other health care professions, and that it has a negative impact on practice, none of the studies utilised a research methodology to facilitate the goal of a deeper understanding of the context in which ageism practices take place, based on open communication, critique, reflection and co-researching between the participants and the researcher. Such a methodological research approach could have the potential to help nurses and other health professionals to lose their 'false consciousness' and gain a state of questioning and confronting their previous beliefs and behaviour in relation to ageist practices (Lather 1986).

Therefore, there was a need to conduct a study which had the potential to emancipate, or free, student nurses and new graduates from their previously held ageist practices (Grbich 1999). Such an approach would have the potential to transform nursing students' and new graduates' attitudes towards ageism before they enter the health care industry, from a base of awareness-raising through the rejection of false consciousness and the pursuit of alternative ways of thinking and strategies to accomplish change (Owens et al 1999). The need for such a study to be conducted is further supported by the emphasis of the then Commonwealth Department of Health and Family Services (1998) which emphasised how a positive attitude toward older people can influence the process of successful ageing. Such was the platform from which this study was conducted.

Research aims

The aim of this study was to explore final year pre-registration nursing students':

1 attitudes towards ageism;

2 perceptions of the issues arising out of practising ageism; and to,

3 critically raise the consciousness levels to develop an

understanding of the issues and to make choices in relation to the prevention of ageism in their future practice as an RN.

THE STUDY

Participatory Action Research Method

Participatory Action Research (PAR) combined with Fay's (1987) version of critical social theory provided the theoretical direction for this study. The rationale for choosing this combination was that, firstly, the Fay approach (1987) fits very well with the emancipatory action research ideology and processes, because he sees that critical social theory encompasses knowing human abilities and attitudes, a theory of value, and, an account of social change through education and politics. He sees the relationship between conditions and ideas not as unilinear, going from point to point as in a straight line, but as a dialectal relationship that undergoes review on a continuing cylindrical basis (Fay 1987, p.22). Hence, this dialectal relationship also facilitates the PAR approach, in that PAR provides a process of inquiry, intervention and evaluation, and is most appropriate when improved practices and problem solving are core concerns. The PAR position involved those at the lower levels of the hierarchy, (eg the participants in this study), who defined the issues to be addressed and assessed action for change in a co-researched manner (Grbich 1999; Lather 1986). The processes that enable the dynamic outcomes of PAR to be achieved are those of collaboration, critical reflection and confidence to the point that PAR participants are emancipated to participate in bringing about social action and change through their awareness raising through the rejection of ageism (Owens et al

1999), and therefore are set free from previous controls such as ageist behaviour and beliefs (Grbich 1999, p.209).

The specific approach to PAR, for this study, was Stringer's (1996) model. Stringer (1996) proposed that PAR was community-based action research providing a process or a context through which people can collectively clarify their problems and formulate new ways of envisioning their situations. The steps of this model of PAR are: setting the stage; looking; and, thinking and acting. By 'look' Stringer (1996) means that participants should define and describe the problem to be investigated and its context; by 'think', he means participants should analyse and interpret the situation in order to develop their understanding of the problem; by 'act', he means that participants should formalise solutions to the problem. The PAR model aligned with Fay's (1987) critical social theory guided the data collection and simultaneous data analysis process in this study to achieve its purpose and aims, as shown in Table 1.

PARTICIPANT RECRUITMENT PROCESSES

After full ethical approval was granted by the USQ Ethics Committee for Research Involving Human Subjects, a verbal invitation was offered to participate, on a voluntary basis, to 110 USQ final year BN pre-registration students. While numerous students expressed interest, many stated that they felt time commitments in relation to finishing their degree and pursuing prospective employment opportunities prevented their participation. A total of nine final year BN pre-registration students returned signed consent forms and agreed to participate in the project. Although this was a numerically small

Table 1: The integration of the Stringer (1996) PAR model with aims and data collection strategies		
Step of PAR model	**Project aims**	**Data collection strategy**
Setting the stage	**Explore participant's attitudes towards ageism**	**[a] Focus Group Meeting 1 - To tap into the participants': attitudes to the older person; attitudes towards ageing process; awareness to ageism**
Looking	**Explore the issues arising out of practising ageism**	**[a] Focus Group Meeting 2 - Group and co-researched analysis of case studies from participants' previous clinical experiences and identification of the issues** **[b] Group and co-researched preparation for clinical and guidelines for maintaining the clinical reflective journal whilst on the forthcoming clinical**
Thinking	**As above**	**[a] Clinical reflective journals** **[b] Focus Group Meeting 3 post-clinical - Group and co-researched analysis and identification of the issues arising out of clinical reflective journals**
Acting	**Critically raise the consciousness levels of the participants themselves to come to terms with the issues and make choices in relation to preventing replication of ageism in their future practice as an RN**	**[a] Focus Group Meeting 4 - Group and co-researched solutions to all the issues arising out of this project** **[b] Individual de-briefing**

sample, it was considered adequate as the primary goal was to understand in-depth the phenomenon of ageism (Llewlyn et al 1999). In addition, the sample was justified as Morse suggests that a good participant is 'one who has the knowledge and the experience the researcher requires, has the ability to reflect, is articulate, has the time to be interviewed, and is willing to participate in the study' (1994, p.228). For example, when applying the above criteria to the sampling strategies utilised in this study, the nine participants' age range was 20-25 years, three were currently working in aged care settings as assistants in nursing, all had one semester to complete both theoretical and a remaining 40 clinical hours to satisfy the Queensland Nursing Council's requirements to be eligible to register as an RN.

DATA COLLECTION AND ANALYSIS

Data collection and analysis for this study was an on-going process of monitoring action by the same techniques used in any other qualitative research that places an emphasis on transcripts of audio-taped focus group meetings and reflective diaries. However, instead of analysing the data inductively through content analysis (Bowling 1997, pp.353-4) to allow emergent themes as in thematic analysis, the data were shared with the study participants in a collective, self-reflective inquiry to allow the inquiry, action and evaluation cycle of action research, controlled by the researcher, to become group planning, acting, observing and reflecting. For example, in Stringer's (1996) PAR model, data analysis occurs simultaneously with data collection throughout the research process, but the final outcomes of the analysis of data are proposed as agreed solutions to the problem and are planned by the researcher and the participants involved. These agreed solutions can be used for foundations for an ongoing relationship as areas for action, and in this current study are proposed as recommendations. Springer's (1996) approach to data analysis is a marked comparison to Morgan's (1983) approach, which also proposes a collaborative approach, but as collaborative theorising which results in theories that possess 'evocative power' (p.298). Therefore, in relation to this current study, Stringer's (1996) approach to data analysis, within a broad framework of PAR, is the most appropriate to achieve the research aims.

METHODOLOGICAL TRUSTWORTHINESS

To ensure validation of findings, on completion of each stage and prior to the next subsequent data collection strategy, issues identified were reviewed and agreed upon in a co-researched manner with both the participants and researcher. In this study, this was integrated and directed by the utilisation of Stringer's (1996) PAR model of: setting the stage, looking, thinking and acting. This process allowed the outcomes of the analysis of this study to have an emphasis on emancipation of the participants through praxis (Grbich 1999, p.209).

FINDINGS

The findings are presented in accordance with Stringer's (1996) PAR model as explained above.

Setting the stage

This was in two stages: firstly, a preliminary survey to allow the participants to become aware of their own attitudes towards ageism; and secondly, by utilising a focus group strategy, to allow the participants to confront the issues emerging from the analysis of the survey.

(a) Preliminary survey

The participants both consented to and completed a preliminary survey questionnaire prior to the first focus group meeting. The purpose of this questionnaire was to identify self-awareness of any present attitudes of ageism in the targeted population. The three-part instrument was adapted from Braithwaite et al's (1993) ageism scale and had an equal number of positively and negatively worded items. All items were rated on a seven point scale from *strongly agree* (1) to *not sure* (the mid-point) (4) to *strongly disagree* (7). Part 1 comprised of eight randomly ordered statements tapping the attitudes towards older people. Part 11 comprised of 16 randomly ordered statements tapping the attitudes towards the ageing process. Part 111 comprised of 10 randomly ordered statements tapping awareness of ageism. The results of this preliminary survey are presented in Table 2.

Table 2 reports the analysis of the preliminary survey. The positive and negative nature of responses to old age, as well as the variability across individuals, can be appreciated through analysing the frequency distribution on the three scales. Given the balance of positive and negative items, the midpoint of each scale can be

Table 2: Results of preliminary survey					
Scale	Number of scale items	Mean (n=9)	% at midpoint	% below midpoint	% above midpoint
Attitude to older people	8.0	3.5	0.0	44.4	55.5
Attitude to ageing process	16.0	4.3	0.0	0.0	100.0
Awareness of ageism	10.0	4.08	22.2	33.3	44.4

interpreted as indicating a neutral attitude or unwillingness to generalise about older people in a positive or negative way. High scores on the scales consistently mean a positive view or endorsement of the concept being measured. With reference to attitudes towards older people, 44.4% scored below the neutral point, while 55.5% scored above the neutral point, showing that most of the respondents were somewhat favorably disposed towards older people. With reference to attitudes towards the ageing process, 100% scored above the neutral point, showing a positive attitude towards the ageing process. However, the overall mean was 4.3, which indicated a tendency to be neutral or unsure of the ageing process as applied to self. With reference to awareness of ageism, the results were somewhat inconclusive. For example, 22.2% were neutral in their awareness of ageism, 33.3% were unsure or not aware of their awareness of ageism, while 44.4% were unaware of their awareness of ageism. In addition, the overall mean was 4.08%, which indicated a tendency to be neutral or unsure of awareness of ageism. The results formed the basis for self-analysis of awareness of ageism in the Focus Group Meeting 1.

b) Focus Group Meeting 1

The first Focus Group Meeting allowed the participants to probe deeper into the influencing factors and to confront the underlying causes of attitudes towards the older person. Based on the results of the preliminary survey as discussed above, these attitudes were found to contribute toward those already in situ, because of both positive and negative experiences with older relatives, upbringing, and personal culture, as exemplified by the participants:

I found when I was doing the questionnaire, because I live with my father who fits into this category, I had to consciously step away because I have some negative problems with him.

The upbringing and cultural environment that you live in can really affect you... the way you view them [the older person].

A fear of the ageing process was also identified:

At the moment, I'm watching my parents get old... they're watching their friends pass on... I'm actually terrified of getting old, because I'm going to be in that same situation where my friends are going to be getting sick and passing on... that is scary... not for me... for the more emotional side of it and being alone...

An interesting finding, in this study, was a personal fear of how the ageing process might affect the individual participant when they become an older person, and also concurs with Braithwaite et al's study (1993). The personal fear was influenced by factors such as: being in the same situation as some older people observed while on clinical and a potential to be disadvantaged because of lack of nursing care resources affected by time and staff shortages, which also concurred in Gibb's (1990a, 1990b) studies:

...when you're there with an old patient, there should be more time given to that patient... and, just given the lack of time, resources and nursing staff... it's very sad... you can't give them the emotional support as well as the physical care... we're all getting older, and you don't know when you're going to end up in hospital, and if things don't change, you could be that person in that bed... it's the real life situation... that fear of laying in that bed... that situation...

This self-identification of personal fear of becoming older had a confronting impact on the participants in that it made them want to explore their attitudes further.

Looking

The participants agreed to explore further the self-identified issues that arose out of Focus Group Meeting 1. They saw this discussion as important for their own self-awareness towards ageism which had the potential to affect their own professional practice when caring for the older person, thus it raised their consciousness levels. As a group in collaboration with the facilitator, they decided they should explore past real life case studies arising out of their clinical practice and life experiences, in the next focus group meeting. The participants self-identified the purpose of this strategy to both prepare them to identify appropriate outcomes and actions to be taken in clinical practice, and to prepare them for maintaining a reflective journal whilst on their forthcoming clinical placement.

At Focus Group Meeting 2, the participants recounted case studies from their past clinical practice. The emerging issues that were both confronted and explored were: inappropriate communication with the older person; negative ageist attitudes of the health care professionals who deliver care for the older person; the influence that ageism has on other health care professionals also delivering care; potential for harm because of inadequate and inappropriate assessment; rehabilitation and discharge planning; and, disempowerment of the older person caused by: paternalism, insensitivity of cultural needs, lack of resources, cost-saving health economics, denial of choices and/or decision-making, lack of privacy and/or respect, and being a victim of institutional routines. These emerging issues concurred with findings of previous studies (Gibb and O'Brien 1990; Gething 1999; Donahue and Alligood 1995; Koenig 1995).

Thinking

The next step was to analyse the discourse arising out of the participant's reflective clinical journals, with the aim of understanding the complexity of the issue in order to develop negotiated change.

Prior to commencement of the clinical during which a reflective journal was to be maintained, each participant was given a set of guidelines upon which to base their reflections, together with an attached stamped and self-addressed envelope to the facilitator, for their return. Within these guidelines there was an assurance that the

clinical journals would be stored in a locked file in the facilitator's home away from her workplace; only the facilitator would have access to them; and that the participant's anonymity and confidentiality would be assured in a summary of the contents. A summary of all clinical journals was forwarded to each participant prior to Focus Group Meeting 3 for further group discussion and exploration.

The clinical journals allowed critical reflection to take place by the participants of the actual practice of ageism, both within themselves and others. For example, as the participants themselves attested:

Once you are aware of the bias you hold, you can more consciously control them... I have learnt a valuable lesson on how the individual elderly folk are... what it is like for them... it has been valuable to me, from a nursing and civilian viewpoint.

The group decided to identify the focus of ageism they had observed whilst on clinical practice, and to identify what they themselves could do to prevent replication in their own future practice as RNs. The group agreed that in the clinical practice of health care professionals, there were not only negative factors that could reinforce ageism, but also positive factors that have the potential to prevent ageist practice from occurring. For example: health care professionals who are in control of a ward or aged care facility, and whose actions demonstrate respect and non-ageism towards the older person, can model non-ageism practice.

The group also identified that in indigenous aged care settings there was cultural respect by the health care professional for the indigenous older person, which appeared to have the potential to negate ageism. In addition, the group identified that there was a decrease in the practising of ageism in health care agencies such as respite centres and community centres, in which the older person has resident status, as compared to the 'routine' care as demanded by public hospitals in which the older person has patient status.

Acting: Solutions to the stated concerns

Based on the findings of this study, the following solutions were proposed as recommendations by the participants in this study. The group proposed that these recommendations could be implemented in the curricula of pre-registration BN programs, for the purpose of minimising any possibility of ageism in future practice as an RN:

- a clinical experience, within an aged care setting, should be encouraged for the final clinical experience before completion;
- inclusion of an assignment of which are criterion is to collect the life history story of the 'healthy older person'; and,
- assessment of students competency in aged care in the final year of the BN program.

CONCLUSIONS

The outcomes of this study provide further confirmation for earlier authors who have argued the need for inclusion of education that focuses upon reducing misconceptions and stereotypes about ageing and older people (Stevens and Herbert 1997). The study also demonstrates the usefulness of employing critical consciousness raising strategies to use in education. The strategies may also be used to guide the design of courses to address inappropriate attitudes and beliefs and to base further action and recommendations aimed at preventing ageist practices.

Results suggest that all educational programs for all health care professionals, regardless of their context, specialty and setting, must incorporate material and experiences that challenge stereotypes and promote cultural awareness within the older population. For example, this study has shown that in indigenous aged care settings there was cultural respect by both the health care professional and members of the indigenous community, and this could have the potential to negate ageism. Education addressing cultural awareness to negate ageism should be incorporated into all aspects of education, not just gerontological courses. Furthermore, Prevost et al (1992), have argued that optimising service provision for older people concerns all segments of the health care sector, not just aged care specialists.

Because of the small sample size of participants in this study, the results cannot be generalised. Further research should be conducted within a larger population to investigate whether the identified attitudes and beliefs, as found in this study, exist in other groups of final year BN students. However, this study, through its research design of PAR (Stringer 1996), facilitated the raising of the participant's critical consciousness to confront the issues and make choices to prevent the replication of ageism in their future practice as an RN. Similar strategies designed to address ageism must be implemented for all health care professionals that have direct dealings with older clients, regardless of setting, context and speciality. Many universities and educational institutions are taking steps to include content within their curricula to combat ageism.

Although this article focused upon final year BN students, the research reported confirms that these strategies are of utmost importance if implemented before any professional embarks upon their career in the health care industry.

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NURSING STUDENTS' PERCEPTIONS OF OLDER PEOPLE: CONTINUING SOCIETY'S MYTHS

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ABSTRACT

This study aimed to identify student nurses' views of older people as a means of offering insight into how these perceptions might influence where students choose to work and the care they might provide to older people. A structured questionnaire comprising of eight questions and demographic data was used to survey undergraduate nursing students (n=103). Findings indicate that nursing students are continuing society's myths of older people being frail and declining in health. There is a need to challenge society's attitudes so older people become valued and the aged care working environment also becomes a desirable place in which to work. Changes needed in nursing education are also suggested.

INTRODUCTION

Countries throughout the developed world are experiencing an increase in their aged population. In Australia in 1999 there were 2.3 million people aged 65 years and over (Australian Bureau of Statistics [ABS] 1999). The number of older people in Australia is expected to increase rapidly to about 4.2 million in 2021 and around 6.8 million in 2051 (ABS 2000). Such growth may result in increased pressure on community and health services to plan for the needs of this population. For example, people over the age of 65 years have been found to be the major consumers of hospital services (Australian Institute of Health and Welfare [AIHW] 2000). Furthermore patients in the 75 years and older group account for the greatest number of hospital bed days and along with the very young account for the longest average length of hospital stay (AIWH 2000). Thus, aged care can no longer be seen as being confined to residential aged care settings. It is, therefore, important that the nursing profession prepares nurses to look after older people in all care situations.

Approximately 9% of the over 70-year population are in residential care (Percival 1999). This number is expected to increase proportionate to the increase in the aged population (Commonwealth Department of Health and Family Services 1997). Although older people may not necessarily be dependent on others, ageing brings with it an increase in disease processes (Walker 2001). Thus, it is anticipated that nursing services will continue to be required in community and hospital care programs, as well as residential care settings.

Ageing has significant impact on society and cannot be ignored. However, an ageing population brings with it a number of challenges. For the nursing profession the increased proportion of older people requiring nursing services and the reluctance of nurses to work in aged care produces major challenges in the light of the current

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shortage of nurses to provide care for this group (Percival 1999). Over the last decade a number of studies have investigated how health care professionals feel about caring for older people with the majority of these studies focusing on nursing students' knowledge and attitudes towards this age group. Nursing students' attitudes to older people have frequently been found to be negative (Dellasega and Curriero 1991; Fagerberg and Ekman 1998/1997; Martell 1999; Murray and Chambers 1991; Stevens and Crouch 1992). However, it is important to keep in perspective that without an international definition of what constitutes 'attitude' and 'knowledge' there is little consistency between such studies (Parker 1999). Many studies measuring attitude and knowledge have used standard measurement tools such as Kogan's Attitude to Old People Scale (Kogan 1961) or the Oberleder Attitude Scale (Oberleder 1962). Such scales may be useful for measurement of knowledge and attitudes to identify the effectiveness of education programs. However, it has been argued that these scales may not be useful for measuring attitudes and knowledge outside the classroom environment (McCabe 1989).

Despite recommendations for the inclusion of more gerontology in nursing curricula (Markstrom 1991) there is little evidence that factors influencing positive attitude formation toward older people have been investigated. Instead, many individuals and organisations have recognised these challenges and have set up recruitment and retention taskforces with an emphasis on aged care nursing. The United Kingdom (UK) has been preparing to fill the shortages in aged care for much longer than Australia. The Health Advisory Service (HAS) 2000 report (1998) argued that to attract practitioners to work with older people and to encourage them to stay within this area of practice a philosophy of care that is attractive to nurses is required. Nolan (1996) argued
that one of the major problems of making aged care attractive to nurses is that gerontological nursing has difficulty in describing its mission and that nurses fail to recognise the potential of gerontological nursing (Nolan and Tolson 2000).

Increases in an aged population also create the need for nurses to have an understanding of the experience of ageing and to have appropriate education at both undergraduate (pre-registration) and postgraduate levels to prepare them to work with older people. The need to place a greater emphasis on aged care within undergraduate nursing programs has received little support to date (Nay and Closs 1999). The reason given for this is an argument that an undergraduate nursing program should not encourage specialisation. The UK has recognised the need for changes to undergraduate nursing. A separate branch for the care of older people and community to encourage an adequate number of aged care practitioners within nursing practice has been included within the undergraduate curriculum. Particular emphasis is placed on aged care to cope with the growth

in this population (United Kingdom Central Council [UKCC] 2001).

Although a lack of educational preparation for working with older people can be partly to blame for the declining numbers of registered nurses (RNs) moving into aged care, it is argued that there are other more substantial influences, such as society's poor image of ageing. As a society we value the young and scorn the older people through media and discrimination in areas such as employment opportunities (Whitfield 2001). There is a general view that ageing is a period of inevitable decline accompanied by illness, dependence, confusion, helplessness and loneliness. Media advertise products they insist will help to erase wrinkles, stop balding and greying hair and generally make us young again. While for some individuals, ageing may mean a decline in health, the media and health professionals' attitudes toward ageing continue the myths of ageing by maintaining the falsehood that illness and disability are inevitable accompaniments to growing old.

As individuals we interpret what we see within our personal construct of the world as this allows us to make sense of what we see and the way we deal with issues. However, our interpretations are often coloured by such things as the attitudes of society and by the media. Such images also encourage stereotyping of groups such as the aged (Whitfield 2001) and may result in ageism.

Ageism refers to 'the process of systematic stereotyping and discrimination against people because they are old' (Stevens 1999, p.151). Stevens and Herbert (1997) explored ageism in nursing practice and identified many examples. They argued nurses and other health professionals have a significant role to play in the production and reproduction of ageism. Moreover they have been socialised to be unaware of ageism and their role in it.

New gerontological nurse practitioners will be drawn from the undergraduate nursing population. Given the need for greater numbers of gerontological nurses it is important to understand nursing students' views of older people. The present study aimed to identify student nurses' perceptions of older people as a means of offering insight into how these perceptions might influence where students choose to work and the care that they might provide to older people.

METHOD

Sample

A convenience sample of students in an undergraduate bachelor of nursing program in Brisbane, Australia, was surveyed. The inclusion criteria for students required that participants were: 1. at least 18 years of age; and, 2. they were enrolled in the Bachelor of Nursing (pre-registration) degree.

Questionnaire development

A questionnaire was developed following a review of the literature to identify major issues related to ageism and nursing practice. These issues formed the basis of the questions developed. The questionnaire consists of eight questions to which participants responded. The questions were intended to elicit students' perceptions and related to age, attributes, employment, what an older person looks like, media portrayal and whether students planned to work with older people. In addition to set questions, participants were also requested to provide socio-demographic information on their age, education level and personal and professional experience with older people.

A pilot study was undertaken with six postgraduate and 12 undergraduate students enrolled in a gerontology course. These students were considered to be a similar age and gender to the potential participant sample. The pilot sample was asked to comment on their understanding and ease of completing the questionnaire. There were no problems identified in relation to the questions and their intent. The pilot group did however suggest additional space for answering the questions. Following the addition of extra question space the original 12 undergraduate students retested the questionnaire to ensure face and content validity.

Data collection

Following university ethics approval, information about the study was placed on student noticeboards. Interested students were asked to access a questionnaire from outside the investigator's office. Written instructions requested that participants complete the questionnaire honestly, without help from others and upon completion return it to the investigator's mailbox. Participation in the survey was anonymous and completion of the questionnaire implied informed consent. Students were assured that non-participation would not bear any consequence to their course progression. The data collection took place over a two week time period in the middle of semester where the questionnaires were openly available for student access.

Data analysis

Responses to the questions were collated. Descriptive statistics (range and mean) were used to describe the characteristics of participants and the questionnaire ratings. Qualitative data were used to support the positions indicated by the participants.

RESULTS

Demographics

A total of 103 of 260 nursing students completed the questionnaire (40%). Female participants made up 88% and males 12%. Participants ages ranged from 18 to 48 years, with a mean age of 28. There were 42 first year, 35

second year and 26 third year students. The majority of students (n=93, 90%) only worked with older people when they were on undergraduate field placement. A small group of students (10%) worked in residential aged care as nursing assistants while they were undertaking their university course. However, just over half (53%) of the participants stated that they had contact with older people through visits with grandparents, neighbours or other relatives.

Questions

To establish students' perceptions of age they were asked to identify: *What age do you see people as aged?* Students were open to identify their perceptions of age. Sixty five per cent (n=67) indicated a person was aged once they were between 50 and 65 years. Students who indicated 50 years were young adults between 18 to 20 years of age. Thirty three per cent (n=35) of students identified with the broad consensus of western society when they indicated that people were aged once they were over 70. The problem with this is that it promotes a view of people over 70 which is not necessarily reflected in individuals. That is, everyone is seen as old at these ages whether they are physically or mentally old.

Two students (1.94%) identified with the theory of subjective age identity as distinct from chronological age (Victor 1994). They indicated that it was not appropriate to indicate an age to determine when people became aged. They believed that physical attributes and mental attitude indicated whether people were aged. Both of these students indicated that they had undertaken an elective subject in ageing and liked working with older people.

Table 1: Students' perceptions of when people are aged	
Age in years identified as aged	n (%) participants
50	8 (7.7)
55	10 (9.7)
60	15 (14.5)
65	33 (32)
70+	35 (33.9)
Inappropriate to identify an age	2 (1.94)
Total	n=103

Students were also asked to respond to the question: *What attributes help to convince you that people are aged?* In response to this students generally indicated the following physical attributes: frailty created by disease processes such as arthritis; declining health and disabilities; tiredness; requiring help with activities of daily living; reduced fitness; a 'stooped' appearance, reduced mental functioning; slow speech patterns, incontinence; loss of memory; dementia; and, mental delusions. These findings are supported by other studies

investigating factors identifying the transition to old age (Thompson et al 1990; University of the Third Age 1984; Ward 1984). It could be argued that any of the above (physical) attributes could be equated to someone with a major physical illness such as multiple sclerosis that might be technically 'young' in age. Thus, physical attributes alone are not appropriate indicators of age.

Forty per cent (n=42) of students indicated other attributes they believe made people look old. These were: hair colour (generally grey), 'bad hair perms', clothing, walking and hearing aids, wrinkles, watery eyes, and odour from things such as mothballs. These students linked health and age identification through a declining body image which perpetuates the myth that to age is to enter decline. Such ageist attitudes can impact on the health potential of older people where nurses may 'neglect' to place any focus on health promotion activities for the aged in the belief that that there is no benefit when their health is in decline. The main goals of health promotion with older people of maintaining independence, delaying dependency and disability and improving quality of life (Cattan 2001) may have little importance when ageism prevails.

Students also indicated emotional factors as indicators of being aged. For example, people's attitudes about themselves and others were considered to be the most convincing emotional attributes to indicate ageing with 70% (n=72) of students indicating that age was a state of mind. A small number of students (10%) commented on the negative impact of adopting ageist attitudes and beliefs and behaviours. Finally, five students indicated retirement as an attribute indicating age. This perception is of concern given the current economic climate where people are often 'forced' into retirement through redundancy and little prospect for employment. People of any age may fit into this category and commonly they may be 'middle-aged' or in their forties. Given the increase in length of life there is the likelihood that some people will be in 'retirement' for half of their lifespan. However, the responses to the next question indicate that this was not a common belief amongst this student group.

The students were asked: *Do you believe that people should stop employment at age 65?* Ninety one per cent (n=94) of students indicated that people should not stop employment at age 65. They qualified their answers with the justification that if people were fit and enjoyed work, and they and their employer believed they were capable of completing the work then they should not be forced into retirement.

Nine students (9%) indicated an ageist perspective about the rights of different age groups to employment when they argued that people over 65 should be forced into retirement so that positions were available for younger people. One student indicated that, although she believed that people were capable of working until they were 70, that it was very selfish of them if they did this. Perceptions such as this reinforce myths that older people are somehow less desirable than the young and are perceived as being less efficient, with declining mental and physical capabilities. They are also seen to be unworthy of occupations that younger people should be in, irrespective of their capabilities.

Students were asked to: *Describe the picture you have in your head of an old person?* They qualified their earlier descriptions of frailty with descriptions of people with grey hair and wrinkles, stooped over, walking with mobility aids and using devices such as glasses and hearing aids. Once again these responses suggest that students equate age with declining health. However, this is not a true picture of older people, as only a small number are in residential care or receiving home help and the majority lead an active healthy life (Cattan 2001; Percival 1999; Gibson 1998).

Students were asked: *Is the image you have of older people the same for both genders?* Sixty per cent (n=63) of students confirmed that the image they had of being old is the same for both genders. Thirty nine per cent (n=40) stated their image differed on the basis of gender. Reasons offered suggest they perceived that men generally seem to, or are allowed by society, to keep their youth longer than women.

Two exemplary comments in this section of the questionnaire were:

I generally never think of males as being old. I think perhaps because the majority of older people in nursing homes are women (25 year old female working in a nursing home as an enrolled nurse).

Another student stated:

Women age faster because they adopt changed behaviours/attitudes and are less empowered by society and culture (30 year old female, no aged care experience).

This myth seems dominant among all age groups in society. For example, in *The Beauty Myth*, Naomi Wolf (1991, p.92) argued that women believe their bodies are inferior to males - 'second rate matter that ages faster'. Furthermore, Wolf stated that men do not age any better than women. It is only in terms of social status that our eyes have been conditioned to see 'time as a flaw on women's faces where it is a mark of character on men's' (Wolf 1991, p.94).

Students were asked: *Do you believe a 'love story' movie featuring older people, as the main stars would be a hit movie?* Respondents were divided on this question with 50% stating no and 50% stating yes to the question. Justification for not accepting this type of story line was generally given that society is not interested in older people and that society encourages the belief that they are 'asexual'. The literature suggests that more than any other

functional area the sexual functioning of older adults is influenced by personal and societal attitudes (Nay and Gorman 1999; Kaplan 1996). Sexuality is typically associated with physical attractiveness, such as thin, adequately endowed women and tall, tanned and muscular men oozing images of youthfulness. These sensual images are not consistent with evidence of fat deposits, wrinkles, and greying or balding hair.

Some comments in response to this question were:

Modern day society is interested in seeing sexy and vibrant people. The aged would not fit this description (34 year old female, limited age care experience).

People would say its disgusting seeing old people in these roles (18 year old female, no age care experience and no contact with grandparents).

Students who responded positively to the idea of a movie featuring older people as the main stars referred to two movies, *On Golden Pond* and *Bridges of Madison County* as providing positive images of older movie stars. They favoured such movies. However, this was because they perceived older people would enjoy these movies but also perceived the younger generation would not be interested in them.

Students were asked: *Do you want to work in aged care?* Ninety seven per cent (n=100) of respondents admitted they had no intention of working in aged care. The majority of respondents indicated they did not want to work in aged care because they saw it as a depressing area where everyone was dying. Three students who indicated they wanted to work in aged care wrote of enjoying the company of older people and the idea of talking with them and helping them. Of the three students, two females, aged 29 and 32, and one male aged 36, only one student had any hands on experience of aged care. She had been working in aged care as an assistant-in-nursing for six months.

Finally students were asked: *What would help to change your mind about working in aged care?* Respondents to this question indicated that a more favourable view of aged care would entice them to consider working in the area. Further comments related to having a greater understanding of aged care and improving working conditions, in particular reducing the amount of heavy lifting and repetitive work.

DISCUSSION

The insights offered by these findings have implications for the care of older people and nursing education in general. If we are to attract nurses to aged care who have a knowledge and interest in older people, we need to challenge society's attitudes so that older people become valued. Consequently, the aged care working environment is likely to become a desirable place in which to work. Health professionals can help reshape society's myths about older people by valuing their presence and showing their importance. Older people should be treated as individuals with particular needs rather than as a problem group. Furthermore, an extensive health education campaign may also improve the health status of older people. Thus, later life would become an integral part of a lifelong approach to health education. Such action requires extensive health care resources and raises further the question of how to convince government that putting resources into older people would benefit society? It is imperative that health care professionals keep the government focus upon older people and the importance of renewed health promotion policies for them.

It is imperative nursing curricula are changed to encourage an 'across the life span' approach to health and illness and to ensure students all have the opportunity to undertake age care experience.

It seems that not all degree programs offer students an aged care placement. Furthermore, those in nursing education need to recognise that working with older people requires nurses who are highly skilled particularly in assessment, diagnosis, pharmacology, palliative and rehabilitative care. Thus, residential care is not an appropriate place to send first year students to practise activities of daily living. First year students need to be in clinical placements where wellness has a greater focus and where individuals do not have multiple disease processes that require monitoring and adjustment of care. Thus, a more appropriate first placement for activities of daily living might be maternity, day surgery, or orthopaedics.

Effective aged care requires an ability to respond to complex situations. Students would benefit from undertaking clinical practice during their third year, when they have adequate assessment skills and a more thorough understanding of the impact of ageing on the bodily systems. Thus, the focus can become a more holistic approach to care rather than just the acquisition of skills in activities of daily living and might encourage students to see the positive aspects of working in aged care.

Reed and Clarke (1999) identified that older people with health problems are often talked **about** rather than talked **to**. Dismissing the voice of older people is frequently a result of ageism. Thus, nursing curricula must also include an exploration of the concept of ageism and assist students to recognise and minimise ageism.

A change in society's attitudes to older people will take time. However, some success has been shown with intergenerational programs using one of three models: older people giving a service to children and youth; children and youth serving older people; and, children, youth and older people serving together (Granville 2001). The concept linking such programs is 'the bringing

together of two discriminated groups in our society, who for various reasons have become separated from each other' (Granville 2001, p.42). The exchange between the two groups 'enables positive social exchanges and mutual support between generations, which improves the individual and collective social health' (Granville 2001, p.42).

While society continues to subscribe to the belief that people should retire at a fixed age, and while ageing is constructed as illness, the belief that all older people need care will continue to prevail. We are entering an era where there have never been as many older people in society. However, we are also in an era where people's health and health technology have never been so good. The concerns about the growth in the older population may not prove as difficult as first predicted. To ensure older people do not automatically move towards dependency it is important for society to recognise that not all older people need to be cared for.

Finally, it is important the media improves their representation of older people. At present society is not interested in normal ageing but rather in the more shocking and exceptional aspects of growing old (Victor 1994). This needs to be challenged if we are to promote perceptions of health and wellbeing of older people.

LIMITATIONS

The data collection method is a limitation of this study. Requesting students to access the questionnaire from outside the investigator's office may have limited the number of potential participants. This approach may also have attracted participants who wanted their views known rather than a representative sample of views. Furthermore, the researcher was unable to control the conditions under which participants completed the questionnaire. Data from the study could be used to construct a matrix or grid questionnaire using a tick box and Likert scale that could be tested with a larger sample of nurses.

FUTURE RESEARCH

This study has provided a useful snapshot of perceptions of older people held by student nurses. The study findings support the premise that members of a student health professional group that should be showing concern for all population groups potentially devalue the aged. The study forms the basis for future research efforts aimed at identifying factors in curricula that influence student nurses' perceptions of working with older people so that we can work towards developing in nurses more positive and sensitive views.

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PERCEIVED EFFECTIVENESS OF CRITICAL INCIDENT STRESS DEBRIEFING BY AUSTRALIAN NURSES

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ABSTRACT

This paper examines the perceived effectiveness of stress debriefing by a sample of 129 Australian hospital nurses and the relationship of their perceptions to demographic variables such as qualifications and work area. The survey generally showed debriefing as helpful, but lack of helpfulness was also recognised because of time taken from personal lives and adverse group processes. Factor analysis identified five scales; three helpful ('Understanding', 'Sharing', and 'Cohesion') and two, unhelpful ('Procedure' and 'Dynamics'). Results suggested that helpfulness of debriefing was unrelated to demographic differences. Although further research is required to replicate these findings, they suggest that replacing the current ad hoc forms of debriefing available at the hospital with a standardised model would overcome short-comings identified by respondents.

INTRODUCTION

The earliest description of Critical Incident Stress Debriefing (CISD) in nursing literature appeared in 1988 when Jimmerson described a program modelled on Mitchell's (1983) prototype. This was seen as a turning point for emergency nurses because they could acknowledge the psychological impact of their work. According to Jimmerson, (1988, p.44A) the experience of CISD had eroded the view of the emergency nurses being 'unhurtable superbeings' and 'pillars of strength'.

In the following decade, the value of CISD in mitigating critical incident stress (CIS) experienced by nurses was recognised by the nursing profession (Cudmore 1998; Jefferson and Northway 1996; Wright and Casier 1996; Laws and Hawkins 1995; Appleton 1994; Martin 1993). Martin (1993, p.39) considered that implementation of Critical Incident Stress Management (CISM) programs in hospitals provided caregivers with a way of countering the insidious, cumulative effects of emotional trauma because 'medical/surgical nurses, oncology nurses, neonatal nurses - *all* nurses involved in traumatic events' could benefit from them. Following the categorisation of critical incidents experienced by the nurses in her study, Appleton (1994) suggested that debriefing could be useful in assisting nurses to cope with CIS and recommended the availability of peer support groups and counselling for all acute care agencies.

Laws and Hawkins (1995) argued that debriefing was essential but lamented the lack of wide recognition of CIS in Australian hospitals and the sparsity of CISD facilities for nurses. Lam et al (1999) also identified the urgent

need for support services such as debriefing and counselling. Jefferson and Northway (1996) reported that CIS was real for nurses, occurred regularly in hospitals, and the time for ignoring potential short and long term-effects of such stress for health care workers was long past. Wright and Casier (1996) proposed CISM as an effective, inexpensive and collaborative approach to mitigating the impact of traumatic events. Similarly, Cudmore (1998) considered developing a policy/protocol for instigating debriefing following critical incidents to circumvent potentially harmful effects of cumulative and critical incident stress for accident and emergency staff.

Despite adoption of CISM programs by the nursing profession throughout the 1990s, a few articles appeared in the literature reflecting doubts about the efficacy of debriefing (Macnab et al 2000; Northcott 1998; Hudson 1995). Northcott (1998, p.32), citing studies critical of debriefing (Bisson 1997; Brom et al 1993; McFarlane 1988), stated that the effectiveness of debriefing in reducing psychological stress and preventing Post Traumatic Stress Disorder (PTSD) was unconfirmed or possibly made no difference. She recommended treating any problems that occurred with prolonged therapy, claiming, 'the right culture and relationships can do much more to ensure well being after traumatic events than the reactive strategies that are so often mobilised'. Hudson (1995) reported that admonitions that one must be debriefed or suffer a post traumatic stress syndrome were false because research had demonstrated that 77% of individuals who suffered acute stress disorder went into spontaneous remission. Furthermore, she suggested that debriefing could exacerbate stress. Cotterill (2000) suggests that CISM is only one option for dealing with critical incident stress and proposes clinical supervision as an alternative.

Of the few published studies evaluating the efficacy of debriefing, three supported the value of debriefing for hospital nurses (Burns and Harm 1993; Mitchell, 2001; Robinson and Mitchell 1993), one was inconclusive (Roffey-Mitchel and Jeavons 1998). Burns and Harm (1993) found that only 32% of nurses surveyed about debriefing had ever participated in debriefing and, of those, 88% reported the process helpful in reducing stress.

Robinson and Mitchell (1993) evaluated debriefing with mainly emergency service personnel, but a small sample of welfare/hospital personnel, including 17 nurses, was included. Of the latter group, 84% found debriefing helpful and 44% were happy with the process. Emergency personnel reported more cognitive stress such as: sleep disturbances; flashbacks; preoccupation with the incident; and, fear of the future than welfare/hospital personnel who reported more emotional distress (sad, weepy, numb, feeling horrified, fearful, enraged, uneasy and shocked). Robinson and Mitchell (1993) suggested that occupation and gender

were both relevant to understanding the stress response and further work was required to separate these variables.

This controversy about the efficacy of debriefing highlights the need for further investigation of Australian nurses' experiences. The usefulness or not of debriefing for nurses would provide valuable support for its introduction in hospitals and identify necessary modifications. The hospital in which this study was undertaken did not, at the time, have a formal debriefing program, although the staff counsellor had been trained in the procedure so may have offered it to individuals. Some staff may also have experienced debriefing at previous places of employment. The objectives of this study were to determine (1) nurses' perceptions of the effectiveness of stress debriefing, and (2) whether their perceptions of stress debriefing were associated with any of the demographic variables: gender, age, nursing qualifications, method of obtaining initial practising certificate, number of years post-registration, current area of work and years of experience in that area.

METHOD

Participants

This study formed the second part of a broader study into critical incident stress in a 750-bed metropolitan teaching and research hospital (O'Connor and Jeavons, 2002). The sample represented 59% of full-time registered nurses (RNs) from the whole study who had attended one or more debriefing sessions in the course of their work. It comprised 129 nurses (88% female) with a mean age of 32.6 years (SD=8.5 years). The original study targeted all full time RNs, with a response rate of 40%. This was lower than expected, possibly because it was conducted pre-Christmas and during major hospital restructuring.

Participants had practised full time equivalent nursing for nine years (SD=6.4 years) and worked in their particular area for four-and-a-half years (SD=3.6 years). Fifty-eight percent had obtained their initial practising certificate by college diploma and university degree (22% and 36%, respectively). Highest qualifications and areas of work are shown in Tables 1 and 2, respectively. Designated titles of the nurses (Table 3) show the largest category of nurses were Division 2 RNs (Enrolled Nurses) (35%).

Table 1: Highest qualifications of RNs (n=129)		
Qualification	Sample numbers	Sample (%)
Hospital certificate	10	7.8
Diploma	4	3.1
Degree	38	29.4
Masters degree	5	3.9
Postgraduate certificate/diploma	55	42.6
Other qualification	17	13.2
Total	129	100.0

Table 2: Areas of work of RNs (n=129)		
Area of Work	Sample numbers	Sample (%)
Aged care	2	1.6
Intensive care	13	10.1
Oncology	4	3.1
Psychiatry	17	13.2
Coronary care	2	1.6
Medical	11	8.5
Spinal care	3	2.3
Paediatric	2	1.6
Emergency department	7	5.4
Neurology	5	3.9
Surgical	23	17.8
Operating theatre	9	6.9
Mixed medical/surgical	10	7.8
Other	21	16.2
Total	129	100.0

Other: ie renal, palliative care and respiratory medicine

Table 3: Designated titles of RNs (n=129)		
Title	Sample number	Sample (%)
RN Division 1	8	6.2
RN Division 2 (EN)	45	34.9
RN Division 3	4	3.1
Associate Nurse Unit Manager (ANUM)	21	16.3
Nurse Unit Manager (NUM)	14	10.8
Clinical Nurse Specialist/ Nurse Educator (CNS/NE)	24	18.6
Other	13	10.1
Total	129	100.0

DATA COLLECTION AND MEASURES

Following ethics committee approval, data were collected using a survey questionnaire that asked for demographic and debriefing information.

Debriefing Questionnaire (DQ). This section contained 20 statements relating to helpfulness or lack of helpfulness of debriefing. It was designed by the authors, based on earlier studies by Burns and Harm (1993) and Robinson and Mitchell (1993). Reliability and validity information was not used for this type of measure but factor analysis indicated the extent to which the items in the scale represented consistent concepts. Debriefing was defined as a structured group meeting, emphasising ventilation of feelings, discussion of reactions to the event, and, education and information about coping strategies. The wording of some statements was altered to obtain equal positive (meaning statements that said it was helpful) and negative (statements that said it was not helpful) items in the scale. These were randomly ordered to avoid biased responding. Respondents were asked to rate level of agreement to statements: 0 neutral; 1 strongly disagree; 2 disagree; 3 agree; 4 strongly agree. The neutral category gave respondents the option of non-commitment. Participants were asked whether debriefing should be voluntary and what other interventions they considered appropriate following a critical incident.

Analysis

Data obtained for the study were analysed using Statistical Package for Social Sciences 6.1 (SPSS). Descriptive statistics summarised the characteristics of respondents and DQ responses.

Factor analysis of the DQ was undertaken firstly to determine the factor structure of the scale. Principal Components Analysis (PCA) with oblimin rotation was performed because it was assumed that all items on the DQ would be correlated with each other since they reflected aspects of helpfulness and lack of helpfulness of debriefing (see West 1991, p.139).

The second purpose was to reduce nurses' responses to a small number of factors to study the relationship between their debriefing experiences and demographic variables. This was analysed using Multivariate Analysis (MANOVA) using the five PCA scales as dependent variables. Four potential independent (demographic) variables were reduced (qualifications, from seven to four levels; basis for obtaining initial practising certificate, from three to two categories; current area of work, from 15 to six areas; title, from eight to five titles) to increase numbers of respondents in cells. Gender was unaltered. Correlations were then obtained between the independent variables with the averaged five scales. Finally, relationships between the effects of the demographic variables and the DQ scales were investigated in a 4-way MANOVA.

RESULTS

Results of the descriptive analysis

Although respondents identified the process as helpful in alleviating distress (Table 4), reasons for lack of helpfulness were also strongly endorsed (Table 5). The items that received low mean Likert scale scores do not indicate that these factors were unhelpful (in the case of helpful items), merely that some respondents did not feel that this item had been important to them. As the neutral option was scored 0, this could reduce mean scores. Helpful themes were: communication, sharing with others who had experienced the same incident, group-cohesion, and self-understanding/stress education. Lack of helpfulness related to: poor timing and duration of the debriefing, discomfort with the group process and poor leadership qualities. Most believed that attending debriefing should be voluntary and many

Table 4: Ranked responses for helpfulness of debriefing by respondents (n=129)	
Debriefing statement	**Mean Likert scale score**
1. Being part of the group that had also experienced the incident.	3.3
2. Talking with others about the event.	3.3
3. Hearing others talk about the incident.	3.3
4. Hearing how others were handling the stress.	3.2
5. Realising I was not alone.	3.0
6. Understanding my situation.	2.9
7. The group gained solution, support, and direction.	2.5
8. It promoted departmental cohesion.	2.2
9. Understanding myself.	2.2
10. My stress levels were less intense.	2.1
11. Learning about stress from the leaders.	2.0
12. The independent forum was helpful.	1.7

Note: Although items were altered in order to obtain an equal number of positive and negative items on the DQ and to enable random ordering, items are presented in this table as statements for helpfulness of debriefing according to their item source.

Rankings based on mean scores on a 5-point Likert scale in response to whether respondent considered the statement helpful: 0, neutral; 1, strongly disagree; 2, disagree; 3, agree; 4, strongly agree.

Table 5: Ranked responses for lack of helpfulness of debriefing by respondents (n=129)	
Debriefing statement	**Mean Likert scale score**
1. I resented the time the debriefing took from my personal life.	3.0
2. I was not comfortable discussing the event in a group.	2.7
3. It was too soon after the event to be helpful.	2.5
4. The leaders had no relevant experience.	2.4
5. The leader did not seek discussion from participants who would not open up.	2.3
6. It was too long after the event to be helpful.	2.3
7. It was too short to be helpful.	2.1
8. There were people present in the group with whom I was uncomfortable.	2.1

Note: Although items were altered in order to obtain an equal number of positive and negative items on the DQ and to enable random, items are presented in this table as statements for lack of helpfulness of debriefing according to their item source.

Rankings based on mean scores on a 5-point Likert scale in response to whether respondent considered the statement lacked helpfulness: 0, neutral; 1, strongly disagree; 2, disagree; 3, agree; 4, strongly agree.

selected alternatives or supplements such as support group and/or stress management classes.

Results of factor analysis

The sample size of 129 for the 20-item DQ met the desired number of cases to variable ratio for the PCA (Tabachnick and Fidell, 1996). The correlation matrix indicated that a considerable number of correlations exceeded 0.3 and thus the matrix was suitable for factoring. The factorability of these items was further supported because the Bartlett Test of Sphericity was significant and Kaiser Meyer Olin measure of sampling adequacy was greater than 0.6 (0.7).

Analysis of the DQ produced six factors with eigenvalues greater than one. However, inspection of the scree plot (Tabachnick and Fidell, 1996) indicated that a five-factor solution was most appropriate. The eigenvalues for these factors were 4.03, 2.24, 1.72, 1.34, and 1.13 and the factors accounted for 20.15%, 11.19%, 8.64%, 6.71% and 5.65% (total 52.3%) of the total variance.

The pattern matrix is shown in Table 6. Individual factor loadings of at least 0.40 were taken as the criterion for deciding whether an item was retained in the construction of the DQ. At this magnitude all items but one (Item 18) loaded on only one factor.

Items that loaded on the first, second and fourth factors reflected helpful aspects of debriefing. The five items that loaded on the first rotated factor denote an 'Understanding' dimension. The five items that loaded on the second rotated factor suggest a 'Sharing' dimension. Although the three items that have a loading on the fourth factor suggest a 'Cohesion' dimension, the loading of one item ('It was not helpful because the leader did not seek discussion from participants who would not open up') appears to indicate that respondents were responding more to the cohesion aspect of debriefing than to its helpfulness and needs further clarification.

Only one item ('realising that I was not alone') has a dual loading on DQ factors, indicating that participants may have considered this at both a social support and cognitive level. They may have experienced debriefing as helpful because they understood that they were not alone and, concomitantly, gained an appreciation that others were similarly affected by the incident through sharing their experience of the incident.

The third and fifth factor items reflected lack of helpfulness. The three items on the third factor appear to denote unhelpful aspects of 'Procedure:' Timing, duration and leadership. Items on the fifth factor appear to denote adverse aspects relating to the group 'Dynamics'.

To further the analysis, five scales were constructed by summing equally weighted scores of the items identified as loading significantly on respective factors. The correlations between the Understanding and Sharing factors was -0.11; Sharing and Dynamics factors, -0.22; Procedure and Dynamics factors, -0.17; and between the

Table 6: Pattern matrix of debriefing questionnaire items					
	Factor loadings (loadings less than 0.40 not reported)				
Item	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
20 Learning about stress from the leaders was helpful.	0.72				
17 My stress responses less intense.	0.64				
09 The group gained solution, support and direction.	0.55				
15 It was helpful in understanding myself.	0.51				
07 It was helpful in understanding my situation.	0.49				
11 Being part of a group that had also experienced the incident was helpful.		-0.78			
03 Talking with others about the incident was helpful.		-0.77			
10 Hearing others talk about the incident was helpful.		-0.63			
18 Realising that I was not alone was helpful.	0.47	-0.56			
02 Hearing how others were handling the stress was helpful.		-0.55			
12 It was too short to be helpful.			-0.78		
14 It was too long after event to be helpful.			-0.74		
05 The leaders had no relevant experience.			-0.49		
16 It was helpful because it promoted departmental cohesion.				0.76	
01 It was not helpful because the leader did not seek discussion from participants who would not open up.				0.52	
13 The independent forum was helpful.				0.47	
08 Not comfortable discussing event in a group.					0.74
04 There were people present in the group with whom uncomfortable.					0.72
06 I resented the time debriefing took from personal life.					0.57
19 Too soon after event to be helpful.					0.45

Extraction Method: Principal Components Analysis; Rotation Method: Oblimin with Kaiser Normalisation; Rotation converged in 13 iterations.

Table 7: Means: Standard deviations and Cronbach Alphas for the five scales constructed from the factor analysis of the Debriefing Questionnaire (DQ)					
Scales	Number of items (range)	Number of cases	Mean	SD	Cronbach α
UNDERSTANDING	5 (0-16)	127	11.71	3.93	0.58
SHARING	5 (0-20)	127	16.18	2.99	0.74
PROCEDURE	3 (0-12)	127	6.80	3.14	0.66
COHESION	3 (0-12)	127	6.30	2.93	0.40
DYNAMICS	4 (0-16)	127	10.31	3.26	0.62

Cohesion and Dynamics factors, 0.25. Scales of Sharing, Procedure and Cohesion were effectively independent, as their intercorrelations were less than 0.1. Table 7 records scale means, standard deviations (SD) and the Cronbach alpha (a) coefficients of internal consistency for the scales.

As can be seen, the potential range for Understanding, Sharing and Dynamics is moderate, for the remaining scales, low. The relatively high negative skew for the Sharing scale indicates that it is more helpful than the other helpful scales. Apart from the Cohesion scale, which shows low reliability (0.40), the remaining scales show moderate reliability.

Finally, in order to compare the means of the DQ scale, a repeated measures ANOVA was conducted where the dependent variables were the averaged mean scores of the items. Using Wilks' criterion, inspection of means indicated that the Sharing scale was the most significant of the five scales on the DQ ($F (4, 120) = 41.10$, $p<0.000$) and was significantly greater than the other scales that did not differ significantly from each other.

Table 8: Correlations of Debriefing Scales (DQ)			
Scales	Number of respondents	Pearson product moment correlation	Probability
Sharing by Procedure	126	0.27	0.002
Sharing by Cohesion	122	0.20	0.032
Sharing by Dynamics	126	0.31	0.001
Procedure by Cohesion	125	0.31	0.000
Procedure by Dynamics	127	0.38	0.000
Cohesion by Dynamics	125	0.51	0.000

Results of multivariate analysis

Significant findings were obtained for the DQ scales (Table 8) and confirm the Factor Analysis findings that the five scales of the DQ are interdependent. However, no significant relationships were found between any of the variables of age of respondents, full-time equivalent post-registration nursing practice and years in current area.

Results of the 4-way MANOVA revealed a significant multivariate main effect for only Qualifications (F (15, 121), =1.923, p=0.020). There were no significant interaction effects. Univariate tests were conducted to identify which Qualification was specifically related to Understanding. Findings suggested that nurses with post-graduate qualifications (n=61, mean=2.12) and nurses with hospital certificate qualifications (n=10, mean=3.02) accounted for significance with that factor (p<0.05). The former nurses experienced the Understanding obtained from debriefing as 'moderately helpful' while the latter group experienced it as 'considerably helpful'. However, because a series of analyses were examined for statistical significance this result needs to be treated as tentative. No significant (p<0.05) correlations were found between gender and experiences of debriefing.

DISCUSSION

Survey respondents identified the most helpful aspects of debriefing as being part of a group who had also experienced the incident, hearing others talk about it, realising they were not alone, and hearing how others were handling their stress. Lack of helpfulness items receiving strongest endorsement were 'resented the time debriefing took from their personal lives' and 'felt uncomfortable discussing the event in a group'. Some respondents also endorsed poor leadership issues.

Resentment about the time debriefing took from their personal lives suggested that those respondents had attended debriefings outside of work hours. This encroachment on non-work time may also have worked against their active participation in the group and reduced the potential value of debriefing. Furthermore, defusing, a shortened form of debriefing, provided prior to staff leaving work, will often eliminate the need for a full critical incident debriefing and reduce the overuse of debriefings (Westerink 1995). Education of all staff, especially nurse unit managers, about appropriate times to use defusing or debriefing, and goals and advantages of each could allay resentment, especially if scheduled before staff left work.

The greatest consensus between this sample and Burns and Harm's (1993) concerned talking to others and hearing them talk about the incident and reduction of stress. However, the greatest disparity occurred for lack of helpfulness, represented by: resentment of the time debriefing took from their personal life, feeling uncomfortable discussing the event in a group and the debriefing being conducted too soon after the event. Variations in findings were probably due to different modes of scoring, differences in sampling procedures and social context. However, when the two levels of helpfulness indicated in this study were combined, reasons for helpfulness roughly equated those of Burns and Harm (1993). In contrast, when the two levels of agreement for lack of helpfulness were combined, a large disparity was evident. For example, this sample more strongly endorsed 'resenting the time debriefing took from their personal life' and 'felt uncomfortable discussing the event in a group' compared to low endorsement by Burns and Harm's (1993) sample. Low endorsement concerning resentment of the time the debriefing took by the USA sample suggested that the debriefing model had been integrated into the work environment and was an accepted procedure for post-critical incident management. Even though only 32% of Burns and Harm's (1993) sample had participated in debriefings, services available would very likely have been consistent with the CISM model based on its popularity within the nursing profession in the USA at the time. Emergency nurses were therefore likely to utilise the service during their work time. Furthermore, the lower endorsement by them of other statements regarding lack of helpfulness indicated that they received debriefing from those trained in its application and were likely to have been acquainted with the debriefing model (CISD) for longer than Australian counterparts.

The five DQ scales offered a parsimonious explanation of the 20 statements relating to helpful and unhelpful aspects of debriefing: three related to helpfulness, Sharing, Understanding and Cohesion; two scales, Procedure and Dynamics, to lack of helpfulness. With regard to the helpful scales, the majority endorsed Sharing, which represented aspects of communication and social support, followed by Understanding. Low correlation of the Cohesion scale with the other DQ scales suggested that its items should be interpreted individually. Understanding, a cognitive process whereby participants

re-appraised or reframed their role in the incident as a result of information from other participants at the debriefing, was the only scale related to a demographic variable. Nurses with hospital certificates found its aspects more helpful compared to nurses with university qualifications which suggests that the former group benefited from educational aspects offered by debriefing possibly because of lack of exposure to stress management during their training in contrast to their university educated colleagues.

The Sharing and Understanding scales comprised elements identified by Everly and Mitchell (1998) as essential to trauma recovery. For example, 'Sharing' included items associated with communication and social support that reflected verbalisation and 'normalisation' of the trauma through discussion and appreciation that others at debriefing experienced similar reactions (Everly and Mitchell 1998). 'Understanding' items related to other essential elements for trauma recovery, mobilisation and stress management. Mobilisation occurred when individual and group strengths were recognised and utilised to assist recovery.

The Cohesion scale was represented by two helpful items, (promotion of departmental cohesion and independent forum) and one item reflecting lack of helpfulness (leader not seeking discussion from participants who would not open up). One explanation was that respondents focussed on the cohesion aspect of the scale and their belief that failure of the leader to encourage participants to speak up worked against cohesion. Alternatively, respondents might have experienced being in the group but not being pushed to talk as beneficial when they had the opportunity to listen and learn from the reactions of others. This would be consistent with 'normalisation'. With regard to lack of helpfulness scales, more respondents endorsed 'Dynamics' rather than 'Procedure'. The former reflected personal discomfort such as with discussing the event in a group; the latter, adverse aspects such as leader's lack of relevant experience. Evidently, personal factors about the process were of greater concern than aspects related to the application of debriefing. It is likely that high endorsement of statements concerning 'Dynamics' were consistent with national characteristics. Generally, Australians are less likely to disclose personal information, particularly in a work setting, because they fear evaluation as 'not coping', which could jeopardise job security. This possibly reflected lack of education and familiarity with an appropriate debriefing model.

There are some limitations to this study. These findings are specific to a relatively small sample of full-time RNs working at an Australian metropolitan hospital. The survey was conducted prior to introduction of CISD/CISM in the hospital to explore nurses' experiences and use the findings to modify the proposed program. Although this study attempted to capture the essence of debriefing according to the study on which it was based (Burns and Harm 1993) by providing a specific definition of the process, many respondents may have applied their own interpretation to its meaning. Nonetheless, the generally positive findings regarding debriefing are promising because they suggest that replacing the various ad hoc forms currently available with a standardised model, would not only improve the quality of service at the hospital, but overcome shortcomings identified by respondents. A standardised approach would also ensure that providers would receive appropriate training and staff members, pre-incident education about CIS and various types of intervention.

CONCLUSIONS

These findings provide an initial description of Australian nurses' perceptions of their experiences of debriefing in a hospital setting. For future research, the distinction and definition of the type of debriefing being evaluated by a study, as well as the training of the people providing it and the population to whom the process is applied remain essential. Otherwise the issue of what is being evaluated will remain unclear and lead to inaccurate results. These distinctions would enable researchers to discover which method of debriefing led by what type of leader is effective and with which population. In addition, a combined quantitative/qualitative research design is recommended to assist the identification of helpful processes of debriefing.

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ETHICAL ISSUES ARISING WHEN PLANNING AND COMMENCING A RESEARCH STUDY WITH CHEMICALLY DEPENDENT PREGNANT WOMEN

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ABSTRACT

A good deal of qualitative research, particularly in the health sector, involves accessing vulnerable groups of people. One such group is chemically dependant pregnant women. Accessing and interviewing chemically dependent pregnant women presents significant ethical challenges which are compounded by the vulnerability of this group, who often experience feelings of guilt, mistrust of health professionals, and a myriad of related health problems which can impact on their unborn child. This paper explores some ethical issues in relation to access, informed consent, the interview process, potential exploitation, invasion of privacy, and confidentiality related to information obtained and the publication of results. Ways in which these issues can be addressed without compromising the research are discussed.

INTRODUCTION

This paper discusses ethical issues, which have arisen in the early stages of a study aimed at identifying and exploring the needs of a group of English speaking, chemically dependent pregnant women and the degree to which a multi-disciplinary team working within a specialised antenatal clinic meets these needs.

Research involving vulnerable groups, such as lesbian and gay men's experience of nursing care (Platzer 1997), the help seeking behaviours of alcohol dependent and problem drinking women (Smith 1992), and the sexual experiences of women with learning disabilities (McCarthy 1998) have identified significant ethical issues relating to the 'duty of care' of the researcher to protect the rights of disadvantaged groups in all facets of the research. Similar ethical issues to those identified in the above studies have arisen in the research described involving chemically dependent pregnant women. This paper will outline the research approach, provide background to the study, focus upon identifying why a study of chemically dependent pregnant women presents specific ethical challenges in its planning and process and describe the way in which these might be managed. Challenges include issues relating to access, informed consent, relations between the researcher and researched in the interview process and publication of results.

RESEARCH DESIGN

An ethnomethodological approach, as articulated by Garfinkel (1967) and adapted by Holstein and Gubrium (1994), was chosen as the most appropriate methodology to identify and explore the needs of chemically dependent pregnant women. While similar to ethnography, ethno-methodology differs in the sense that it sets aside the notion that behaviour is rule governed, or motivated by shared values and expectations, and pays close attention in analysis to how talk is considered as the action through which local realities are accomplished.

A feminist theoretical perspective underpins the methodology. It is generally agreed that the principles of feminist research, described by Grbich, who draws on the ideas of Stanley (1990) and Oakley (1981) are as follows: Feminist research places a focus on the 'social constructedness' of gender, accepts that women are oppressed (to varying degrees); attempts to be egalitarian, non-exploitative and emancipatory; exposes the researcher's experiences and emotions and addresses issues of 'power, honesty and ownership' (Grbich 1999, p.53). A feminist perspective promotes open reciprocal interactions between the researcher and the researched with a balance created between potential harm and potential good, confirming the accuracy of the study findings by paying particular attention to critiquing designs, analysis and conclusions (Seibold et al 1994). The philosophy of feminist researchers is succinctly described by Punch (1994, p.83) as: 'You don't rip off your sisters'!

The study employs participant observation of clinical encounters between the women and the staff of the clinic, including midwives, social workers, administrative staff, interviews with the women attending for care at a specialised antenatal clinic, and access to medical records. Ethical clearance was gained from the Australian Catholic University Human Research Ethics Committee and the Mercy Hospital Research Ethics Committee, where the specialist clinic is situated. The data collection phase is in its early stages and women interviewed so far are at least second generation Australian.

BACKGROUND TO THE STUDY AND ISSUES IMPACTING ON CHEMICALLY DEPENDENT WOMEN

Prior to the mid 1990s, treatment programs for chemically dependent pregnant women were fragmented and research focussed on infant and childhood outcomes in relation to perinatal chemical dependency. Since the mid 1990s, the need for specialised treatment programs has begun to be addressed and emerging research has investigated the attitudes and feelings about pregnancy of chemically dependent pregnant women (Lewis et al 1995; Murphy and Rosenbaum 1999), evaluated the outcomes of methadone treatment programs in pregnancy (Morrison et al 1995) and investigated addiction recovery in an outpatient perinatal addiction treatment program (Nardi 1999). Nonetheless, research in a world-wide context investigating the attitudes and feelings, as well as the perceived needs of chemically dependent pregnant women is scarce and virtually non-existent in Australia.

There is a need for further studies to break down health professionals' and others prejudices towards chemically dependent women. Chemically dependent pregnant women are stigmatised because of the perception of addiction held by society and the perceived reckless and criminal nature of their actions in risking the health of their unborn child. Public opinion is often punitive and supports the belief that babies of chemically dependent pregnant women are abused and 'poisoned in the wombs of their own mothers' (Paone and Alperen 1996, p.1). Their actions are seen to run counter to the normal perception of being a caring 'good mother'. These women are often denigrated, discriminated against, condemned, ostracised and subject to intolerance, ignorance and mistrust (Lewis et al 1995; Murphy 1999; Morrison et al 1995). The opinion that chemically dependent women are unconcerned and uncaring about birth outcomes is challenged by anecdotal evidence and emerging research data (Lewis et al 1995; Ezerd 1998; Murphy 1999). Societal attitudes, while improving, are still a major factor in increasing the marginalisation and vulnerability of chemically dependent pregnant women.

Women who participate in this research by providing information about their life experiences, will do so while compromised by a uniquely vulnerable life situation, which stems from the physical, psychological and social ramifications of being a woman who, not only has a chemical dependency, but is also pregnant. Their pre existing health and social situation revolving around chemical dependence becomes exacerbated by a pregnancy that in the majority of cases is unplanned (Lewis et al 1995). Early and appropriate intervention in the form of specialist care can mean far better outcomes for mother and baby. Chasnoff (1992) reported that women who used drugs during pregnancy and received prenatal care had newborns with higher birth weights than those who used drugs and did not receive prenatal care.

A review of the physical, psychological and social factors impacting on chemically dependent pregnant women highlights the need for specialist care. In physical terms, the women have a greater propensity for eating disorders, poor nutrition, chest infections, sexually transmitted diseases and are often smokers and therefore susceptible to smoking's harmful effects. Exposure to the health issues surrounding infection with HIV, hepatitis B and hepatitis C is also a significant issue (Chasnoff 1988). The greater propensity to be involved in domestic and sexual abuse also poses a threat to the health of chemically dependent pregnant women (Murphy 1999).

Psychological issues revolve around the fear and guilt the women experience with regard to the damage their habit, lifestyle and associated health problems may be having on the health of their unborn baby (Lewis et al 1995). This is compounded by the added risk of pregnancy complications such as prematurity, ante-partum haemorrhage, restricted growth of their unborn baby, maternal infection, stillbirth and the remorse and distress they often feel in imposing what they see as 'the terrible symptoms of withdrawal', which they have experienced themselves, upon their babies (Murphy 1999). Fear also emanates from the increased risk of the involvement of child protection agencies, as well as the threat of

incarceration if any illegal practices are detected (Chavkin 1990). Loss of control over their lives, negativity and hopelessness and mistrust of health professionals and agencies may also be factors exacerbating the vulnerability of these women. If antenatal hospitalisation is required, because of physical problems, their sense of vulnerability is increased by exposure of their situation to hospital staff and other women in the unit. This issue has arisen as a significant concern for two women interviewed to date.

Social factors impacting on the women can include a lack of family support, poor housing, poverty, unemployment, exposure to violence and criminal behaviour, a history of parental substance abuse, a culture of illicit drug use in their friendship network and a chaotic lifestyle and marginalisation from mainstream society (Murphy 1999; Howell et al 1999).

All these factors illustrate the sensitivity of the research and the vulnerability of the intended participants. The 'duty of care' to protect the rights and dignity of the women, while at the same time gathering meaningful data therefore must be a primary aim (Orb et al 2001). This requires ongoing diligence in examining the ethical issues affecting the research participants. These issues, while apparently covered in current ethical clearance procedures determined by the National Health and Medical Research Council (NH&MRC) necessitate much deeper consideration and go beyond getting ethical clearance from the participating hospital and university. Ethical issues are currently being teased out, reflected upon, debated and addressed. A feminist research perspective such as described above may provide some of the answers. The first step for interviewing, accessing the women, one aspect of the proposed data collection methods, will now be addressed.

GETTING STARTED: ACCESSING THE WOMEN

Who and how to approach

The first issue to arise was; who should be interviewed? Being mindful of a need to protect the rights and wellbeing of the participants, while, as a researcher, remaining conscious of the need to obtain relevant data, was and continues to be a balancing act. A decision was reached that in order to conduct valid research, invitations to participate in the study should be even handed. Nonetheless this has proven less than straightforward. In the clinic setting, some women attending the clinic can be drug affected to some degree, or be in a situation of crisis due to lack of adequate housing or finance, abuse from a partner or under threat of intervention by a child protection agency. One question the researcher debated was, 'Is it ethically and morally correct to approach women who appeared compromised?' Excluding women because they are perceived as 'too difficult' or 'too vulnerable' may diminish data collection. The most valuable data may come from these women and excluding them because of

extreme difficulties in their lives, may mean the data will lack the richness a diverse group could provide. This remains a vexing dilemma and each potential participant will be assessed individually.

The next challenge to resolve was how to approach the women. Ethical guidelines stipulate that once women agree to participate they should be given adequate time to read and consider the explanation letter, before agreeing to be part of the research. The legal implications mean there is an increased requirement for vulnerable women to be fully informed and this can only occur if they are given ample time in a relaxed environment to consider participation. Taking the step to attend a specialised clinic for antenatal care is a major step for some women. Approaching them for consent at their first visit is problematic because of the considerable emotional stress they are under due to multiple demands, such as seeing members of the multi-disciplinary team and having various procedures such as haematology testing and ultrasound ordered or performed. In an attempt to address this, suitable women are invited into a private area of the clinic at their second visit, usually two weeks after the first visit, and a verbal explanation of the study provided. If the woman is interested in participating, the explanation letter is given to take home and read again. Permission is obtained to telephone the woman to confirm her willingness to be interviewed and a time and place for the interview is arranged. If not amenable to being telephoned, the woman is contacted again at her next antenatal visit.

Specific issues relating to accessing Koori women

It became apparent, very early in planning the study, that Koori women would form part of the potential participant group. Gaining access to pregnant Koori women, who are chemically dependent, has been found to pose almost unsurmountable ethical problems within the three-year time frame available for this research.

Accessing the appropriate Aboriginal and Torres Strait Islander agency for ethics approval of any proposal involved with Aboriginal groups is compulsory under NH&MRC guidelines (1991). Written consent from the appropriate Aboriginal research ethics committee must be obtained and the protective guidelines relating to 'consultation, community involvement, ownership and publication of data' adhered to (NH&MRC guidelines 1991, pp.6-8). The research ethics committees of both institutions involved in this research stipulated this requirement. When the Koori community was approached, no local Aboriginal and Torres Strait Islander Research Ethics Committee was currently in existence and a process of referral to a number of agencies and individuals occurred.

The Koori representative, finally able to give some direction, expressed strong pejorative views and emphasised that any academic non-Koori researcher needs to have considerable experience within the Koori community in order to develop trust, and confidence in the study. Cognisance of the cultural, ethical and

methodological issues underpinning the Koori perspective, by the researcher, is vital and is of greater relevance here, because of the sensitivity of the study topic. This reflects the underpinning of the NH&MRC guidelines which point out that in the past there has been a: 'failure to appreciate that the researchers social status as determined by a community, will be a vital consideration in determining whether access to sensitive areas will be permitted' (1991, p.5).

The objections raised included the way in which academic research in the past has been exploitative and invasive, has not had any perceived benefit and findings have often not been disseminated back to the community (Holmes et al 2001). There is also a suspicion that the findings of research by non-indigenous researchers may be used against them or will not be published at all (see *Decolonizing methodologies* by Tuhiwai-Smith (1999) for a summary of these issues).

It was also noted that, even if permission was granted, there are other significant issues that would need to be taken into account in accessing Koori women for this research. Most notable is the risk of identification. Strong kinship links to 'aunts', 'mothers', 'cousins', 'brothers', 'sisters' and 'fathers' and a large family network within the community makes identification of participants very easy, especially when acceding to the moral responsibility and NH&MRC guidelines of giving study findings to the community to be reviewed before publication of them. In qualitative research the use of direct quotes and divulging even the general study location increases the potential risk.

A second issue is the sensitivity of 'women's business' or reproductive issues (see NH&MRC guidelines 1991, pp.4-5). These are considered to be extremely private and personal and something that is not read, learned about or discussed by men. The Koori ethics approval body for this research would therefore need to comprise women only and findings only disseminated to the women in the community.

A third issue in relation to informed consent is the anxiety, insecurity and fear already existing for these women based upon removal of children in the past, combined with, in some instances, poor literacy skills and different language concepts (Holmes et al 2001). To help overcome this an Aboriginal liaison officer could be co-opted to assist and explanation letters and consent forms would need to be reformatted in plain language and a peer interviewer employed to ensure that the purpose of the study and the data collection methods are clearly understood.

The researcher has been informed that obtaining clearance from a specially constituted Aboriginal Research Ethics Committee could take up to two years, which is problematic for the three year life of this study. Therefore, the unpalatable outcome is, because of the insurmountable difficulties described, and in respect of the Koori communities' wishes, Koori women will not be included in this research. So that the significant needs of

Koori women are not overlooked an approach considered is to conduct a post-doctoral research study in partnership with the Koori community after the findings of the current study have been generated. This would require consultation and collaboration with the Koori community in order to devise a unique and appropriate design and methodology to provide a culturally and ethically sensitive approach to the study topic. Having decided that it was practical to exclude Koori women from the study, the next issue to address was informed consent.

INFORMED CONSENT

Once the woman has agreed to participate in the study, ensuring consent that is truly informed needs to be addressed. An approach that could be termed gaining 'provisional' informed consent has been and will continue to be utilised. After ensuring privacy and adequate time, participants are provided with as much information about the study as is deemed necessary. This is given in a respectful manner, while emphasising that participation is voluntary. One issue relating to honest disclosure is to fully inform participants of the legal implications in relation to mandatory reporting of child abuse (Responding to Child Abuse 2002).

The consent form, in keeping with Victorian Department of Human Services guidelines (NH&MRC 1991), states that identity will remain strictly confidential 'except as required by law'. This is an area of particular concern which relates to the *Victorian Children and Young Person's Act 1989*, (including amendments as at 1 March 2002, pp.61-80), in relation to mandatory reporting, whereby the confidentiality of participants can be breached in order to report suspected child abuse.

The legislation requires that a child, under 17 years of age, is deemed to be in need of protection if he/she has suffered or is likely to suffer physical injury, sexual abuse, emotional or psychological harm or harm to physical development or health (Section 63, c, d, e, f, p.65). If any such abuse comes to the attention of the health professionals, cited under Section 64, 1c, p.67), it must be reported. Professionals include nurses registered under the Victorian Nurses Act (1993), such as the researcher, or teachers/ lecturers under various education acts (Section 64, d, da, db). The research supervisors may fall into both categories. Therefore there is a legal obligation to report to a 'protective intervener' at the Victorian Department of Human Services if researchers deem upon reasonable grounds (Section 64, 1, and 1a, p.66) that a child is in need of protection.

The researchers are aware that a report must be made 'as soon as practicable after forming the belief' that a child is in need of protection, and after each occasion on becoming aware of further reasonable grounds for the belief (p.6). They are also aware that by reporting suspected child abuse to a protective intervener 'honest and reasonable belief' is a defence for the person

reporting (64, 1g), professional ethics are not breached (Section 64, 1h, 3, p.69), and the person making the notification is not subject to any liability if the report is made in good faith (Section 64, 1h, 3b, p.69). The *Act* also protects the identity of the person making the notification (1h, 3a, 3b, 4). However, where does this leave the study participant who has agreed to assist in the research and by so doing may reveal issues that require the researcher to breach confidentiality? This needs to be, and has been made absolutely clear to participants in the information letter and consent form.

The interviewer in this study has found the above requirement to be a very delicate one, needing honesty, tact and diplomacy. She has also been aware of a need, not to appear to label the women as potential abusers because of their chemical dependency. One strategy that has been devised is to broach the topic by making a general statement to the effect that:

Every woman participating in a study involving pregnancy or parenting needs to be aware of the legislation concerning mandatory reporting. These days there are a greater number of reportable acts relating to the safety of children in the community. Because I am a nurse and a researcher, I must tell you it is my duty, after careful consideration, to report any event of a child at risk that I am told about at any time.

This appears to be acceptable, as the women already interviewed have responded positively. At this point there has been no issues of that nature raised, however, some thought has been given to how this might be handled if and when it occurs. Given that a disclosure is made, and the role of the researcher is solely that of interviewer, the interviewer will, after consultation and in collaboration with the social worker assigned to the research participant, ensure that appropriate reporting procedures to the Victorian Department of Human Services are followed. As a matter of course, counselling and support would be provided by the social work department.

Permission now needs to be sought from the women to access their medical records. This is clearly stated on the information letter and has been incorporated into the consent process for this research, both verbally and in writing and therefore complies with the Health Privacy Principles, Schedule 1, Section 19 of the *Victorian Health Records Act (2001)* which became fully operational in July 2002, and the Guidelines under Section 95 of the *Privacy Act (1988)*. A great deal of sensitive information is contained in the medical records of some chemically dependent pregnant women. Reports by social workers, medical officers and midwives, can describe illicit drug habits, psychological problems, notifications to the Victorian Department of Human Services, adherence to treatment programs, and social issues such as references to their partners, or own, criminal behaviour or incarceration. A primary focus must be to ensure that such information is only accessed with the participants'

knowledge and consent. The ethical and now legal requirement of informing participants that the researcher will be seeking to access their medical records has been addressed. To date no potential participant has withdrawn consent because of knowledge of this requirement.

THE INTERVIEW PROCESS

Numerous ethical challenges have arisen around the interview process and the 'duty of care' to protect the well-being of the chemically dependent women participating in this study. These challenges comprise: the avoidance of exploitation, duress or obligation to participate; ensuring privacy and a non-threatening interview environment; avoidance of emotional distress or embarrassment; respecting personal privacy; provision of a non-hierarchical relationship; and, ensuring that counselling is available for participants and interviewer, if necessary, to address unforseen distress.

The avoidance of exploitation, duress or a perceived obligation for a woman to participate in the study is a primary issue. The researcher will not be providing clinical care, but will remain independent as a participant observer and interviewer only. This process will be used to avoid pressure being imposed upon the woman to consent. Gaining the confidence of the women again is a balancing act and will precede any interviewing.

Finding a suitable venue to conduct the interviews is also a challenge. Adhering to feminist tenets and ethical procedures by seeking to conduct interviews in a private, comfortable, neutral, non-threatening environment is essential in order to provide the participant with security, confidence and trust in the researcher.

The options available at present are the antenatal clinic, offices adjacent to the clinic or within the hospital, the coffee shop or the home of the participant. The antenatal clinic or offices within the hospital have the potential to alter the power dynamics in a negative way. The coffee shop, while having the advantage of establishing a more casual environment, is too exposed. While the participant's home may be an option in some cases, advice from clinic midwives suggest it may be interpreted as an invasion of privacy and an attempt to spy in order to provide information to the Victorian Department of Human Services, which may result in removal of their babies. At the same time the researcher is not equipped to deal with any problems which may arise at the time of the interview. For this reason, it is unlikely that any first interviews will be conducted in the home without a full assessment of the individual situation.

Having assessed all the options, a decision has been reached that the participant would be provided with several options as to time and place and be given the opportunity to choose one. In this way we hope to give the participant some sense of control. Initially,

participants were willing to be interviewed in a consulting room or meeting room out of clinic hours when the area was quiet and conducive to privacy. The women interviewed appeared relaxed and there were no interruptions or threats of the conversations being heard by anyone else. Consequent interviews have been conducted in a park adjacent to the hospital at the suggestion of one of the participants. As the research proceeds, the choice of interview venue will be adapted according to the wishes of the women.

A further ethical challenge within the interview process emerged when considering the question, 'is it possible to fully inform potential participants when the aims and direction of the study may well change?' (Grbich 1999, p.72). Realistically, we are unable to predict the depth of information about traumatic aspects of the women's lives, which may emerge during the interview. In fact, because of the sensitivity of the issues surrounding chemical dependency during pregnancy, the interview is very likely, to appear to invade their lives. The researcher, will not set out with the intention to deceive participants regarding the purpose, direction and content of the interview. However, issues which create emotional distress and embarrassment, may be unintentionally and unexpectedly touched upon. To attempt to counteract emotional distress by providing very detailed explanations of the type of traumatic experiences, which may inadvertently be touched upon during the interview, may impede participation in the study. Therefore, a balance needs to be struck to ensure that the participants are aware of the risks of some emotional distress occurring, while being given information regarding their rights to address this. One measure in place to address this problem in relation to invasion of privacy, is outlined below.

Considerable thought has been given to the ethical question of what constitutes unreasonable invasion of privacy, during the interview process. It was aggreed that we need to be sensitive as to what might be construed as 'crossing the line' and employ a feminist research approach in the interview process to address this issue. Feminist methods require: sensitivity to the interviewer/interviewee relationship; input of study participants in both data collection and analysis; emphasis on the protection of privacy and well being of participants; and, reflexivity on the part of the researchers (Murphy 1999). Feminist interviewing techniques strive to be humane, interactive and equitable in approach. In the context of the interview, the participant provides the information and the researcher, becomes the 'tool' to collect it (Oakley 1981, p.48).

To date, establishing a non-hierarchical relationship through using a conversational, empathic approach with non-confrontational probing questions and a respect for participants' wishes not to answer or proceed with the interview if it is causing distress, has proved effective.

Finally, we also have an ethical responsibility to this vulnerable group when the interview ends to ensure the participants are not emotionally distressed or insecure about the information they have given. While it is not the role of the researcher as interviewer to provide counselling, it is essential she not only inform the participants before each interview that a counsellor independent of the research is available to provide counselling or debriefing, but also assesses the degree of need for this. As a further measure to manage emotional distress, McCarthy (1998, p.142) advocates obtaining permission of the participant to divulge a limited amount of information to a nominated care giver (staff member) in order to provide added participant support. This has not been necessary in interviews done to date. However, a follow-up phone call has been made to participants to ensure that the interview has not affected their well being in any way and has not been a negative experience.

POWER RELATIONS IN THE OWNERSHIP OF DATA AND THE PUBLICATION OF RESULTS

A further dilemma presents itself in considering how data should be used. For example, researchers have a 'duty of care' to legitimately use data in the way it has been described to the women participating. McCarthy describes the researcher's position in relation to data as a reflection of power thus:

'The researcher is going away with your answers, analysing, coming to conclusions about you and your situation (which you may not even understand much less agree with) and then informing other people what they have discovered about you and people like you' (McCarthy 1998, p.143).

To balance this and provide a degree of ownership of the data to the women, considerable thought was given to providing the participants with transcripts of all interviews and the study findings. As have other researchers (Grbich 1999, p.72), we have had to consider the question that, if the women are given access to transcripts and the study findings and are unhappy with the substance of the transcripts, or the interpretation of the transcript, what happens then? A decision was reached, that women will be given the option of reading the original transcript, and/or a summary of research findings to date, before commencing the next interview. Any complicating factors relating to legal and psychological issues, would hopefully have been dealt with during the conduct of the interview and follow up phone call, so reading of the transcript will hopefully not pose a threat to the research in terms of withdrawal of permission to use the data.

We as feminist researchers adhere strongly to the principal that with research conducted with any vulnerable group, where participants have made a serious commitment and provided sensitive information in order

to benefit others, there is a duty to publish the findings. We are also morally bound to publish results without distortion (Smith 1992) to ensure that the research fulfils its purpose in addressing a significant health issue and is disseminated to the community as intended. This is our aim, while at the same time ensuring that every effort is made to protect the identities of participants.

Finally, interviewing vulnerable groups on very sensitive topics can be a 'psychologically and emotionally wrenching experience' for the interviewer. (Burr 1996). The researcher in this study proposes to debrief, or review difficult case studies with the study supervisors, in order to deal with issues as they arise.

CONCLUSION

This paper has outlined some ethical issues in one study of chemically dependent pregnant women in relation to accessing participants, informed consent, confidentiality, invasion of privacy and exploitation in respect to interviewing, and how these issues might be addressed. Many more questions have been raised than answered and the issues are likely to become more complex when the needs of chemically dependent pregnant women from other ethnic backgrounds are considered in later research. However, the ethical issues, which arise when accessing and interviewing vulnerable groups on particularly sensitive topics, are problematic and at times lack definitive solutions. An attempt has been made to address the researchers' 'duty of care' as an important component of the process by adopting tenets of feminist research. Research, such as described, is necessary for improving the care provided to vulnerable chemically dependent pregnant women, probably the most stigmatised and misunderstood group in the community. However, in conducting it, reducing 'potential harm' to the study participants must be the priority and a balance needs to be established between the necessity to protect the rights of the participants, while at the same time achieving reliable and potentially beneficial findings.

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STUDENT NURSES' PERCEIVED GOALS AND FUTURE CAREER PATHWAYS WITHIN NURSING: ARE THEY REALISTIC?

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ABSTRACT

The purpose of this study is to explore student nurses' perceptions of nursing, their perceived goals as nurses and their future career pathways. The study involved a cross sectional approach using Ford's (1986) taxonomy of human goals as a theoretical framework. This paper presents a part of a larger study that involved two groups of nursing students, however the findings from one group only are reported. A questionnaire was administered to 126 nursing students enrolled in the first semester of a nursing degree program. Results revealed four main goals students hold as a nurse: first, Happiness (satisfaction for self and others), second, Evaluation (self efficacy), third, Social Validation (opportunity to help others), and, fourth, Safety (job security). Results also indicated that nursing provides opportunity for travel and the participants had a limited perception of career paths. Findings have implications for nurse education (long and short term) especially in regard to providing a realistic view of nursing as a profession and future career pathways. These findings are especially significant given the current shortage of nurses.

LITERATURE REVIEW

According to Kiger (1993) student nurses come into the profession with a strong perception of what it entails. They see it as not just a job but a career, profession or vocation; indeed, some may see it as a calling (Raatikainen 1997). However, over the last decade there has been global concern regarding the decreasing number of individuals who are selecting nursing as a career option and the high attrition rate of student nurses and qualified nurses (Buchan 1997; Campbell and Dickson 1996; Cowin 2001; Helmsley-Brown and Foskett 1999; Jalili-Grenier and Chase 1997; While and Blackman 1998). Today this situation is more acute and the international shortage of nurses has both short and long term implications in the provision of quality health care (While and Blackman 1998). Both nurses and the general population are ageing and Cowin (2001) asks the fundamental question: 'Who will replace this workforce?' (p.313). Campbell and Dickson (1996) propose that 'now, more than ever, it is essential to promote success and reduce the number of students who leave schools of nursing' (p.47). To reduce this attrition Day et al (1995) advocate that educators should 'imbue students with a realistic view of the role of the professional nurse' (p.357). Within this goal is the proviso to ensure a flow of motivated nurses who possess the abilities, skill and knowledge to perform at a competent level in the clinical area (While and Blackman 1998).

Findings from a study by Helmsley-Brown and Foskett (1999), which investigated the reasons why young people (ages 11, 15 and 17 years) selected nursing as a career path, showed that the main reason for choosing nursing was a desire to help people and children. A study by Happell (1999) involving 793 first year undergraduate nurses across 12 universities in Victoria, Australia, found that career aspirations concentrated on midwifery, paediatrics and areas that involved a high-tech focus. These students were less favourable toward caring for older people, people with mental health problems and people with a physical disability. This limited perception

of career pathways within the nursing profession has serious implications for future patients and health care provision.

According to Bacon et al (2000), Happell (1999), Jessup (2001), Kiger (1993) and Rossiter and Yam (1998), within the media the stereotypical images of nurses and nursing persist. In the media the nurse is nearly always female (male nurses are shown on programs such as *All Saints*), depicted as a battleaxe, a sex symbol or in a subordinate role, or, portrayed as less important than doctors. These persistent images do not serve to encourage young people into the profession and do not indicate the many career pathways that are available. These images may also influence the prospective nurse's family since according to Spouse (2000a) studies have shown that individuals who decide to undertake nursing do not have the support of their family.

Considering these influences 'students enter nursing with strong images of how they will practise' (Spouse 2000a, p.730). Therefore, this study also explored student nurses' perception of nursing and themselves as nurses. Ford's (1986) taxonomy of human goals was used as a theoretical framework to underpin this study. These goals identify internal cognitive goals and range from arousal, evaluation, experiential, psychological, social relationship and task goals. Identification of specific gaols, which encourage the person to select nursing as a career, will help indicate the best direction on how to recruit students in the future.

The recruitment of future student nurses seems an arduous task, however, with a determined effort from both educators and clinicians marketing of nursing as a professional career, which offers specialised career paths that could be achieved. Thus, an aim of this present study is to identify the goals newly enrolled student nurses hold in relation in their perception of being a nurse and nursing and their future career pathways. Essentially, results could determine if these goals and perceptions are realistic enough to sustain them through the rigours of a nursing degree course and into the future.

AIMS

The research presented in this paper sought to explore the following:

1 The reasons why first year student nurses select nursing as a career and their perceptions of being a nurse; and,
2 Individual goals in relation to being a nurse and future career pathways.

METHOD

This exploratory study involved a cross sectional design using both qualitative and quantitative approaches. This paper is part of a larger study and will report findings in relation to one group only. This group consisted of 126 nursing students currently enrolled in Semester 1 of a nursing degree program at a tertiary institution in Perth, Western Australia. The findings related to this group are significant given the initial recruitment issues and determining the reasons and images people bring with them as they embark on a nursing career.

Instrument

Following a review of the literature, the researchers developed a questionnaire, consisting of demographic data and open-ended items related to students' images and expectations of becoming a nurse. Also included were items asking about their perception of the nursing profession, the reasons they selected nursing as a career path, perceptions of status of nurses, possible factors (ie parents, relatives, friends or the media) that might have influenced their choice.

A questionnaire can be used to collect data related to the aforementioned issues, however, the use of art may help the students to express thoughts, feelings, fears and expectations more graphically (Spouse 2000a, 2000b). Furthermore, use of drawings may also be a means to explore and identify students' feelings and anxieties (Styles and Radloff 2000) and again this information could provide academic staff with the first building blocks on which to provide interventions to help retain students within the profession. Students were also asked to draw a picture of how they saw themselves as a nurse at the time of completing the questionnaire and in the future. The students were informed that they did not have to be an artist as the researchers were seeking their interpretation. Only the data and drawings relating to Ford's (1986) taxonomy of goals and career pathways are presented here. For further details of stereotypical images of nursing, perceived status of nurses to other health professionals and who and what influenced them in their chosen career see Ward et al (2002).

Procedures

The tertiary institution granted ethics approval to conduct the study. Following a successful pilot study the researchers administered the questionnaire to students in the fourth week of their nursing degree program. Distribution of the questionnaire early in the semester helped minimise the influence that nurse education may have had on their perception of the nursing profession and future career paths. The questionnaire was distributed in lecture time to increase the likelihood of a higher return rate. To ensure individual responses to items in the questionnaire the students were asked not to confer. The students were informed that participation in the study was on a voluntary basis; any student who did not want to participate could return the questionnaire. To safeguard anonymity they were advised not to write their name or student number on the questionnaire. The students were assured that involvement or non-involvement in the study would not impede on their study progress.

Data analysis

Demographic data were managed, and statistical analyses carried out using the SPSS and responses to open items within the questionnaire were transcribed, coded and then managed using the Non-numerical Unstructured Data Indexing Searching and Theory Building (NUD•IST 4) software (Richards and Richards 1994). Ford's (1986) taxonomy of human goals was used to categorise responses to questions. For example, Evaluation, Happiness, Social Validation, Safety, Social Responsibility, Arousal and Task goals. Other data were coded according to themes which emerged from the data, for example, future plans and negative aspects of nursing. These data assisted in building a picture of the participants' images of nurses and nursing, possible anxieties related to clinical practice, and career pathways.

The drawings were categorised according to Ford's (1986) taxonomy of goals. They were categorised into the appropriate goal, Happiness or Social Validation. Some students provided detailed images whilst others a more representative cartoon of what they wanted to depict.

FINDINGS

Of the 140 students enrolled in semester one of the nursing degree course, 126 completed the questionnaire - a response rate of 90%. Thus, the sample is accepted as representative of this particular cohort of students. Of the 126 respondents, 118 (93.7%) were female and 8 (6.3%) male. Ages ranged from 17 to 53 years (m= 21.63 yrs, SD 7.54). In relation to country of origin, 105 (83.3%) participants were born in Australia and the remainder originated from various countries such as the UK, Asia, and the USA. In total 119 (94.4%) participants were Australian citizens. None of the participants was of Aboriginal descent.

Of the 126 participants, 87 (69%) produced a drawing in response to the item in the questionnaire which asked them to draw a picture that illustrated how they envisaged themselves as a nurse at the present time and in the future. Seven drawings were excluded, as they were incomplete, thus, in total, 80 (63.5%) drawings were accepted for inclusion in the study.

Table 1 provides a description of the types of goals the participants identified in relation to seeing themselves as nurses. In increasing order of frequency, when percentages mentioned by participants are totalled (ie Happiness and Evaluation), goals included: Happiness - satisfaction for others and self; others 54 (42.9%) and self 50 (39.7%) - total of 82.6%; Evaluation - self efficacy: positive 68 (54%) and negative 13 (10%) - total of 64%; Social Validation - 54 (43%); Safety - employment 40 (31.7%); Social Responsibility - altruism: 22 (17.4%); and Arousal - excitement 20 (16%). Questionnaires were identified numerically and this code number is used when a quote is presented in Table 1.

Table 1: Goals identified by participants and coded using Ford's (1986) human taxonomy of goals			
GOAL	**Definition**	**n & %**	**Statements from participants**
HAPPINESS Satisfaction for self and others	Caring for patients will make the self and others happy	54 (42.9%) 50 (39.7%) (Total = 82.6%)	**Others** *Make people's last days of their life a bit more enjoyable'* (105) **Self** *'The caring and patient side and then helping them will be the best feeling'* (08)
EVALUATION Self-efficacy (positive) Self-efficacy (negative)	Wanting to perform as a nurse to the best of one's ability and providing the best care Being undecided about their decision to be a nurse	68 (54%) 13 (10%) (Total = 64%)	*'I have high demands of myself. I know I'll become a good nurse and will always try to get better'* (103) *'I'm still unsure of what I want to do'* (100)
SOCIAL VALIDATION	Nursing providing an opportunity to help others	54 (43%)	*'I would like to help care for people in our society and I just love the interaction with people'* (01)
SAFETY	Nursing offering job security	40 (31.7%)	*'There is a constant need for nurses every day. So in the end I would be able to have a steady reliable job'* (101)
SOCIAL RESPONSIBILITY Equity and fairness	An altruistic approach to caring. A desire to help less fortunate individuals	22 (17.4%)	*'I want to travel and work all over the world especially in remote areas such as South America and Africa and care for people'* (06)
AROUSAL Entertainment	Wanting a job that is not boring - plenty of variety and excitement	20 (16%)	*'Hands on work. Always on the go. Meeting new people'* (14)
TASK Mastery	Wanting to develop in competence and excellence	5 (3.9%)	*'To provide the best system possible and change the way nurses think and feel about the system'* (41)

Figure 1: Drawings by participants reflect the 'Happiness Goal'. The images portray a smiling face or 'sunshine' illustrating enjoyment.

| Participant (100) | Participant (64) | Participant (101) |
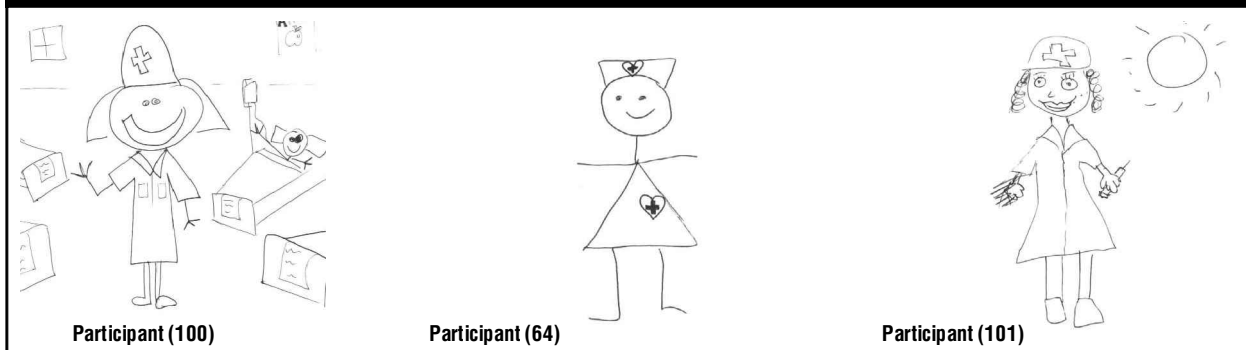
In relation to the 80 (63.5%) students who had drawn a picture which illustrated how they perceived themselves as nurses, 47 (58.8%) drawings reflected the Happiness Goal. The students portrayed themselves with smiling faces or a 'sunshine' representation reflecting enjoyment (see Figure 1). Although 22 (17.4%) participants identified a goal of social responsibility (equity and fairness), only five (6.3%) participants represented this goal through their drawings. These participants presented images of working in a third world country or working in various places (rural, hospital and community) helping people.

One of the goals identified by Ford (1986) within the category of Social Relationship Goals is Self Determination, which involves *personal control, freedom* and *autonomy*. According to Ford (1986) this goal involves defining one's identity as a separate person and promoting personal control over life circumstances. These factors could relate to how nurses might conduct their career progression; that is by possessing the control, freedom and autonomy to manage and enhance their elected career pathway. For example, participants judge they have the freedom to select an area of nursing in which to practice, and where and how this practise will be experienced.

Of the 126 participants 101 (80.2%) mentioned a career path (see Table 2). Results showed that 32 (25%) participants selected a combination of midwifery and paediatrics, 14 (11%) selected midwifery and 10 (8%) selected paediatrics. In total, 56 (44%) participants selected either paediatrics or midwifery as a career path. In contrast, only 10 (8%) participants selected theatre or surgery as a career path. Results also showed that a large proportion of participants (35, 27.7%) viewed nursing as a passport to 'travel'; perhaps highlighting they have the freedom to broaden their career choices and pathways.

Table 2: Self Determination Goal (involving personal control, freedom) or career pathway mentioned by the participants.

Career path	n & %
Travel	35 (27.7%)
Midwifery and/or paediatrics	32 (25%)
Midwifery	14 (11%)
Paediatrics	10 (8%)
Theatre/surgical	10 (8%)

Of the 126 participants, 80 (63.5%) completed a drawing. Of these 80 drawings, 18 (22.5%) depicted their vision of their future career path. Of these 18 drawings, 13 (72%) related to traditional clinical environments (nursing in a hospital environment) and five (27%) related to either midwifery or paediatrics. These five drawings showed a nurse caring for pregnant women and children in a hospital setting.

Under the category of Task Goals (a higher level goal) Ford (1986) identifies five types one of which is *Mastery* which refers to achievement, competence and excellence. The goal of *Mastery* was evident in only five (3.9%) of the 126 participants' responses. In relation to the drawings made by the students, 13 (16.3%) illustrated 'self growth' as they progressed through their nurse education program by illustrating specific attributes of being a nurse; being knowledgable, caring, compassionate, and efficient (see Figure 2).

Figure 2: Drawings by participants illustrating the Mastery Goal which illustrates achievement though learning and specific attributes such as competence and efficiency.

Participant (86)
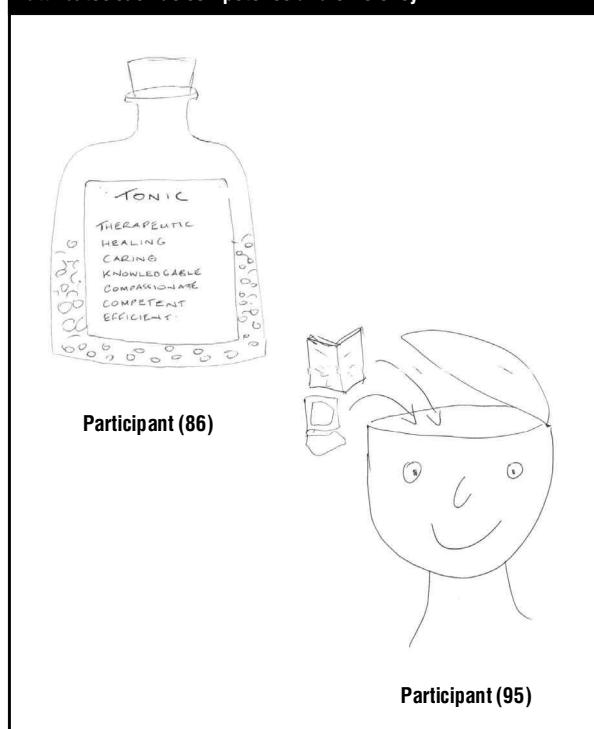
Participant (95)

Negative aspects of nursing

Negative aspects or areas of care were mentioned by the participants (See Table 3) as factors in their consideration of nursing as a career. Twenty-one (16.6%) mentioned death or dying; 21 (16.6%) mentioned conditions (eg pay, shift work, staffing levels); 10 (8%) an aversion to handling bodily fluids; and eight (6.3%) mentioned the care of the elderly.

Table 3: The negative aspects of nursing or areas of care mentioned by the participants.	
Negative aspects of caring	n & %
Death/dying	21 (16.6%)
Conditions: Pay, shift work, staffing levels	21 (16.6%)
Body fluids	10 (8%)
Elderly care	8 (6.3%)

DISCUSSION

As expected, the participants were predominantly female, Australian and in general came from a young age group. Findings from the study show the participants identified a limited range of goals. Reasons for this may be related to the development level of the students (at the beginning of their nurse education), and their limited knowledge of what nursing and the nursing profession involves. The limited range may also reflect the goals which are pertinent to the students at the time in their life span. The two most frequently mentioned goals related to Happiness (satisfaction for self and others) and Evaluation (self-efficacy). These goals appear to represent the satisfaction that the participants wanted to achieve through helping others. Happiness, represented as smiling faces and sunshine, was also reflected in the drawings made by the students. The notion of happiness and caring for others supports findings of Hemsley-Brown and Foskett (1999) who found that young people proposed that the attributes of caring, being loving and friendly are the attributes inherent in nursing.

Participants mentioned caring for people in third world countries, reflecting the goal of Social Responsibility (equity and fairness). This altruistic approach indicates that the students want to help those individuals perceived as less fortunate than themselves. It is significant, however, that not one participant mentioned an intention of working within the Aboriginal community. Perhaps nursing in a third world country seems more romantic and would also provide an opportunity to travel. Furthermore, an altruistic approach also reflects the happiness goal in that it would further enhance participants' feelings of self-satisfaction derived from providing care. This finding supports that of Hemsley-Brown and Foskett (1999) who found that young people make a career choice based on the enjoyment this employment would give them.

Results related to Evaluation goals reflect those of Ferguson (1990) who suggests that satisfaction and

fulfilment in one's career is very important. Evaluation gaols relate to behavioural outcome rather than cognitive accomplishments (Ford 1986) and this group of students wanted to strive to do their best and perform to the best of their ability. There was, however, no emphasis on cognitive exploration as to how this performance would be achieved. For the purpose of this study, Ford's (1986) Safety goals (an important part of everyday life) were interpreted as safety in employment as this factor is fundamental to supporting the person and/or family. The participants viewed nursing as a secure career path, thereby providing consistent opportunity for work. This potential may reflect the view that nursing continues to be perceived as a female occupation and that participants were projecting their future employment needs of remaining in the workforce while they pursued a family life. Moreover, they perceived nursing as a 'passport' to work and to see the world, perhaps indicating an encouraging outlook in regard to employment, and a means of further enjoyment and freedom.

Results, which identified a very limited range of desirable nursing contexts, reflected those of Happell (1999) who observed that individuals have a narrow view of the dimensions of nursing and the career paths that it can offer. Participants in this study tended to select the 'nice' high turnover environments, such as midwifery and paediatrics. These environments may be perceived as 'happy places', caring for mothers with newborns and children, and thus providing participants with increased self and employment satisfaction. Furthermore, they may consider that these areas of care have no tragedies because dying is a remote possibility. This maintenance of happiness is also indicated in the recognition of, and desire to avoid, the negative aspects of care (death, dying, aged care). It appears these students possess a limited view of the intricacies of caring. As Happell (1999) observes this limited view of career pathways, and the reluctance to work in aged care, psychiatric nursing or with people with physical and mental disabilities, has far reaching implications for the profession.

The stereotypical images of nurses evident in this study support Bacon and McKendrick's (2000), Jessup (2001), Kiger's (1993) and Rossiter and Yam's (1998) findings. The participants, in their drawings, depicted the nurse wearing a starched cap, even though for nurses in Australia, the cap has not been part of the uniform for approximately 20 years. Perceptions of the provision of care in the drawings showed nurses caring for patients predominantly in a hospital setting. These persistent images reflect how health care is portrayed through the media, in effect reinforcing stereotypical images of caring. However, according to Jessup (2001) the nursing profession has the potential 'to throw off a negative self image' (p.215) and challenge the media's perspective of nurses and nursing. This view is shared by Bacon et al (2000), who report that people are now beginning to 'see nurses as well educated, independent thinking

professionals' (p.31). All nurses therefore, including both clinically based and educators, cannot afford to rest on their laurels but must strive to reinforce this progressive image, and once and for all reject those outmoded myths.

CONCLUSION

In conclusion, findings demonstrate that students enter nursing with a limited perspective of what the nursing profession entails. Essentially, the participants perceived nursing as a means of receiving pleasure from providing care, from interactions with patients, and from fulfilling pleasure and providing activities such as travel. Consistent with this view is the fact that students tended to select areas of care, such as midwifery and paediatrics, which perpetuated this prospect of happiness. The participants also perceived nursing as a means to ensure employment security; either within Australia or if they elected to travel. The altruism expressed by some students who wished to help others did not, however, extend to indigenous Australians.

The most apparent limitation of this study is that the results cannot be generalised to all individuals who elect nursing as a career. Focus groups may have given the participants opportunity to expand on their responses, in particular in relation to the negative aspects of nursing, and thereby provide clarity to the results. Another limitation was not ensuring that participants who were repeating the semester were excluded from the study. Also, if the participants were asked to rank a list of nursing career choices the results may have provided a clearer indication of future career paths.

Despite these limitations, results do substantiate previous research and highlights that the profession needs to be more proactive and dispel the notion that nursing offers limited carer opportunities. As Happell (1999) observes, nurses work in a wide variety of care settings and 'the nursing profession must seek actively to portray the equal importance of all aspects of nursing care, and to deter the situation where certain aspects of practice are considered more important and/or more desirable than others' (p.505).

It is the responsibility of nurse educators to provide prospective nursing students with information, which gives a realistic, and not a romantic vision of nursing. This may be addressed by persuading the media to present a more realistic and balanced portrayal of nursing and by providing more information to schools and presenting talks at schools by role models who reflect the diversity and complexity of the nurses' world. In doing so, the nursing profession might be better placed to attract and retain future nursing students and nurses in the workforce, thus ensuring adequate provision of appropriate health care in a wide range of settings.

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COLLABORATIVE PRACTICE BETWEEN REGISTERED NURSES AND MEDICAL PRACTITIONERS IN AUSTRALIAN GENERAL PRACTICE: MOVING FROM RHETORIC TO REALITY

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ABSTRACT

Collaborative practice between medical practitioners and nurses is purported to improve patient access to services, improve health outcomes, provide a more 'seamless service', increase efficiency of care, reduce health care costs and improve practitioner job satisfaction. Therefore, it is important to understand what hinders and what facilitates this type of interdisciplinary functioning. This paper will examine these factors in the context of the Australian general practice setting. It is timely because recent Government financial incentives have been provided to increase the number of nurses employed in this sector and also to expand their role. Awareness of these factors may enable nurses in general practice, both individually and collectively, to better understand the dynamics of role expansion in order to move towards collaborative partnerships with their medical colleagues. Recommendations to advance collaborative practice are given and a model of practice proposed that identifies possible autonomous, collaborative and dependent functions for nurses in general practice.

INTRODUCTION

Collaborative practice between registered nurses and medical practitioners has been the subject of discussion, debate and research for decades. However, despite purported positive outcomes from such interdisciplinary functioning, it has been the exception rather than the dominant pattern in health care. This paper will present some of the known facilitative and hindering factors to collaborative practice and examine these in the context of the Australian general practice setting. Awareness of these factors may enable practice nurses (PNs), both individually and collectively, to better understand the dynamics of their relationships with general practitioners (GPs) in order to move from a role that is predominantly dependent towards one that is more collaborative in nature. This is important because of the recent release of substantial amounts of money in the 2001-2 Commonwealth Budget to employ more nurses in general practice settings and to expand their current role.

Collaborative practice

The terms collaborative practice, joint practice, associated practice, interprofessional working, transprofessional care, shared care and partnership are often used interchangeably in the health field, yet their definitions are at times vague and highly variable (Baggs and Schmitt 1988; Henneman, Lee and Cohen 1995; Jones 1992; Stichler 1995; Taylor 1996). This lack of clarity and a contention that collaboration between nurses and medical practitioners is a key variable in explaining patient outcomes, led Baggs and Schmitt (1988) to undertake a literature review of the use of the term 'collaborative practice'. Their review identified the critical attributes to be: sharing of planning, goal setting, decision making, problem solving and responsibility; open communication; cooperation; coordination; and, recognition and acceptance of separate and combined areas of activity.

Henneman et al (1995) also addressed collaboration, undertaking a concept analysis to create operational definitions of the term and provide the basis for tool

development and evaluation. They identified additional defining attributes as shared power and authority based on knowledge or expertise as opposed to role or function, and non-hierarchical relationships. However, these authors assert that before collaboration can take place, a number of personnel and environmental antecedents must occur. Personnel factors include readiness to engage in the process, understanding and acceptance of levels of expertise and role boundaries, confidence, and effective group dynamics. These must be combined with environmental factors which include flat organisational structures that encourage participation and inter-dependence between its members and leaders, who foster individual creativity and autonomy in decision-making while facilitating unified direction.

Taylor (2002) concurs, adding several fundamentals of collaborative practice. She lists the following as the behaviours that characterise autonomy: knowledge of current trends and issues in nursing; engagement in collective activity with other nurses to improve patient care and advance the profession; competence in both medically dependent and medically independent nursing activities; assertiveness in initiating, documenting and articulating nursing actions and their outcomes and willingness to take risks on the patient's behalf or to preserve the integrity of the profession.

If the two groups adhere to this type of approach, it is likely to lead to improved patient outcomes in the form of decreased mortality (Knaus et al 1986; Rubenstein et al 1984) and improved functional status (Alpert et al 1992). Biggs (1993) claimed that interprofessional collaboration in community care resulted in improved clarity of objectives for the client, and a more 'seamless service' due to a reduction in duplication of assessments. Vautier and Carey (1994) found that patients who were collaboratively case-managed rated their care more positively than did other patients. Further, the benefits of team and collaborative care to underserved populations have been documented by Baldwin (1996) and include enhanced patient compliance, greater patient satisfaction, reductions in broken appointments and decreases in hospitalisation and use of physicians. In ambulatory care, collaboration has resulted in increased patient access to and choice of provider, a greater focus on preventive care, increased community involvement and increased patient self-care (Dunevitz 1997).

Collaborative practice has also rendered positive outcomes for the professional participants. Alt-White, Charnes and Strayer (1983) and Alpert et al (1992) reported a significant correlation between nurses' job satisfaction and engagement in collaborative practice. Baggs and Ryan (1990) found a statistically significant correlation between nurses' perception of collaboration and satisfaction with decision-making.

Clearly, collaborative practice has the capacity to lead to enhanced health care. However, despite all these documented benefits, it remains the exception rather than the norm (Dower and O'Neil 1997; Evans 1994; Henneman 1995; Keleher 1998; Kendrick 1995; Taylor 1996; Willis, Condon and Litt 2000). The reasons for this become apparent when the educational and socialisation processes that nurses and medical practitioners have experienced are compared to the antecedents that are necessary for collaboration to take place. Many of the antecedents are dependent on the individual's readiness to engage in this type of interpersonal process. Education that prepares a person for an interdependent role and prior collaborative experiences are important factors in facilitating readiness (Henneman et al 1995).

A particular barrier to nurse-medical practitioner collaborative practice has been identified as a lack of understanding on the part of medical practitioners and nurses of each other's roles and responsibilities (Bradford 1989; Evans 1994; Stichler 1995). Professional competence is the essential component that creates the respect and valuing necessary for entitlement and the development of truly collaborative relationships. Each member of the partnership brings a specific set of skills, talents, information or resources to complement the other. A collaborative relationship cannot evolve if team members do not value one another and respect one another's competencies and this is impossible without a clear understanding of what they are (Stichler 1995; Taylor 2002).

Interdisciplinary functioning in ambulatory care

Hastings (1997) contrasts two models of inter-disciplinary functioning that can be used to describe current approaches to ambulatory (or primary) health care; the Provider Substitution Model (PSM) and the Collaborative Practice Model (CPM). The PSM is based on the oldest and most common form of ambulatory care - the medical practitioner's office visit. It assumes that medical diagnosis and treatment are the primary purpose for the visit and that, theoretically, the medical practitioner could provide all the necessary care. Implicit in this model is the assumption that the medical practitioner has the authority to delegate tasks to other licensed and unlicensed assistive personnel (UAP) up to their maximum scope of practice. Hastings contends that this model emerged from the fact that practices are owned and managed by medical practitioners as small businesses. The primary purpose of employing other providers is to increase 'throughput' and thereby reduce costs and increase profits. In this model other providers, like nurses, are viewed as substitutes for the medical practitioner.

In contrast, the CPM is based on the premise that a team of health professionals is required to provide patient care; each professional licensed with a unique but overlapping scope of practice (Hastings 1997). The purpose of the patient visit can vary from visit to visit and the involvement of specific team members is dictated by

patient requirements. However, it is assumed that medical practitioners are generally the leaders of the team, have the largest scope of practice and retain the authority to refer to or direct the care of other disciplines. In this model, specific disciplines delegate work to, and supervise UAPs. According to Hastings, this model forms the basis of care for chronically ill patients requiring long-term therapy and is most commonly associated with hospital-based outpatient programs or large group practice medical centres.
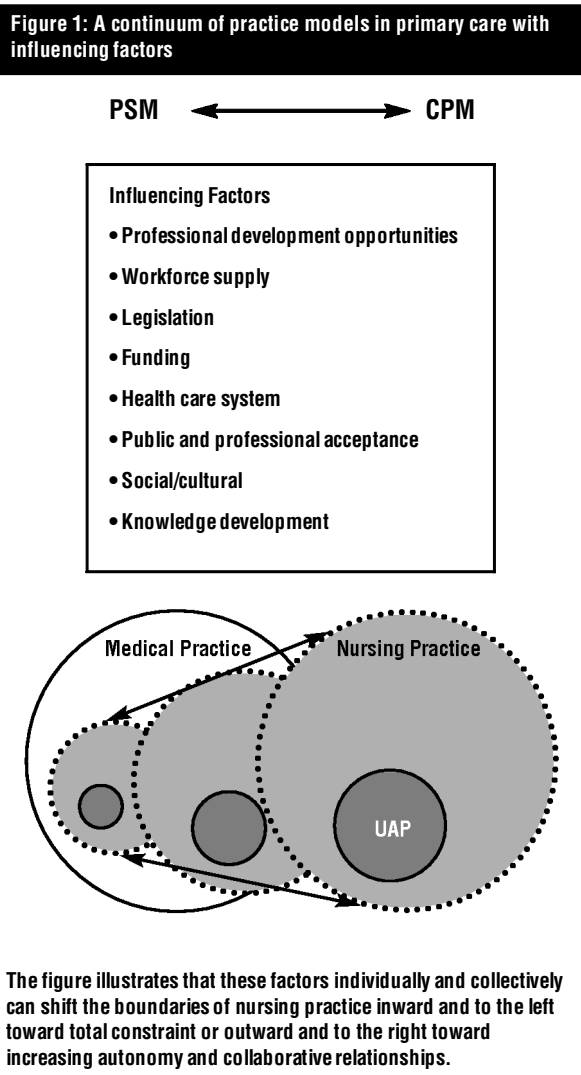
Hastings (1997) asserts that where there is a clear and universally accepted requirement for nursing care, collaborative practice between medicine and nursing has the potential to evolve, based on mutually dependent but distinct, if overlapping, areas of work. This is most likely to occur in inpatient acute care and extended care settings where patients are unable to care for themselves due to illness, disability or the nature of their treatment. However, when the patient is managing self-care the nursing role is not so clearly defined and professional boundaries can become blurred. In this context, expansion of the traditional or universally accepted nursing role may be viewed, by different groups, as medical substitution, role encroachment, or the rightful claim of nursing territory.

We would argue that, rather than there being just two contrasting models to conceptualise the boundaries of nursing practice, there may be a continuum of models (see Figure 1). At one end, nursing practice is totally constrained, not only by its legislated scope of practice, but by medical authority and control of reimbursement for services. The PSM is situated at this end of the continuum. While cooperation may exist between nurses and medical practitioners, there is no evidence of collaboration in this model, as described in the theoretical literature. Towards the other end is Hastings' CPM in which nursing has recognised and accepted autonomous functioning but is still constrained, somewhat, by the medical practitioner's authority to refer to or direct nursing care. This model still reflects a hierarchical relationship between nursing and medicine where power rests with medical authority rather than knowledge and expertise. This negates any claim that it is truly collaborative in practice.

At the extreme end of this continuum, we propose, is a model that better reflects the attributes of collaboration, where nursing and medical practice retain unique elements but have areas that overlap. The scope of each discipline's practice and team leadership and case management are dictated by patient need and practitioner competence. Practice roles, therefore, change from one patient context to another as determined by the team. This model acknowledges the possibility that a nurse may assume the broadest scope of practice, lead the team and refer to other practitioners, including doctors, when their knowledge, expertise and/or competence is more appropriate to the patient's needs than is the nurse's. The boundaries of nursing practice, in this model, are limited only by professional accreditation standards and

government legislation and not by medical 'gatekeeping'. At this end of the continuum, nursing's contribution to health care has the potential to be fully realised. This type of arrangement also may reflect patient centredness rather than any professional scope of practice. In this respect, the roles revolve around ensuring quality patient care, rather than expediting managerial throughput.

Both Australian and overseas studies reveal that the nurse's role in primary care is influenced by many different factors. These include the funding and local arrangement of health services, national and local health priority goals, professional medical and nursing organisations, health-related policies and legislation, the availability of educational programs and professional support bodies, the supply of GPs, and the beliefs, attitudes and values of individual medical practitioners and nurses. These factors individually and collectively have the power to shift the boundaries of nursing practice inward toward total constraint or outward toward increasing autonomy and collaborative practice arrangements (see Figure 1).

Figure 1: A continuum of practice models in primary care with influencing factors

PSM ⟷ CPM

Influencing Factors
- Professional development opportunities
- Workforce supply
- Legislation
- Funding
- Health care system
- Public and professional acceptance
- Social/cultural
- Knowledge development

Medical Practice   Nursing Practice

UAP

The figure illustrates that these factors individually and collectively can shift the boundaries of nursing practice inward and to the left toward total constraint or outward and to the right toward increasing autonomy and collaborative relationships.

Practice nursing in Australia

General practice is perhaps the only health care setting in Australia where medical practitioners currently have almost complete control over the employment of nurses and their scope of practice. The majority of general practices in Australia function without nursing input (Bonawit and Watson 1996; Le Sueur and Barnard 1993; Patterson, Del Mar and Najman 1999a). Of those practices that do employ nurses, nearly all fund their positions from the income generated by the GPs. A few PNs are employed by divisions of general practice for specific projects and a few are employed in publicly funded medical clinics. Therefore, most PNs in Australia are employees of medical practitioners.

Findings from studies conducted in Western Australia (Le Sueur and Barnard 1993), South Australia (Willis et al 2000), Victoria (Bonawit and Watson 1996; Keyzer et al 1996) and Queensland (Patterson et al 1999a) illustrate that, to date, the PN's role has been primarily that of assistant to the GP to facilitate the efficient running of the practice. The PN performs this role in three ways: one, by undertaking basic physical assessment tasks to aid the medical diagnosis; two, by carrying out delegated therapeutic procedures to facilitate management of the medical condition, and three, by contributing to the administrative functioning of the practice. The PN appears to be predominantly task or condition oriented and dependent on medical delegation or direction. Autonomous nursing initiatives are confined to immediate first aid pending medical attention or are incidental to other prescribed activities. In many cases, independent activities are limited to providing emotional support to patients and clarifying medical instructions given to them. Thus, GP-PN functioning resembles that of Hastings' (1997) PSM.

The Medicare Benefits Scheme (MBS) in Australia does not have a fee structure that includes independent nursing services in general practice; only fees that are medically initiated attract a rebate as part of the overall medical consultation. Because of this, medical practices are restricted in their ability to generate income from nurse-initiated activities. This arrangement severely restricts nursing autonomy but encourages the involvement of nurses in medically delegated tasks to speed up the throughput of patients. However, recently, as part of the Commonwealth Government's Enhanced Primary Care initiative, new MBS items were introduced for annual health assessments of individuals over 75 years (over 55 years in Aboriginal and Torres Strait Islander people). These health checks are to include assessment of the person's health and physical, psychological and social function (Byles 2000). Although GPs are central to the process, the schedule allows for other health professionals (including RNs) to conduct these assessments 'on behalf' of the registered service provider (Sims, Kerse, Naccarella and Long 2000). Anecdotal information indicates that the introduction of these new MBS items has stimulated the employment of more nurses in general practice and a perceived increase in autonomy.

The 2001-2002 Federal Budget provided funding of $104.3 million over four years for general practices in areas of high workforce pressure, particularly in rural and remote areas, to employ more nurses (www.health.gov.au/budget2001/index.htm). The funding, to be provided to eligible practices through the Practice Incentives Program (PIP), is available through Divisions of General Practice for mentoring and training of PNs and in the form of scholarships for rural nurses to assist in their re-entry to the nursing workforce. The Government envisages that PNs will contribute to better management of chronic diseases and be involved in population health activities. Whether their role will continue to be merely supportive of GPs or evolve to be collaborative will depend on GPs' and PNs' readiness for such functioning and future funding arrangements.

While some studies (Patterson et al 1999b; Willis et al 2000) have identified that most medical practitioners are reluctant to accept autonomous nursing function in their practices, the nurses' 'readiness' is also questionable. According to George and Davis (1998), distinct generations in the nursing workforce are wedded to different sets of values and of what is important at work, some seeing little advantage in the new 'professionalism' proposed by nursing leaders. These nurses, they assert, are generally the older, least ambitious nurses who have other commitments and interests. The demographic characteristics of PNs reported in the previously cited Australian studies indicate that the typical PN is a female, middle-aged, hospital-trained RN who is not engaged in further education. In addition, George and Davis (1998) assert that the dominant-subordinate relationship between individual medical practitioners and nurses is often accommodated because the relationship has been built up over time and is based on trust, personal loyalty and mutual recognition of specific areas of expertise. This typically rules out challenge and conflict. Again, this assertion has been substantiated in the cited Australian studies about PNs.

Patterson et al (1999a; 1999b) assert that PNs' isolation from the wider nursing profession has been a constraining influence on their role development. They found that many PNs work in a situation where they are the only nurse on the premises so they do not have the opportunity to exchange ideas with other nursing colleagues or support from peers to initiate new ventures. As previously noted, the vast majority of PNs studied in Australia had no tertiary nursing qualifications nor were currently undertaking tertiary nursing study so they were unlikely to be exposed to contemporary nursing ideals of practice or challenges to their own practice.
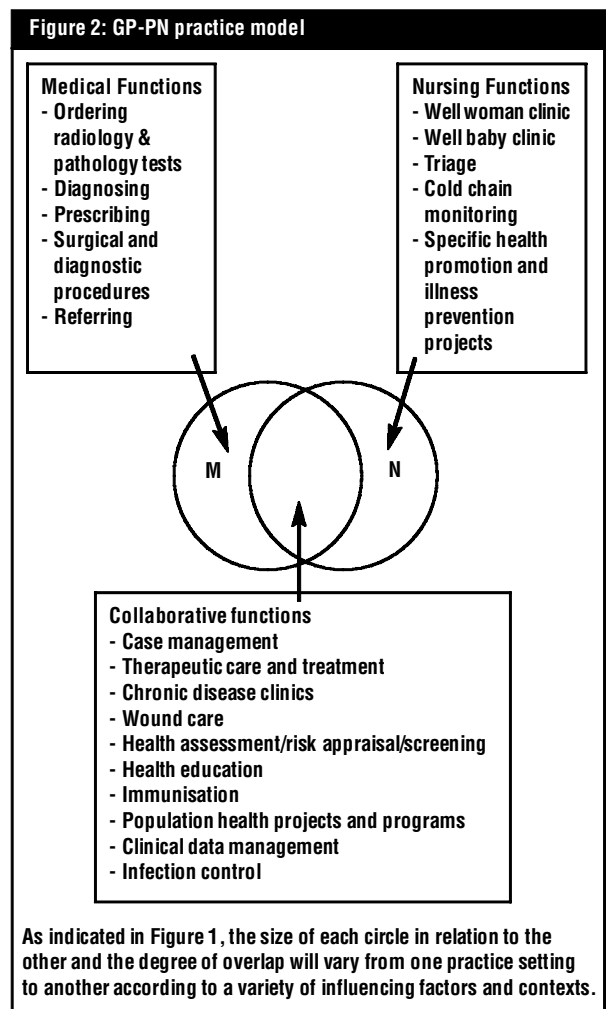
Le Sueur and Barnard (1993) and Patterson et al (1999a) also found that a lack of opportunities for further education was a barrier to the expansion of the PN role in Australia and this was consistent with the situation in the

United Kingdom (UK) prior to the introduction of accredited courses for PNs. These studies indicate that some PNs are availing themselves of opportunities to increase their knowledge and skills about particular aspects of their clinical practice (eg. wound care) resulting in acknowledged expertise (albeit without legitimate power). However, as identified in the UK (Atkin, Hirst, Lunt and Parker 1994), this form of further education only addresses specific shortcomings in knowledge and skills and does not address the overall development of the role. In contrast, a case study presented by Pearson, Hegney and Donnelly (2000) demonstrates that, despite economic and legislative restrictions, PNs in Australia can achieve significant role expansion when they are adequately and appropriately educated.

Moving from medical substitute to collaborative practitioner

The concept of collaborative practice and the nature of nursing have been the subject of discussion and debate for many years, particularly in relation to extending and/or expanding the range of nursing responsibilities (Percival 2001). Nursing has undergone a process of growth in its scope of practice through medical delegation, technological advances, physician shortages, reforms in health care delivery and the growth of nursing research and knowledge. Pressure for change has often resulted in legitimisation of the status quo rather than an actual expansion of role.

While some local areas or states in Australia may have been active for a time in trying to promote and develop practice nursing, it has only been since the beginning of this century that significant national activities have taken place. The Australian Practice Nurse Association (APNA) and the National Steering Committee on Nursing in General Practice have been established while postgraduate courses specific to practice nursing have been implemented. Practice nursing in Australia now stands poised for an exciting future, not just in terms of a new specialty area within nursing, but in terms of its potential contribution to population health. Overseas studies (see for example Atkin and Lunt 1996; Charlton, Charlton, Broomfield and Mullee 1991; Dent and Burtney 1997; Drury, Greenfield, Stilwell and Hull 1988; Hibble 1995) have indicated that PNs, with appropriate education and experience, can and do practice effectively across a range of activities from medically prescribed to autonomous. Findings from these studies provide some indication of how GPs and PNs can function collaboratively (see Figure 2). However, it must be noted that Australia has different funding arrangements from those in the UK where these studies were undertaken. In Australia, the current fee-for-service funding of general practice would not easily facilitate such functioning. In addition, it is likely that variations in GP-PN functioning will occur from one practice setting to another due to location (urban, rural or remote), community profile (age, ethnic origin, socio-economic status, identified health targets), supply of doctors/nurses, access to

Figure 2: GP-PN practice model

Medical Functions
- Ordering radiology & pathology tests
- Diagnosing
- Prescribing
- Surgical and diagnostic procedures
- Referring

Nursing Functions
- Well woman clinic
- Well baby clinic
- Triage
- Cold chain monitoring
- Specific health promotion and illness prevention projects

M   N

Collaborative functions
- Case management
- Therapeutic care and treatment
- Chronic disease clinics
- Wound care
- Health assessment/risk appraisal/screening
- Health education
- Immunisation
- Population health projects and programs
- Clinical data management
- Infection control

As indicated in Figure 1, the size of each circle in relation to the other and the degree of overlap will vary from one practice setting to another according to a variety of influencing factors and contexts.

professional development opportunities, and professional and community acceptance or readiness.

After reviewing the theoretical and empirical literature about collaborative practice (in general) and practice nursing (specifically) we make the following recommendations that may help to advance collaborative practice between GPs and PNs in Australia from rhetoric to reality:

- That PNs undertake regular self and/or peer assessment and take appropriate action to improve competence in identified areas of need.

- That PNs identify and articulate areas of expertise within their practice and negotiate with their employer to fully utilise this expertise.

- That PNs seek out and access available educational resources and research data to improve their practice.

- That PNs join a professional interest group, like APNA, to provide a collective 'voice' for their issues and needs, to facilitate the sharing of knowledge and skills and to promote their professional identity.

- That PNs, with GPs, seek out funding to support specific projects that enhance the potential for collaborative practice for specific population groups.

- That APNA encourage its members to engage in

education that promotes and facilitates comprehensive role development in addition to any that addresses specific shortcomings in skills.

- That providers of nursing and medical education investigate and utilise shared educational opportunities for nursing and medical students/practitioners in order to promote a better understanding of each other's knowledge and skills and more collaborative relationships.

- That further research is conducted to evaluate different practice models involving PNs with respect to defined patient outcomes and cost effectiveness.

CONCLUSION

This paper has brought into focus factors that have constrained or enhanced collaborative practice between PNs and GPs. It has identified that constraining forces have outweighed those that are facilitative, resulting in a nursing role that has been limited in scope and function. Identifying and highlighting these forces may enable PNs, both individually and collectively, to better understand their role in the wider context of health care. Greater awareness can be instrumental in empowering nurses to strive for an enhanced role if they choose. While nurse academics and others in positions of influence can provide the potential for PNs to expand their roles through advanced education and lobbying government, there has to be a considerable degree of intrinsic motivation on the part of the PNs to change. The extent to which this motivation will lead to a different reality in future depends on widening the circle of collaborative practice, both inter and intra professionally.

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