EXPLORING THE ROLES OF NURSE PRACTITIONERS IN FIJI: A CRITICAL SOCIAL THEORY PERSPECTIVE

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For the Doctor of Philosophy

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I declare that this thesis is my own work and has not been submitted in any form for another degree or diploma at any university or other institution of tertiary education. Information derived from the published or unpublished work of others has been acknowledged in the text and a list of references is provided.

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STATEMENT OF THE CONTRIBUTION OF OTHERS

This thesis has been made possible through the support of many people, as follows:

Supervisors:

Primary Supervisor: Professor Kim Usher, School of Nursing, Midwifery and Nutrition, James Cook University.

Secondary Supervisor: Professor Colin Holmes, School of Nursing, Midwifery and Nutrition, James Cook University.

Peer reviewers:

Professor Karen Francis: School of Nursing and Midwifery, Monash University.

Professor Anne Gardner: Chair of Tropical Nursing, Townsville.

ACKNOWLEDGEMENTS

I liken the writing of this thesis to the running of a marathon, a feat I successfully completed for the first time in 2007. In both cases arduous training was required which, if not done, would find one mentally and physically unprepared for the rigours associated with the task. During the run, there were times when it was effortless and others when it was a real 'grind'. To cross that finish line exhausted but satisfied with my effort was a feeling I will never forget. So too the journey undertaken during my years of candidature. Instances of inspired insight were mixed with long periods of sheer persistence, as I experienced the highs and lows of producing an original piece of work. Like running a marathon, to complete this work I knew that it could only be done as I took each step. Doing this, the finish line would look after itself.

Projects such as this cannot be completed without the visible and invisible contributions of my supervisors, colleagues, family and friends. I am deeply indebted to my Principal Supervisor, Professor Kim Usher, whose mentorship, guidance and encouragement throughout the highs and lows were invaluable sources of support. Sincere thanks also go to Professor Colin Holmes, my co-supervisor, who always brought a different perspective and thus challenged me to run harder, further, for longer, and explore different paths along the way.

I must also express my sincere appreciation to all the participants in this study, particularly the Fijian Nurse Practitioners. You are truly inspirational and I hope that I have helped to give voice to your struggle as you provide a unique level of care to your communities.

Most importantly, I wish to thank my family, friends and work colleagues for their encouragement and support, especially my fellow PhD student Lee Stewart who led the way and inspired me to follow. To my wife Joan and children Travis, Meagan and Daniel I offer my thanks for your patience and support and granting me the 'space' to complete this journey. To my mother, Joy, sister Margaret and brother Bruce I thank you also for your encouragement and interest throughout this journey.

I dedicate this thesis to my father John Murray Lindsay, who died suddenly before seeing it completed. Your scholarly example, unwavering belief in me and continued interest in this project are embedded within every word.

KEY TO TRANSCRIPTS

In the presentation and analysis of the research findings (Chapters 4, 5 & 6), where excerpts from the participants' transcripts are included, the following abbreviations and font styles have been used:

Long quotes: The names of the participants within this study have been presented as pseudonyms. Quotes are indented, italicised and within single inverted commas. I am identified as DL. Pseudonym name, transcript page and sentence number/s identify excerpts from participant interviews, for example as follows:

> *'Take for instance in ah rural health centres ah and I think also from maybe anecdotal ah reports of MBBS graduates going to the health centres and after serving one or two years, coming back and telling their supervisors that it was a waste of time, you know training for full six years, going to the health centre and see only maybe 10 patients and maybe out of those 10 patients you are doing five dental extractions because you do dental extractions too, so (short laugh) whether it's worth it or not…'*
>
> (Paul, p. 2, 45-51).

[ ] has been used to indicate if words have been left out of a quote, usually for the sake of brevity.

Short quotes: Where a word or words have been included within a sentence, this has been identified by using single quotation marks, for example as follows:

'I just treat them' (Pasepa, p. 3, 66).

Additional information True to the critical discourse analytic approach used to interpret the data, additional information is included where a word or words were said more forcefully, more softly, included significant body language or there were other external factors that impacted on the linguistic features of the text. The use of brackets and italics identify such instances, such as follows:

(*Says*) WINET (*then spells out W I N E T*) (Alumita, p. 18, 507)

ABSTRACT

Background

Rapidly changing patterns of health service delivery, together with an increasingly globalised health workforce have strongly influenced, and also been influenced by, the development of the nursing profession. One significant outcome of these changes has been the emergence of advanced clinical practice roles, including that of Nurse Practitioners (NPs) (Pearson & Peels, 2002). Many countries around the world now utilise NPs in specialist roles within hospital or community settings, and/or in rural areas which are often under-served by medical and allied health personnel and associated primary, secondary and tertiary health care services. Considerable research has been conducted exploring the roles of NPs in developed countries such as the United States of America, Australia and the United Kingdom, yet there is a paucity of studies which focus on these roles within smaller, non-western countries such as Fiji. This study describes the unique, multidimensional role of NPs in Fiji and the vital role they play in the delivery of health care, predominantly in remote inland or small island communities. The many barriers and difficulties experienced by NPs in Fiji in the delivery of their role are described, and contextualised within the complex and at times highly unstable socio-political milieu that has characterised Fiji in recent years. Exploration of the NP role in Fiji has been chosen for the following reasons:

- The NP role in Fiji has only been implemented within the past decade, thus as an advanced nursing role and wider health workforce initiative, it is in its early stages of development;
- No published studies have been found that focus on the role and experiences of NPs in developing countries in the Western Pacific region;
- Research into the NP role will provide a valuable resource within Fiji and also within the broader discourse on NPs in developing countries;
- Fiji's complex socio-political and cultural climate offered a fertile context within which to explore the development of this important nursing role.

Research question

What can be learnt from NPs and key stakeholders in Fiji that will contribute to improving the professional role and function of NPs, and increase their recognition and effectiveness within the health workforce?

Aims

The main aims of this study were to:

- Describe the evolution of the NP role in Fiji, within the context of health care provision in remote areas;
- Examine the different clinical contexts in which the NPs practice and their interprofessional relationships with other members of the multidisciplinary team;
- Document the professional barriers described by the NPs in the implementation of their role and,
- Identify strategies to support the NPs and enhance their role within the health workforce in Fiji.

Methodology and method

Critical inquiry was employed as the methodology by which to explore the professional world of Nurse Practitioners in Fiji, with its emancipatory, change oriented goals and premise that relations of power, oppression, domination and inequality exist within society. Use of the case study method enabled identification of Nurse Practitioners in Fiji as the case, and informed decisions regarding data collection and use of a variety of data sources including nineteen interviews with NPs and other key stakeholders, newspaper articles, Government documents and World Health Organization reports. Utilisation of this method provided thick, multi-perspective descriptions that optimized the opportunity for me to understand the case.

Interpretive framework

Based on the view that discourse and discursive practices are situated within a broader social sphere, and with its focus on the linguistic features of a text, Fairclough's three dimensional framework for critical discourse analysis was applied to examine the sources of data used in this study. Few nursing oriented studies have specifically applied this

framework, and it proved to be highly effective in assisting me to link texts with discursive and socio-cultural practices.

Findings and conclusions

This study identified that the professional world of the NPs in Fiji contains evidence of disempowerment and exploitation, which negatively impacts on the effectiveness of the role and their development as a vital component of the workforce. New models of health care delivery now exist as NPs have become established in remote communities, and also been utilised within a variety of clinical contexts in regional, peri-urban and urban settings. Significant scope of practice issues arise when NPs work outside their clinical protocols and as defined in the Nurse, Midwives and Nurse Practitioner Act, 1999. NPs in remote areas work at the nexus between traditional and allopathic approaches to medicine, though the latter (and its associated discourse) is being subjugated by the former. The NP role in Fiji comprises a truly unique blend of nursing, midwifery, public health, primary care, primary health care and health promotion. The NPs lack a professional identity and voice, and remain a relatively disparate group despite the importance of their role.

Significance

This study has demonstrated that the NPs in Fiji provide health care which uniquely blends knowledge and skills from the fields of nursing, midwifery, primary medical care, public health and health promotion. It identified that articulation of these many fields within the one role requires more substantial educational preparation, greater ongoing professional support, and a career structure that reflects the advanced nature of the role. Much can be learned by foregrounding these issues, not only for the Government, key stakeholders, professional groups and consumers in Fiji, but other countries in the Western Pacific and, indeed, beyond. Moreover, highlighting the difficulties experienced by the Fiji Government in implementing an appropriate model of health professional and health care delivery for remote areas also assists organizations involved in health policy and health workforce development, such as the World Health Organization and the many aid organizations on which Fiji relies for support. By raising awareness of the social,

cultural, political, religious and historical factors that have impacted on the health workforce in Fiji, and the effects they continue to have on the NPs and the communities they serve, it is hoped that strategies can be implemented to ameliorate their effects.

This study also described, for the first time, the experiences of Fijian NPs working at the interface between traditional and allopathic approaches to medicine, and the challenges this presented for the NPs and people in remote communities, in particular. This provides much needed insights into a previously unexplored dimension of the NPs role, and offers a potentially important area for further inquiry. Lastly, it is clear that a policy of Feldsherism, where mid-level practitioners are developed as a 'stop-gap' response to an acute shortage of physicians, is no longer an appropriate health workforce model in countries such as Fiji. The NPs have clearly demonstrated that they are able to provide a comprehensive, safe and sustainable level of care to rural and remote communities, and should therefore be supported and recognised for this vital role that they play within the wider health system. They are not merely doctor substitutes, but leaders and pioneers in providing a unique and legitimate level of health care that effectively addresses a broad range of health care needs in these communities. Increasingly, they are also being utilised in regional hospitals, peri-urban health centres and urban hospital and community mental health settings. This study provides important new evidence that the NPs are significantly changing the skill-mix of nurse and doctors across a broad range of practice settings, and draws attention to the urgent need for a review of their educational preparation, scope of practice, careers structure and professional development.

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CHAPTER 1: SETTING THE SCENE

Introduction

In this chapter, I provide the background to this research and situate it within the global and historical contexts of health and health workforce development. The issue of rural to urban migration is discussed in terms of its impact upon health services and the health workforce and it will be shown that these processes have contributed to the development and evolution of advanced nursing roles, notably that of the Nurse Practitioner (NP). This process has not been without its hurdles, and a number of barriers to the implementation of the role are described. Post-colonial theory is introduced as an important contextual factor in the development of Fijian society, and ways in which it intersects with this study are identified. I also outline why Fiji was chosen as the site for this study, and propose a number of important reasons for its significance. Lastly, I detail the aims of the study and set the scene for the ensuing literature review.

To highlight the difficulties associated with providing a health workforce across Fiji's widely dispersed geography, the chapter begins with a brief overview of these areas.

Fiji – demographic and geographic profile

There is copious information about Fiji, either published or available via the Internet. For example a recent, thorough overview of Fiji has been published by the Fiji Ministry of Information & Media relations (2003). Entitled "Fiji Today", it describes issues such as the geography, economy, government, trade and investment, agriculture, tourism and health and education. This publication is critiqued later in this thesis in relation to its descriptions of nurses and NPs.

The Fiji archipelago is comprised of approximately 320 islands, located between 16^{o} and 20^{o} South, 177^{o} West and 175^{o} East, placing it within the South West Pacific Region. Four major islands form the group – Viti Levu, meaning Big Fiji, Vanua Levu, meaning Great Land of the people, Taveuni and Kadavu. Most of the islands are volcanic in origin, while limestone reef deposits and coastal sediments have formed others (Ryan 2000). Approximately 240 islands are uninhabited, and most of the 800,000 people who live in Fiji are based in urban areas (Sharma, 2002). The following map of Fiji shows the dispersed nature of the Fiji Islands.

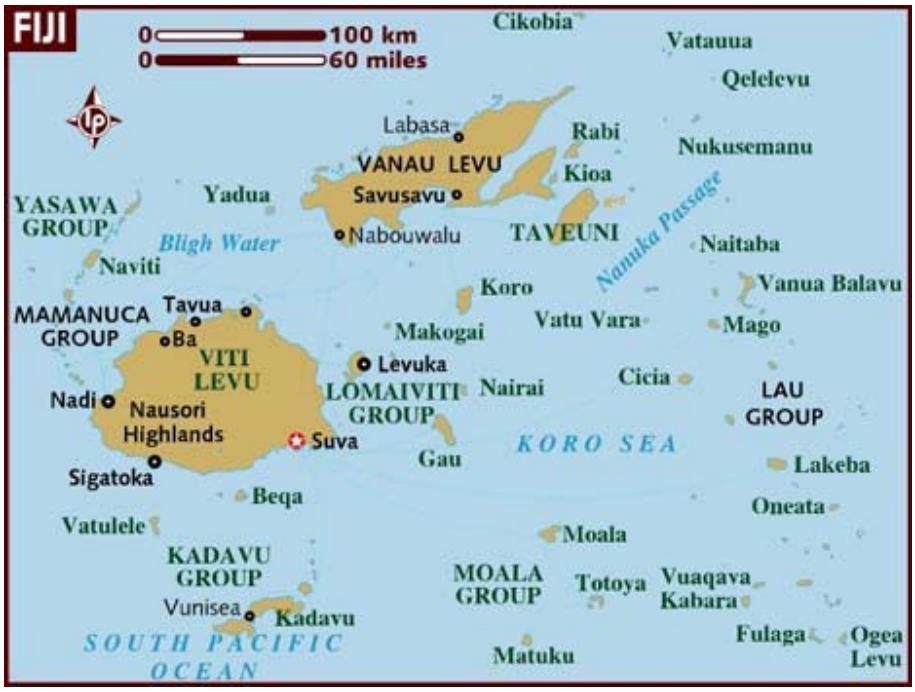

Figure 1 Map of Fiji obtained from http://www.lonelyplanet.com/maps/pacific/fiji/ on 26th April, 2008.

The mountains in the interior of the main islands create a rain shadow, thus making the western areas drier than the east, which predominantly receives its rain via the southeast trades. Colloquially, the local Fijians call the western areas of Viti Levu "the burning west" because of its dry weather in comparison to the wetter, eastern side. Rugged highland areas are characterised by dense rainforests interspersed with large expanses of bare, weathered rock. Along the many rivers that lace the inland regions of the main islands are small rural communities, populated by indigenous Fijians**.** Cultural factors, such as the strong family ties and ownership of land by native Fijians sees many of them living in villages dispersed across the many Islands that comprise Fiji. Many of these islands are quite isolated, have small populations and limited infrastructure other than that needed to maintain the lifestyle of their inhabitants.

Lowland and coastal areas are comprised of rainforests, mangroves, swampy marshes, mixed grassland, coral reefs and inland lagoons (Ryan 2000). Known as a popular destination for tourists, Fiji's blend of Melanesian, Polynesian, Indian, European and

Chinese cultures is reflected in the food, language, religious practices and architecture evidenced throughout the many Islands (Jones & Pinheiro, 2000).

Fiji is endowed with forest, mineral, and fish resources, and is one of the most developed of the Pacific island economies, though still has a large subsistence sector. Sugar exports and a growing tourist industry are major sources of foreign exchange, though growth slowed in 1997 because the sugar industry suffered from low world prices and rent disputes between farmers and landowners. Drought in 1998 further damaged the sugar industry, but its recovery in 1999 contributed to robust GDP growth. Long-term problems include low investment and uncertain property rights. The political turmoil in Fiji has had a severe impact with the economy shrinking by 8% in 1999 and over 7,000 people losing their jobs. Repeated coups d'etat have been a primary reason for the dramatic workforce shortage experienced across a range of sectors, including health. As will be discussed throughout this thesis the widely dispersed population, economic downturn, internal political turmoil and emigration of many medical officers has contributed to the Government needing to explore new health workforce models, particularly in remote areas.

Human resources for Health 'in crisis'

The WHO in the Western Pacific's *Regional Strategy on Human Resources for Health 2006-2015*, quoting the *World Health Report 2006*, describes the current global health workforce as being in crisis. The *Strategy* outlines a number of health workforce challenges in the Western Pacific Region, including:

- Skill mix imbalances that create inefficiencies;
- An uneven distribution of workers made worse by unplanned migration from rural to urban areas and abroad;
- Poor salaries and remuneration;
- Work environments with inadequate facilities, medical supplies and equipment, and
- A weak health workforce knowledge base which hampers planning, policy development and programme operations.

In addition to these challenges, population aging, the growing burden of chronic disease, the trajectory of the HIV/AIDS epidemic, emergence of diseases such as severe acute respiratory syndrome (SARS) and avian influenza, as well as natural disasters such as floods are all having a profound effect on the health of Fijians, which creates an enormous burden for the Government and frontline health care providers such as NPs. Importantly, the *Regional Strategy* mentioned above recognised that the health workforce crisis that exists "cannot be effectively resolved without taking into account the broad context of health systems, such as infrastructure, technology, logistics, supplies and financing, as well as the need for a coordinated, multisectoral approach and effective partnerships." (p. 5). In the context of this study, it will be shown that the emergence of the NP role in Fiji resulted from a substantially diminished medical workforce, particularly in remote areas but also in some peri-urban and urban centres. Thus, they not only continue to be directly affected by these issues but in fact exist as a result of them. Political upheaval and the *coups d'etat* have substantially compounded this situation in Fiji, and dramatically weakened the capacity of the interim Government to provide leadership, good governance, strategic and policy direction to a health sector already under considerable duress.

Health services and health professional education in Fiji

The major hospital, the Colonial War Memorial Hospital (CWMH) is located in Suva. It has approximately 500 beds, a hyperbaric Unit to treat diving injuries, an extremely busy midwifery Unit (Fiji has double the birth rate of Australia), and is the major referral and teaching Hospital for Fiji. There are also three specialised hospitals located in Suva, providing services in the areas of tuberculosis (Tamavua Hospital), Psychiatric services (St. Giles Hospital), and leprosy (P.J. Twomey Hospital). Overall, the curative and primary care services in Fiji comprise 16 Hospitals, 74 Health Centres, 100 Nursing Stations and 3 Aged care Homes. The Fijian peoples' health needs are met by the network of health centres located in both regional and rural areas, and by nursing stations in the more remote locations. Private health services in Fiji have been on the increase since 1987. There is a modern private hospital in Suva, although the cost of admission is beyond the means of the vast majority of Indigenous Fijians.

Fiji has a medical school and two nursing schools. All medical and allied health education takes place within the Fiji Medical School. There is a shortage of qualified medical officers in Fiji and as a result, it is difficult to attract them to rural and remote areas. As mentioned above, political instability and offers of better pay and conditions have also contributed significantly to the drain of medical graduates to overseas positions. The doctors' grievances began after the military coups in1987, when about 120 doctors fled the country, taking their much-needed skills with them and leaving the medical profession in limbo. For those who stayed in Fiji and remained in the public service, the Government allocates the area in which they will work, as they prioritise medical officer placements. Overseas doctors are recruited where possible but the salary is not sufficient to make it attractive to doctors from many countries. As a result, Registered nurses are the mainstay of the Fijian health workforce, particularly in rural and remote areas. Increasingly, they are also being enticed to overseas positions, with many going to New Zealand, Australia and the United Arab Emirates, for example. As this study will show, the political environment in Fiji over the past two decades has largely contributed to the changing skill mix within the health workforce, and subsequent emergence of the NP role.

Burgeoning rural-urban migration: its effect upon health services and the health workforce

Rural to urban migration is not a new phenomenon, nor is it limited to Fiji. Many minority and majority world countries are experiencing this burgeoning, urbanizing trend (Wu & Zhou, 1996; Rye, 2006) and its various effects across many sectors of society, particularly the economy and associated labour markets (Kuznets, 1955; Harris & Todaro, 1970; Stark & Bloom, 1985; Bhattacharya, 1993). Like other countries, life in rural and remote areas of Fiji is markedly different to that in urban areas, with the former characterised by semi-subsistence farming, low rates of paid employment, high rates of poverty and lower living standards (Gounder, 2005; United Nations Development Programme, 2007). In addition, there is significantly reduced infrastructure, including a lack of telecommunications, unsealed roads and poor transport services, few retail agencies, low access to electricity, reduced educational and health facilities, improper sanitation facilities and reduced access to a reliable and safe piped water supply (Asian

Development Bank, 2003). The Fiji Government's '50/50 by Year 2020' plan recognised that both 'push' and 'pull' factors were contributing to urbanization, stating that "Although Fiji's socio-economic development status has improved significantly over the last three decades, considerable disparities still exist in the distribution of the benefits of development between rural and urban areas, as well as between provinces. As already indicated, 59% of indigenous Fijians live in rural areas principally as subsistence farmers, and the majority lack access to basic social services. Urban migration has been increasing and it is likely that this has been encouraged to some extent by the poor living condition in some rural areas." (Fiji Government, 2002, page unnumbered).

The 2007 *Population and Housing Census* indicated that compared to the last census (1996), the rural population in Fiji had decreased by 8,768 and the urban population increased by 61,591 (Fiji Islands Bureau of Statistics, 2007). Whereas a decade ago there had been approximately 54% of the population living in rural areas, based on the latest data it is now less 50%. This 4% difference is not large, and may be explained variously as a reliability error in the survey method, the terminology or definitions used, or the methods of statistical analyses and interpretation. Alternatively, it may due to lower population growth in, or emigration from rural areas, or as a reflection of the gradual suburbanization of areas previously counted as 'rural' and the resultant change in geographical boundary changes rather than a population movement *per se*. Notwithstanding these considerations, there appears to be a continuing shift in the rural-urban population, with both Indigenous Fijian and Indo-Fijian populations migrating to urban areas in large numbers. For many Indo-Fijian families, rural-urban migration has resulted from the non-renewal of sugar cane land leases, which also meant displacement from their homes and relocation to squatter settlements in peri-urban areas (Lingam, 2005). Insecure land tenure has thus caused significant hardship for many displaced Indigenous Fijian and Indo-Fijian families, many of whom had been cane farmers for generations. Families who moved from rural to urban locations seeking better employment opportunities also often lacked housing in these areas and had to rely on relatives, friends or squatter settlements for shelter.

As noted in a recent *Asian Development Bank Report* (2003), Indigenous Fijians are not exposed to the same 'push' factors as Indo-Fijians, but are attracted to urban areas by

'pull' factors including improved access to training, paid employment, schools, health services and other social and economic resources. The impact of this dramatic rural-urban population shift in Fiji has been discussed elsewhere (Reddy, Naidu & Mohanty, 2003; Lingam, 2005; Mohanty, 2006). It is important to acknowledge here the changing rural-urban population profile and consider the associated implications for health and health care. Clearly, a trend toward greater urbanization is placing increased pressure on health services in these areas, and also impacting on the social determinants of health, such as adequate housing, unemployment and safe workplaces (Gounder, 2007). With minimal health infrastructure and a reduced health workforce, people in remote communities are significantly disadvantaged in comparison to those in regional or urban areas. As the Commission on the Social Determinants of Health (2007, p. 14) has stated, "All societies have social hierarchies in which economic and social resources, including power and prestige, are distributed unequally." The unequal distribution of health resources across the remote-urban continuum impacts negatively on the health of the most disadvantaged, who in Fiji are most likely to be Indo-Fijian women in remote areas (Chattier, 2005). Moreover, Indo-Fijian women are more likely than not to be the victims of domestic violence (Lateef, 1990). The subordinate status of women has been identified as a key obstacle to alleviating their poverty (WHO, 2002), and women in many countries have been found to be victims of high rates of domestic violence, abuse and socioeconomic deprivation (Standing, 1997; Braveman & Tarimo, 2002).

Thus, from a critical perspective, issues of power inequality in relation to health services are simultaneously evident across a number of dimensions, namely geographic location, ethnicity and gender. Of salience to this study is the fact that NPs working in remote areas are regularly engaging with some of the poorest and most disadvantaged people in Fiji. No published literature could be found that described this phenomenon, and the voices of these nurses and the vital work they undertake is thus unheralded outside Fiji and largely taken for granted within it. As mentioned earlier, an intention of this study is to illuminate the professional world of these NPs, and it is evident that continued rural to urban migration is having a negative impact on health services in many remote communities. For NPs who live and work in rural locations, these are significant issues not only for themselves and their families but also the communities in which they are

located. These issues may also be disincentives to potential students considering the NP role as a career option. I take up this point later in this thesis in a discussion regarding the notable absence of Indo-Fijian NPs, in particular the perceptions as to why this has occurred.

It is likely that the current internal migration trajectory toward urban areas will continue, and directly impact health systems across all levels of the remote-urban continuum. Considerable work is being done at the regional level to address these effects, yet for the NPs in remote areas they constitute enormous challenges, and add substantial stress to an already complex, difficult and challenging role.

The Millennium Development Goals

In the year 2000, all United Nations Member States adopted eight Millennium Development Goals (MDG), which provided a global framework to address the key determinants of poverty in developing countries. The target date for achievement of these goals is 2015 (United Nations, 2007). These eight goals are:

Goal 1: *Eradicate Extreme Poverty and Hunger*

Goal 2: *Achieve Universal Primary Education*

Goal 3: *Promote Gender Equality and Empower Women*

Goal 4: *Reduce Child Mortality*

Goal 5: *Improve Maternal Health*

Goal 6: *Combat HIV/AIDS, Malaria and other Diseases*

Goal 7: *Ensure Environmental Sustainability*

Goal 8: *Develop a Global Partnership for Development*

Each of these goals has an associated target; for example, the target for Goal 5:*'Improve Maternal Health'*, is to 'reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.' (United Nations, 2007, p. 16). Fiji was a signatory to the Millennium Declaration (2000) and is committed to the achievement of the above goals by the target date (Fiji Government, 2004). As stated in the National Report on Fiji's progress toward achieving the MDGs:

> In the past decade, however, political instability, economic down-turn, concerns over law and order, growing pressure on the environment and on social services, an eroding sense of community, and a widening gap between the rich and the poor have diminished the quality of life for many people. There has been a fundamental shift in lifestyles over recent decades, and the decrease in deaths from infectious causes has been partly countered by increased deaths from degenerative and chronic diseases, principally diabetes, circulatory diseases and cancer. There is an increased vulnerability to poverty. Many rural people have migrated to town, and many skilled people overseas.
>
> (Fiji Government 2004, p. 2)

It is evident that Fiji faces many internal challenges if it is to achieve the MDGs by 2015. For example, the recent Fiji Poverty report (2007) identified that over 25% of households were living below the poverty line, with many others living in a highly vulnerable state wherein loss of their livelihood, an accident, a family row, or the injury or untimely departure of a bread-winner would place them in an impoverished state (United Nations Development Programme, 2007, p. 3). The burden of non-communicable diseases (NCDs) such as diabetes and obesity is also increasing and maternal and child health also remains an area of enormous challenge. High incidences of infant malnutrition and maternal anaemia have been identified (Food and Agriculture Organization, 2003), and basic public health infrastructure such as safe water and proper sanitation are problematic in many rural communities, as well as in squatter settlements in urban areas (Asian Development Bank, 2003). While Fiji is progressing better than many other Pacific Island countries toward achievement of the above MDGs, there are clearly a number of areas where considerable investment and change needs to occur.

Goals 4, 5 and 6 are those that particularly come within the remit of the NPs, yet there does not appear to be a coordinated, national approach which engages these highly trained and experienced nurses to work in specifically targeted environments where their knowledge and skills would be best utilised. With their nursing, primary care, maternity and public health expertise they clearly are a potentially powerful group for bringing about change, yet because of their relatively low numbers and dispersed deployment they

remain a significantly marginalised component of the health workforce. It is suggested that they are also underutilised in terms of their contribution to decision making regarding health in remote communities. When asked during interview about their involvement in decision making outside their clinical roles, all the NPs bar the one who was the President of the Fiji Nurses Association stated that they did not have any time to be involved due to their constant and heavy clinical load, and opportunities were certainly not created for them to contribute in this way. It is suggested that this reflects their lack of voice and identity, and further reinforces their state of disempowerment as a group.

Postcolonial theory – its relevance to this study

While this study has not been underpinned by postcolonial theory, it is appropriate given the discussion thus far to acknowledge the growing corpus of work devoted to exploring elements of Fiji's more recent history through a postcolonial lens. In particular, it is important to identify how and where this theory might intersect with this current study, which focuses on the professional world of NPs in a country still shaking off the vestiges of British colonialism. Like other critical theories, post-colonial theory is somewhat vexed and slippery to define; moreover, when these terms are joined as 'postcolonial critical theories', the potential for added complexity and confusion becomes more acute (Mohammed, 2006). Slemon (in Castle, 2001, p. 100), has noted, "probably no term within literary and critical studies is so hotly contested at present as is the term "post-colonial"; probably no area of study is so thoroughly riven with disciplinary self-doubt and mutual suspicion." Not surprisingly, this lack of clarity and consensus about the meanings, purposes and validity of postcolonial critique has given rise to impassioned polemics and polarised views, but along the way created a rich ferment of debate and discourse within a variety of spheres, such as the social and political sciences, and literary, historical and cultural studies (Barker, Hulme & Iversen, 1994; Mishra & Hodge, 2005). As a result, post-colonial theory, post-colonial*ism* and one of its cognates postmodern*ism* has had as many critics as champions, with authors interrogating and applying the terms in a plethora of ways and within myriad contexts (McClintock, 1992). For the purposes of this study, the hyphenated term 'post-colonial' provides a temporal marker that distinguishes it from pre-colonial and colonial eras, and generally refers to countries that had once been colonies but are now independent (Barker, Hulme &

Iversen, 1994). Postcolonialism and postcolonial theory, on the other hand, refers to the wider analytical field of study that is concerned with "Western structures of knowledge and power, particularly those of the post-Enlightenment period." (Mongia, 1996, p. 2). The seminal work of Edward Said, *"Orientalism"*, published in 1978, has been widely recognised as a major springboard for the development of postcolonial theory and postcolonial discourse analysis, with its focus on unmasking the 'ideological disguises of imperialism' (Gandhi, 1998, p. 66; Moore-Gilbert, in Elliott & Ray, Eds., 2003; Mishra and Hodge, 2005). Importantly, Said argued that to understand Orientalism one had to examine the discourses and associated knowledge that were shaped and controlled by it, including how this knowledge was produced and disseminated through various text forms, including philology, art and political science (Mongia, 1996). It may therefore be included under the broad umbrella of critical discourse analyses that interrogated narratives of nationalism, modernity as progress, and the tenets of freedom and democracy, which underpinned the Enlightenment project (Mongia, 1996).

As mentioned, postcolonialism and postcolonial theory have been embraced by scholars representing a wide array of disciplines and, for the field of health care and nursing, offers a way in which to further articulate 'subjugated knowledges' and 'existing inequalities' in relation to health and illness (Kirkham & Anderson, 2002, p. 1). These authors, both of whom are nurse academics, also indicate that postcolonialism is a critical theory, in the sense that it "allows access to the everyday experiences of marginalization, as structured by the micropolitics of power and the macrodynamics of structural and historical nature." (p. 2). Such goals have always been fundamental to the critical project, and much of what is espoused under the rubric of postcolonialism will readily resonate with criticalists who concern themselves with the task of unearthing existing power structures, hegemonic interests, injustices, oppression and domination within the social world (Crotty, 1998). With its focus on themes such as diaspora, subalterns (notably, a Gramscian term), race, subjectivity, power and hybridity, postcolonial discourse adds a fruitful analytic framework by which to conduct critical nursing research (Mohammed, 2006).

As a nation still emerging from a process of de-colonization, and with continuing ongoing political and social turmoil caused by ethnic tensions between Indigenous and

Indo-Fijians that have intensified following the coups d'etat of 1987, 2000 and 2006, Fiji remains significantly fragmented along a number of fundamental lines. These divisions continue to cause many contradictions and conflicts across issues of race, culture, religion, politics and land ownership (Alam, Lawrence & Nandan, 2002). By so doing, they may be seen as instrumental in creating or contributing to systems of oppression by defining the multiple identities of people in terms of their difference. As Mohammed (2006, p. 100) states, "Through discursive practices that have legitimized past injustices and ongoing legacies of oppression, social power imbalances and infrastructures have been constructed that persist today." This is certainly the case in Fiji, as will be highlighted throughout this study. For example, the gap between traditional and mainstream, allopathic approaches to health care described later in this thesis may be interpreted as being a result of the 'exoticization' of traditional medicine, but this gap only exists as a social construction in respect to the dominant Western biomedical model which is supposedly the 'gold standard' against which all others are compared. Thus, de-centering mainstream medicine and its hegemonic effects in favour of a culturally and historically grounded epistemology of traditional medicine would be a goal of the postcolonial project in countries such as Fiji.

The very act of hyphenating the signifier 'Indo-Fijian' also reinforces an 'other-ness' and difference that reflects a wider process of racialization that pervades contemporary Fijian society and (re)produces echoes of imperial exploitation and the colonial project (Kirkham & Anderson, 2002). Contestation and problematization of these processes is fundamental to the postcolonial project, together with an interrogation of other socially constructed, colonialist essentialisms (Mohammed, 2006). Much has been written regarding the influence of postcolonialism on these issues, and in the context of this study they may be conceptualised in terms of their impact on the health of communities, and thus health care professionals such as NPs who live in those communities and also provide care to them. As Anderson (2004, p. 240) has poignantly stated, "What makes this discourse especially pertinent to nursing science is that it focuses our attention on the processes of dehumanization and human suffering throughout history, and gives us a context for understanding health inequalities. *It brings to the forefront the issue of 'race' and makes explicit how this socially constructed category has been used in the colonizing*

process, and the effect that this has had on peoples' lives and life opportunities." (italics included in the original). There is a clear challenge for the nursing workforce in Fiji, and the NPs as a minority group within it, to interrogate ways in which their practices and professional relations serve to either reinforce or ameliorate unequal power relations between the two major ethnic groups in that country. Theoretical 'space' needs to be created where issues of difference, racialization and 'Othering' can be explored within the contexts of nursing and health care; such space does not currently exist in any overt fashion within Fiji, and there is an urgent need to create opportunities for the development of a Fijian nursing scholarship that articulates such issues in a culturally appropriate manner. In particular, the voices of the NPs need to inform and shape the discourse that emerges from this field of scholarship, for they bring a unique perspective that traverses the boundaries of a number of health professional groups. All of the NPs have also lived through and encountered first hand the recent coups, and experienced their impact on the health and well being of all Fijians, and continue to work with some of the most marginalised, racialised and disempowered people in remote communities. Giving voice to these NPs has been a goal of this study, and care has been taken throughout to avoid making assumptions and impose personal biases or agendas on the data. Moreover, as a researcher it has been important to be sensitive to postcolonial constructions of 'Other', and 'Othering', which as Kirkham & Anderson (2002, p. 6) note, "is an act of representation by which identity is assigned, human existence is categorized, people are characterized according to certain criteria (such as worldview or similar anthropological construct), and experiences are homogenised." These authors also highlight the construction of 'self/us' that juxtaposes 'other/them', where white dominant, first world culture is equated, often unconsciously with normality. Maintaining a reflexive stance in relation to the research process and the knowledge created is thus a vital concern of this study, and an important step in its orientation toward praxis. As Mohammed (2006, p. 107) has commented, "Praxis-oriented nurse scholars draw on postcolonialism to explicate the multilayered contexts of social inequalities, advocate for social changes that will lead to improved health, and alter current healthcare practices."

In summary, postcolonial critical theory offers great potential as a research approach for nursing in Fiji, particularly when aligned with discourse analysis. It creates space for NPs

to examine ways in which Fiji's post-colonial, historical, political and sociocultural identity impacts on health and health inequalities, for example in the exploration of the gap between traditional and Western biomedical approaches to healthcare. Importantly, it also has the potential to assist the NPs to examine how their role might reinforce hegemonic structures and maintain unequal power relations as they engage with marginalized and disempowered people in remote communities.

Emergence of NP roles

Over the past 43 years the emergence and evolution of the many NP roles that now exist globally has impacted greatly on the skill mix within health workforce, the planning and delivery of health services in both minority and majority world countries and, most importantly, the profession of nursing itself (Sibbald, Shen & McBride, 2004). Originating in the Unites States in 1965, the NP 'movement' has spread to become a worldwide phenomenon, and along the way produced dramatic changes to health care and the nursing profession (Sheer, 2000). Pulcini & Wagner (2002) have chronicled the growth of NPs and education programs in the United States, noting that the NP role in the US "began more than 35 years ago as a response to shortages of primary care providers especially in rural and urban areas." (p. 51). Rapid growth in the nurse practitioner role in the US ensued throughout the succeeding decades. In 2000, the number of NPs in the US was estimated to be over 78,000 (Pearson, 2001), and in 2008 at the time of writing one could reasonably assume that this number would now have swelled to over 100,000. Many other countries have now also embraced the NP role, including Britain, New Zealand, Sweden, Canada, Africa, the South and Western Pacific and Australia, to the extent that it can legitimately be described as a global movement within the nursing profession. In all countries, the major catalysts for the development of these and other non-physician roles have been the ferment created by health service reform, expanding scopes of nursing practice, increasing physician specialization, the World Health Organization's policy of 'Health for All by the Year 2000' and a shortage of physicians in rural and remote areas (Cawley & Golden, 1983; Brush & Capezuti, 1996). Rural and regional areas have often been linked to NP roles, because they are frequently under-served by medical and allied health personnel and associated primary, secondary and tertiary health care services.

Concomitant with this numerical growth has been a dramatic increase in the number of published journal articles and texts describing aspects of the NP role, such that there now exists a vast corpus of literature related to the topic. Of particular salience to this study is the fact that hardly any of these studies describe the practices of NPs in minority world countries, and even fewer focus on the Western Pacific. None pertain to Fiji. This is of concern, for it means that their unique stories remain largely untold, their voices unheard and their struggle for professional recognition and identity unknown. Consequently, these NPs are unlikely to contribute to or shape the profoundly dominant, western discourse about NPs. As this study will show, there is much that can be learned from these highly skilled nurses, given their unique role within a country confronted with many internal and external challenges. Theirs is a story of overcoming adversity in order to serve their people and their communities, through the provision of a model of care which transcends disciplinary boundaries in order to meet the health needs of those they serve.

Not all smooth sailing

Despite their burgeoning growth, the NP role has at times become highly politicised, ostensibly due to opposition from the medical profession. The nursing profession in Australia, for example, has experienced substantial resistance from some Medical bodies to the implementation of NP pilot projects, despite extensive collaboration and cooperation. In other countries in which NP roles have had a significantly longer history, particularly the United States, barriers to effective collaboration between NPs and physicians have been identified (Phillips, Harper, Wakefield, Green & Fryer, 2002). Such barriers include a lack of knowledge of NP roles and scopes of practice by some physicians, poor communication between NPs and physicians and a lack of respect for the NP role. Strategies to ameliorate these barriers have been suggested (Clarin, 2007), and a raft of studies published exploring collaborative relationships between NPs and physicians, for example Neale (1999) and Hallas, Butz & Gitterman (2004).

In some developing countries, implementation of a variety of mid-level cadres of health worker including Russia's Feldshers, China's barefoot doctors, village health workers, Physician Assistants and NPs has led to the notion of medical 'substitution', implying that primary care is best provided by physicians and that 'the ultimate and lasting solution to primary care problems is to produce more doctors" (Cawley & Golden, 1983, p. 73). It

has been suggested, however, that the term ‘medical substitution’ is somewhat of a misnomer given the absence of internationally recognised health care providers (such as nurses, doctors and pharmacists) in many parts of Asia, South and Central America and Africa (Cawley & Golder, 1983; Dovlo, 2004). Indeed, the legitimacy of the NP role is now unequivocal, such that they can no longer be considered merely as medical substitutes, but increasingly valid and important members of the health workforce in both developed and developing countries. As Cawley & Golder (1983, p. 73) note, “The term feldsherism has been used to denote the policy of using non-physicians to provide primary care.” often during a time of socio-economic and political disruption and subsequent medical workforce shortage in a particular country. Thus they have been seen as an interim or ‘stop-gap’ solution to an acute shortage of physicians. While the implementation of the NP role in Fiji has clearly been as a result of a shortage of physicians in rural areas (i.e. as a result of a policy of feldsherism), it will be shown that they are now an increasing and seemingly permanent component of the health workforce.

A framework for role development

Nurse practitioner roles invariably involve advanced nursing practice, a process of credentialing, attainment of specialised competencies, relevant tertiary qualification at Masters level, increased autonomy and scope of practice yet greater involvement in multidisciplinary teams, legislative protection, increased remuneration and professional recognition (Gardner, 2004; Gardner & Gardner, 2005; Carryer, Gardner, Dunn & Gardner, 2007). Such roles have not been limited to any one geographic *context* of practice, such as urban, peri-urban, rural or remote areas. Nor have they only focused on particular *specialty* areas, such as family health, mental health, Intensive Care or Midwifery. In Australia, the NP role has only relatively recently been defined and documented. Fourteen years ago, Keyzer (1994) described the need for nurse practitioners within the Australian Health system, particularly in rural areas. Citing Trnobranski (1994), Keyzer stated, “The time of the nurse practitioner has arrived and is witnessed by the increasing number of journals, international conferences and published texts dealing with this aspect of nursing.” He further stated, “The time has come for us to create nurse practitioners and nurse-led services in the rural and remote areas of Australia.” (1994, p. 7). More recently, reports on the NP role in Victoria (Dept. Health

& Aged Care, October 2001) proposed a number of models of NP practice, including wound management, haematology and neonatal NPs. The majority of these are rural and/or community based models of practice, and their implementation is yet to be fully trialled. As will be discussed in detail later in this study, the World Health Organization (WHO) has worked closely with many developing countries to implement Primary Health Care principles, carry out health workforce reform and strengthen their nursing workforce management systems.

Identifying intersections with this study

In Fiji, NP roles have not developed within the frameworks described above, nor have these highly qualified nurses been able to develop a coherent professional voice. As has already been highlighted, the NP role in Fiji has rapidly evolved within a particularly complex and unstable socio-political milieu, and nurses in these roles consequently lack many of the desired elements on which to build a robust professional identity. Fiji's well documented political turmoil was a key factor in the emergence of the Nurse Practitioner role. Approximately 50% of the medical workforce, mostly Indo-Fijians, left the country in the last decade, reportedly as a result of political instability which escalated the two military coups of 1987, another in 2000 and also in 2006. These events have heightened socio-political discord and produced dire economic consequences, with reduced investment from overseas, and uncertainty within the Fiji business sector. Not surprisingly, these factors have impacted dramatically on the financial and human resources available within the Fijian health system and, coupled with the burgeoning globalization of the medical workforce, have contributed directly to the emergence of the NP role in Fiji. The Fiji Government has endeavoured to provide an acceptable level of health care to a medically underserved population scattered across thousands of square kilometres of the South West Pacific, via its support for the development of the NP role. These are substantial challenges, and not limited to Fiji. Many other countries with dire shortages of medical officers, such as Papua New Guinea, Indonesia and the Philippines are acting to ameliorate the effect of this crisis by introducing new models of health care practitioner to address the health needs of their populations.

The idea for this study grew out of my professional interest in advanced nursing roles, and experience in visiting Fiji as part of a WHO sponsored project to evaluate the impact

of the NP role in that country. The results of that project have been published (Usher & Lindsay, 2003/4), and collectively these experiences provided the springboard for the in-depth inquiry described within this thesis. During that first visit, I observed that the NPs were facing profound difficulties in the conduct of their vitally important role, and appeared to lack appropriate mechanisms and resources by which they might be addressed. As I reflected on these issues in the formative stages of this study, I came to realise that critical theory afforded a means by which they may be understood and described. I grappled with the language, heritage, major tenets, proponents and critics of that approach to inquiry, and realised that it resonated strongly with elements of my own pre-existing world view. Critical inquiry focuses on unequal power relations, oppression, ideological interrogation, domination, hegemony, injustice and emancipatory praxis, and it thus fuelled the enterprise in which I became immersed. As Crotty (2003, p. 157) declares, critical inquiry "…is at all times alive to the contribution that false consciousness makes to oppression and manipulation and invites researchers and participants (ideally one and the same) to discard false consciousness, open themselves to new ways of understanding, and take effective action for change." Thus, I recognised that throughout the study I had to be prepared to challenge and critique my own assumptions and understandings, and maintain a critically reflective stance that would permeate both my thinking and writing. I was acutely conscious that being a white, male, academic from a wealthy country coming into a different culture for the purposes of conducting a study in order to gain a PhD, would impact on the way the participants interacted with me and responded to my questions. These issues of themselves can create unequal power relations, and I agonised over the potential for the research process to (unintentionally and unknowingly) reproduce systems of oppression (Kincheloe & McLaren, 1994).

With this caveat firmly though somewhat uneasily in mind, I felt that I was able to engage with the participants in a way which helped me to understand more fully the issues they described, how they communicated these to me and the contextual factors behind their descriptions. It also shaped how I listened to, interpreted and wrote about their responses. Importantly also, a number of the NPs at the close of the interviews expressed their great appreciation for the opportunity to express their concerns and opinions, and hoped that by doing so change would occur. I remember feeling a profound

sense of responsibility to ensure that the study would indeed make a positive difference and bring about change that would be empowering for them. As Crotty (2003, p. 157) has noted, “Critical inquiry cannot be viewed as a discrete piece of action that achieves its objectives and comes to a close.”

During the years in which I have been completing this study, the NP role was slowly and sporadically evolving in Australia and one might ask: Why not focus on the evolution of the NP role in my own country? I reflected at length on this question, and concluded that there was a far greater likelihood that the voices of the NPs in Fiji would not be heard compared with their Australian counterparts, and that their role was very different to NPs in Australia. Moreover, as this study will show, when viewed through a critical lens the NPs in Fiji experience significant disempowerment in areas such as influencing Government policy, shaping their scope of practice, receiving remuneration commensurate with their experience, educational preparation and responsibility, and having access to the resources they require to implement their role effectively. Lack of a professional profile also emerged as an important issue that contributed to their feelings of ‘being used’. The compelling nature of these factors brought into sharp relief the difficulties experienced by these NPs in comparison to those in majority world countries such as Australia.

Significance of this study

This study identified the presence of unequal power relations between NPs, their medical counterparts, and bureaucrats within the Fiji Ministry of Health. This was found to be evidenced within the discourse surrounding the NP role, as well as in many of the practices and processes involving how the NPs were deployed as a component of the health workforce. It also drew attention to the unique, multi-faceted role of the NP in Fiji, which blends knowledge and skills from the fields of nursing, midwifery, primary care, public health and health promotion. The adjective ‘unique’ is not used lightly; they perform a role that is truly distinctive and it is reasonable to say that they are in fact now irreplaceable. Without them, people in remote areas would simply not have local access to such comprehensive health care, and would have to travel long distances to receive similar care, and that by a number of different health professionals.

The study also demonstrated that more substantial educational preparation, greater ongoing professional support, and a career structure that reflects the advanced nature of the role is required. Some of these issues were reported earlier by WHO consultants, yet they remain significant disincentives to the recruitment of new students into the NP program, and thorns in the flesh of those already practising.

Importantly, this research described for the first time that NPs in Fiji work at the interface between traditional and allopathic medicine. Many of the NPs recounted scenarios when they had treated patients who presented having used a range of traditional medicines which had failed to relieve the complaint, and often exacerbated it. Traditional medical knowledge and practices are deeply embedded within both Indigenous and Indo-Fijian cultures, and this presented the NPs with a form of dissonance when treating many conditions and providing education about health and health care.

Lastly, the study raised significant questions in relation to the use of NPs as medical 'substitutes'. It proposed that NP-led health services must be recognised as a legitimate and effective model of health care that supplants (not merely substitutes) the more traditional, physician-led model of health care delivery. This has important ramifications for the health workforce throughout the Western Pacific, where a variety of 'mid-level practitioners' are employed; indeed, the term 'mid-level' is a misnomer as it suggests that these clinicians are located somewhere between a nurse and a doctor, effectively denying them their status as practitioners in their own right.

In summary, this study contributes valuable knowledge and insight into the implications of introducing NPs into a country's health workforce. Such decisions have profound and far reaching effects, like ripples spreading in ever-widening circles after a pebble is dropped in a pond. Throughout the region, particularly in Australia and New Zealand, NP roles are becoming established and the findings of this study offer an important contextual resource that can inform the development of these roles.

Study aims

This study aimed to answer the question: What can be learnt from NPs and key stakeholders in Fiji that will contribute to improving the professional role and function of Fijian NPs, and increase their recognition and effectiveness within the health workforce?

To this end, the main aims of this study were to (1) Describe the evolution and current status of the NP role, and the clinical contexts in which they work; (2) Examine the unique scope of practice of the NP in Fiji, within the context of health care provision across the remote to urban continuum; (3) Draw attention to the professional barriers described by the NPs in the implementation of their role, and (5) Propose strategies to support the NPs and enhance their role within the nursing and broader health workforce in Fiji.

This research substantially extends a series of short term WHO funded projects that described aspects of the implementation and early development of the NP role in Fiji. These projects were conducted prior to the commencement of this study, and helped to crystallise my thinking regarding the difficulties experienced by the NPs. It is anticipated that by answering the research question and achieving the above aims, this study will emphasise the vital role played by these advanced nurses in delivering a multi-dimensional level of health to some of the most marginalised people in Fiji.

Summary and structure of this thesis

The following chapter provides a review of the literature pertaining to Nurse Practitioners from both global and local perspectives. Attention is drawn to how the role has been situated within the broader health and health workforce contexts, and a description is provided of the historical development of a variety of so called 'mid-level' practitioner roles across the Western Pacific region, of which the NP is one. Importantly, how the NP role in Fiji has evolved and the forces that have shaped this process are investigated. Conceptions of health care delivery in remote areas are explored and the nexus between the powerfully influential Western, biomedical model and traditional approaches is examined. Political, cultural and social factors are particularly highlighted in terms of their impact upon the development of the NP role and scope of practice within Fiji.

The significant influence of the World Health Organization (WHO) in shaping the health agenda and health workforce is explored, specifically in the context of the NP role in Fiji.

In chapter three the methodology, method and interpretive framework used within this study are described. True to the qualitative 'tradition', the design for this study emerged as I reflected upon and made decisions about issues such as how best to collect my data,

the size of the cohort of NPs and other key stakeholders to be interviewed, and how the data sets would be analysed (Polit & Beck, 2006). As a qualitative researcher, I acknowledge the subjective nature of this study and understand that it is not value free; I bring to it my own biases and preconceptions, and declare these openly. More specifically, this approach enabled me to gain a rich understanding of the experiences of the NPs within the broad social and professional contexts in which they practice.

As indicated earlier, critical inquiry is concerned with critiquing society and, with its action and change orientation, seeks to bring about transformation, enlightenment and freedom from oppressive forces. It brings to light issues of power and oppression, and aims to expose structures and processes which promote injustice and hegemony (Crotty, 2003). No specific critical tradition was drawn upon within the study, which resonates with Kincheloe & McLaren's claim that "Critical theory should not be treated as a universal grammar of revolutionary thought objectified and reduced to discrete formulaic pronouncements or strategies." (2005, p. 304). Thus, as a criticalist, I foregrounded and problematised the unequal power relations and forms of oppression that exist in relations between the NPs and doctors, and the NPs and the Ministry of Health. The traditionally subordinate role of the nurse *vis a vis* the doctor is no-where more directly challenged than in the NP – doctor relationship, and although there is a clear acceptance of their role they will never enjoy the level of remuneration, social status, professional privilege or power that the medical profession enjoys and guards so adroitly.

With its roots in sociolinguistics, critical discourse analysis (CDA) was used as the interpretive framework by which the data in this study was analysed. For the purposes of this study, discourse is conceived of as a form of social semiosis (Blommaert, 2005), and CDA thus draws attention to power imbalances and ideological structures and processes evident in discourse within society. As Perakyla (2005, p. 871) notes, "Critical discourse analysts are interested in the ways in which texts of different kinds reproduce power and inequalities in society." Norman Fairclough's (1989) framework for critical discourse analysis (CDA) was used to conceptualise and analyse the variety of texts that comprised the data for this study. These included Fiji government documents, my interview

transcripts, Fiji newspaper articles and WHO reports. Fairclough's matrix identifies three dimensions of discourse: discourse as text, discourse as discursive practice and discourse as sociocultural practice. Three dimensions of discourse *analysis* link each of these dimensions, such that at the level of the text, or communicative event (my interview transcripts, for example) I sought to describe how linguistic features such as grammar, text structure and vocabulary were linked to an interpretive phase, in which the ways the texts were produced and consumed were analysed. Lastly, I sought to offer an explanation of the relationship between the text and wider social practice in which it is situated. Reading my data through a critical discourse analytic lens enabled me to identify a range of themes and conceptualise them using Fairclough's schema. This proved to be an extremely useful approach, as it enabled me to ask important questions of my data and think quite differently about the relationships between texts and social practice, and how these are mediated by discursive practice.

Fairclough's framework thus informed the analysis of three themes described in chapters four, five and six. These themes arose from the data, and their analysis in these chapters gave rise to a variety of related sub-themes that are discussed throughout under separate headings. The three broad themes are as follows:

(1) The professional world of the NP in Fiji is characterised by relations of power and exploitation;

(2) NPs work at the interface between traditional and Western health practices and their roles are diversifying, creating unique and complex blends of professional knowledges, skills and attributes, and

(3) The NP role is significantly shaping nursing, health care and the health workforce in Fiji.

Chapter four, entitled *Nurse Practitioners: relations of power and exploitation*, situates the NP not only within the broader health workforce within Fiji, but also within the Western Pacific region. The difficulties in providing an 'appropriate' health workforce in remote areas is discussed and I highlight the role of the WHO and the Fiji Government in establishing the NP role following the failure of other mid-level practitioner models, such as Medical Assistants. The series of WHO projects that culminated in the development of

the NP curriculum, identified their scope of practice and evaluated their effectiveness are critically analysed. It became clear from my interviews with both doctors and senior Government officials that placing doctors in rural and remote areas was perceived as being a waste of a valuable resource that was already in short supply, and that doctors preferred to work in urban, peri-urban and regional centres. NPs have thus become the main health professional in many remote sites, and I describe the ways in which this has transformed health and health care in these areas. On one hand this has dramatically empowered these advanced nurses to the extent that they are given the appellation 'vuniwai' by the public, which means doctor, as there is no Fijian word for Nurse Practitioner. Despite this, the NPs remain a disparate group who feel educationally under-prepared for the rigours of remote practice. It also became clear that governance and management practices and processes in relation to the NPs were characterised by profoundly unequal power relations that appeared incongruous with their vital role and function. This was evidenced, for example, by the protocols that have been developed by medical officers to guide their practice; it is argued that from a critical standpoint such protocols serve a hegemonic function and limit the decision making processes of the NPs. Strong feelings of being exploited by the Government were voiced by the NPs, and I describe the uneasy tension that has been created by the pragmatic need of government to provide a health workforce in remote areas in an environment of medical undersupply.

Chapter five, entitled *Nurse Practitioners: practice contexts and intersection with traditional health practices* provides a description of the clinical environments in which NPs are employed, which has shifted from having a purely remote focus to now including regional, peri-urban and urban settings. A number of concerns regarding their scope of practice, relevance of clinical protocols and educational preparation are raised, particularly in terms of how they shape the interprofessional relationships that NPs develop. An important finding described at some length in this chapter is the nexus between traditional medicine and more scientifically based Western, allopathic practices. It became clear through my analysis that the NP role is situated at the interface between these two paradigms and that for NPs in remote areas it presented considerable

challenges, particularly when their medical and pharmaceutical supplies ran out, as was frequently the case.

Lastly, an issue of particular salience to this study is the vital role that NPs appear to play in remote areas as community capacity builders through health education and promotion. Despite this role, their contribution appears to be largely unacknowledged and somewhat lost in the broader practices and decision making associated with health promotion across Fiji.

The final analysis chapter, entitled *Nurse Practitioners: shaping health care delivery, the health workforce and nursing in Fiji* explores the change in disciplinary boundaries and interprofessional relationships that has occurred following the implementation of the NP role. I introduce Bourdieu's concepts of 'field', 'habitus' and 'voice', as a useful way of conceptualising the practice of the NPs and the important ways in which they are shaping health, health care and the health workforce. The unique blending of nursing, midwifery, public health and health promotion knowledge and skills embodied within the NP role is discussed, and I argue that this is potentially empowering for nursing although this has yet been largely unrealised.

Chapter 7, the final chapter, presents a concise and focussed discussion regarding a number of important issues that arose out of the three analysis chapters. Four key recommendations are proposed and rationales provided for their identification within the context of this study. Practical strategies for addressing a number of the problems raised throughout the study are suggested. To conclude the chapter, a number of final reflections about this study are provided and a list of topics for further research stated.

CHAPTER 2: LITERATURE REVIEW

This chapter provides an overview of the literature relating to elements of the NP role at the time of writing, focussing not only on the Fijian context but also more widely to developed countries such as Australia, Canada, New Zealand, the United States and the United Kingdom. The NP role has been the focus of increasing numbers and diversity of publications over the past two decades to the extent that there is now a substantial corpus of work describing topics such as their clinical practice, inter-professional relationships, ethico-legal responsibilities and the establishment of private practice. This reflects the evolution of this advanced practice role, its increased profile within the health workforce, and the increasing number of countries that are implementing the role. Importantly, professional organizations for NPs in the United States have now developed journals solely dedicated to publishing articles about NP practice. The health care milieu in which NP roles have emerged and developed has also been explored, to enable important contextual factors to be incorporated into this discussion.

Key issues to be drawn out in this review include:

- Conceptualisations of Health in Fiji, traditional and Western models;
- NPs and the Public Health and Primary Health Care movements;
- Advanced nursing practice and Nurse Practitioners;
- The utilisation of mid-level practitioner and NP roles in Fiji;
- The role of the World Health Organisation (WHO);
- Defining the NP role in the Fiji context, and
- Interprofessional interactions that occur between NPs and other members of the health care team, particularly doctors.

In the development of this study, consideration was given to the purpose and extent of the literature to be reviewed. Speziale & Carpenter (2003) note that some qualitative researchers propose that the literature review be initially very small, with the intent of merely providing some focus to the study. Others, they also note, suggest that *no* literature review be conducted before the commencement of the study, as it may lead the researcher to develop a biased view or presupposition concerning elements of the topic under consideration. In this instance, they recommend that the review take place after the

data analysis, to “place the findings of the study in the context of what is already known.” (Speziale & Carpenter, 2003, p. 21). A further, more liberal variation is offered by Patton (2002), who suggests that a review of the literature could be conducted before, during or after data has been collected, or as an ongoing process throughout the study. It is the latter approach that I have chosen in this study, so that a creative interplay can be generated as I gather and analyse the data, and continually add to a critical review of the relevant literature.

Review process

When searching for references, databases accessed were the Cochrane central register of controlled trials, the Cochrane database of systematic reviews, CINAHL, Medline, Blackwell Synergy, ProQuest 5000, Ingenta, Health and Medical complete, FirstSearch and Infotrac Health Reference Centre Academic. These were readily available to the researcher and also provided abstracts and occasionally full-text copies of articles. The World Wide Web was searched using the Google, Google Scholar and Dog Pile search engines when the web address was not known or when doing a general search. Key search words, alone or in combination included : health and illness, Nurse Practitioner, Western Pacific, Fiji, World Health Organization, traditional medicine, advanced nursing practice, primary health care, biomedical, mid-level practitioner, physician assistant, education and underserved.

Conceptualising health, illness and disease – Western and traditional approaches

Any thorough, critical discussion about health and health care must acknowledge that it can be viewed from many different perspectives, and that these perspectives are invariably based on assumptions, ideas and strongly held values (Williams 1983, cited in Baum, 2002). Biomedicine and its related discourse have grown to become the dominant paradigm by which western societies understand concepts of health, illness and disease (Grbich, 1996; Jones, 2004). Gillett (1994, citing Newton-Smith, 1981) defines a paradigm as “a total matrix of beliefs and methodologies which give rise to normative judgements about theories, research questions, the quality of data, and the type of phenomena which can be usefully investigated by ‘proper’ researchers. Davis & George (1998) have summarised the development of the biomedical model of disease, tracing its origins from ancient societies such as Egypt, Greece and Rome and incorporated

discussions of topics such as the role of the Church, folk healers, the rise of surgery, hospitals, public health, medical practice and social interests, laboratory medicine, and changing doctor-patient and doctor-nurse roles. Medicine's role in health, and the pre-eminent place that the scientific ideology and its use of reason and technology have in shaping the health of people, has drawn sharp and at times strident criticism from the media and other sources of social construction analysis.

An increasing number of medical sociologists have critiqued (and criticised) the dominant role that medical care has had on constructions of health, health services, health policy, and health economics within Western cultures (Germov, 2002; George & Davis, 1998; Willis, 1989; Navarro, 1988; Illich, 1974; Freidson, 1970). Such critiques add to the growing corpus of social and anthropological research that is providing useful insights into the role and influence of medicine within contemporary western health systems. For example, Kenny & Duckett (2004) have examined the relationships that exist between rural doctors and rural hospitals in Victoria, Australia. In their qualitative, descriptive study they argue that "crucial shortages of rural doctors provide medicine with a mandate to dictate the way in which medical resources will be allocated and used by the hospitals and the community." (p. 1059). They affirm the increasing debate over the last two to three decades concerning the maintenance of medicine's dominant position in the health care system, but note that "The corporatization of medicine, managerialism and proletarianisation are touted as factors that are increasingly countervailing medical dominance and power."(p. 1059). Jones (2004) observes that in recent years, in western countries in particular, many have attacked medical orthodoxy's position, including sections of the feminist movement concerned with issues of paternalism, subjugation and power. He notes also that earlier others such as Wolpe (1994), Scrabenek and McCormick (1994), McKinley and McKinley (1977) and Illich (1975) have presented alternative ways to assess the value of so-called scientific research, and approaches to health and healing espoused by the western biomedical model.

Jones (2004) cogently argues that from a socio-historical, social constructivist perspective, heresies and schisms present as *necessary* ideological challenges, and that the development of orthodox medical knowledge and its subsequent power base has many parallels to that of orthodox religion and its associated sects and cults. He contends

that shaking entrenched ideologies (such as religious and medical orthodoxy) "is healthy and desirable, entirely fashionable in the age of post-modernism and pluralism, and thoroughly necessary to invigorate the dynamics of any particular approach" (p. 711). Tousijn (2002), in his analysis of medical dominance in Italy, contends that it is in *partial* decline (at least in his country, Italy), in areas such as control over work, control over other health occupations and control over policy making.

Despite these growing challenges, George & Davis (1998) argue that the history of medicine and its practitioners has always been marked by scepticism, mistrust and criticism alongside "celebrations of scientific medicine's achievements and more sober depictions of the medical profession as a virtuous occupation" (p. xvi).

As highlighted earlier, one must look beyond western medical orthodoxy, and acknowledge the legitimacy and recent rapid growth of traditional methods of medicine and healing, and the roles that they have played in many cultures over millennia. The WHO (2002, p. 1) has defined traditional medicine (TM) as "a comprehensive term used to refer both to TM systems such as Chinese medicine, Indian ayurveda and Arabic unani medicine, and to various forms of indigenous medicine." They note that in countries such as Australia, where the dominant health care system is based on allopathic medicine, that TM is often referred to as complementary, alternative or non-conventional medicine (WHO, 2002). This global overview of TM also outlines a policy framework incorporating strategies and a plan of action for the time period 2002-2005. Closer to Australia, the WHO Regional Office for the Western Pacific which is based in Manila, has for some years strongly supported the principles and practice of TM, to the extent that a Regional Strategy for Traditional Medicine in the Western Pacific has been published (WHO, 2001). This strategy "is designed to ensure that traditional medicine in the Western Pacific Region is developed and used appropriately, contributes to building health populations and communities, and combats ill health" (WHO, 2001, p. 1). The World Health Assembly has also adopted several resolutions relating to traditional medicine. Clearly, there is strong support within the WHO for the integration of traditional medicine into mainstream or orthodox approaches to health care. The report also notes (p. 14) that "people living in rural and remote areas in developing countries often seek first line health service from traditional systems of medicine because they are

the only available and affordable form of health care." This is an important statement, and will be discussed further later in this thesis where it will be shown that NPs in remote areas of Fiji are frequently working with people who present having first used TM to treat certain illnesses and injuries.

The published literature on traditional, complementary and alternative therapies within mainstream medical journals is growing rapidly. Application of an evidence-base to the use of traditional medicine has been reported as an important step in its increasing acceptance in orthodox medical circles (WHO, 2001). Searches of more recent 'mainstream' medical literature reveals a growing number of articles describing the use of traditional and complementary medical techniques and treatment regimens alongside orthodox medical practices (Zollman & Vickers (1999); Vickers (2000)). Interesting, early descriptions of traditional healing practices in Fiji have been published. For example Spencer (1966) has documented her ethnographic study of traditional theories of disease and associated therapeutic practices (including ethnopharmacology) in the District of Namataku, based on her observations and interviews with Indigenous Fijians. She notes the strong influence of Christianity, European government authorities and the establishment of a native medical school (1884) based on European medical practices as the key factors that have modified traditional health beliefs and practices. Early texts such as that by Reverend Thomas Williams, a Methodist preacher, have described in detail many aspects of Fijian life and their traditional methods of treating the sick and attending to the dead and dying (Williams & Calvert, 1859). Thompson's ethnological study (1940), based on fieldwork conducted in the Fiji Islands from 1933-34, describes *inter alia* the practices of Fijian witch doctors in treating the sick. Sister Mary Stella, a Catholic nun and nurse has provided a fascinating history of the development of organised care for leprosy patients at the leprosarium on the island of Makogai, Fiji (1978). More recently, Katz (1999) has described the traditional healing practices of Fijian spiritual healers (*dau-va-gunu*) as he researched them in the middle to late 1970s and mid-1980s. He notes that many much earlier (traditional) practices have been lost and therefore not able to be documented.

Robust societies, professional groups and respected journals on ethnomedicine, ethnotherapeutics, ethnobotany and ethnopharmacology now bring together and

document the findings of scientists, researchers and practitioners of traditional medicine from a wide range of non-western cultures including India, Africa, China, South America, Polynesia and Europe. Such has been the growth in interest in traditional medicine that it is now being increasingly included within the curricula of medical undergraduate programs in Western countries.

Informative websites on these topics can also readily be found. For example, the European Society of Ethnopharmacology (ESE) website: (**http://membres.lycos.fr/ethnopharma/links2.htm)** provides links to many useful sites on a broad range of ethnopharmacological topics. The following site also provides a wealth of information about Indian medicinal plants and their uses.

http://www.indmedplants-kr.org/index.htm

Interestingly, the front page of the latter site contains the World Health Organization's 1948 definition of health, i.e. "the complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity" (WHO, 1974, p. 1). Despite its age, this definition is regularly and widely used as the reference point for framing discussions about disease and illness, despite attracting criticism from some quarters for being too utopian and unachievable (Nutbeam, 1986; Sax 1990, p. 1 in Baum, 2002), and "fails to capture the dynamic or action-oriented nature of being health and well. Health is not a static entity; it is ever changing." (McMurray, 1999, p. 7).

Weir and Oei (in Clinton & Nelson, 1996) build on the WHO definition in their discussion about *mental* health, by using the Australian Health Ministers (AHM) 1991 Conference definition, which asserts that mental health is:

> …*the capacity of individuals within the groups and environment to interact with one another in ways that promote subjective well-being, optimal development and use of mental abilities (cognitive, effective and relational) and achievement of individual and collective goals consistent with justice."* (p. 25)

General nursing texts also utilise the WHO definition, but add terms such as illness, disease, disability and wellness, arguing that they are all "different parts of the same process" (Crisp & Taylor, 2001 p.3).

Health for All through Primary Health Care – nursing's commitment

In the decades leading up to the 1970s, it had become increasingly clear that public health systems in many countries were failing to meet their public health needs, and that a new, comprehensive approach was required (McMurray, 2003). The WHO, in conjunction with the United Nations Children's Fund (UNICEF), held a global conference at Alma-Ata (a city in the former USSR) in 1978 to "develop new solutions and new directions in public health" (McMurray, 1999 p. 10). The goal of Health for All using the vehicle of Primary Health Care (PHC) was formalised in what became known as the Alma-Ata Declaration (WHO, 1978). International Council of Nursing (ICN) delegates at the Conference strongly endorsed nursing's commitment to the principles, philosophy and practices of PHC. Throughout the 1980s, however, it became evident that the role of nursing needed to undergo a fundamental shift, in order to take a greater leadership role in the decision making regarding health care (Krebs, 1982; Salvage, 1993). A number of international nursing conferences, projects, publications and resolutions throughout the 1980s and into the new millennium further consolidated this need, as the WHO continued to advocate globally for a strengthened nursing and midwifery workforce. Resolution 54.12 (WHO, 2001), for example, requested the Director-General "to ensure the involvement of nursing and midwifery experts in the integrated planning of human resources for health". In 2003, at the 56th World Health Assembly in Geneva, the Secretariat of the 'Strengthening Nursing and Midwifery' project (WHO, 2003) in resolution A56/19 reported that involvement of nurses and midwives in policy and decision making "was critical in informing the design and implementation of health care policies" (p. 3), yet noted that in many countries nurses and midwives had little or no opportunity to contribute in these areas. Importantly, the WHO in their policy "Nursing & Midwifery Services Strategic Directions 2002-2008 (WHO, 2002), state that "Failure to strengthen the provision of nursing and midwifery services will seriously impair the quality of health care, access to services, well-being of practitioners, and the achievement of national and global health goals." The five key areas requiring urgent action were identified as:

1. Health and human resources planning and capacity building;
2. Management of health personnel;

3. Evidence-based practice;
4. Education, and
5. Stewardship and regulation.

Naeema Al-Gasseer (WHO's Senior Nursing and Midwifery Scientist) and Vena Persuad (WHO Technical Officer) have recently published on the "general principles and scientific criteria ….to guide the selection of potential indicators for monitoring global progress in strengthening nursing and midwifery services" (2003, p. 310). Oulton (2003, p. 313), the then CEO of the ICN, responded to their paper, commending the WHO initiative but stating that "Mobilising the nursing community is not up to WHO. Getting real, needed nursing policy on national agendas is up to us as nurses and midwives."

In effect, what these authors are calling for is a united 'top down' and 'bottom up' approach, involving governments, policy makers and nurses from all sectors of the nursing workforce, including education, clinical practice and management.

The WHO's World Health Report (WHO, 2003) reaffirms the core role that the original philosophy, principles and practice of PHC have in improving the health of all people. In particular, the principles of:

Universal access to care on the basis of need;

Commitment to health equity as part of development oriented to social justice;

Community participation in defining and implementing health agendas;

Intersectoral approaches to health

are identified as being most significant (WHO, 2003, p. 107).

In order to meet the goal of "Health for All" the Fiji Government adopted the principles and practices of Primary Health Care. As stated in the NP curriculum document, "This approach is designed to make comprehensive health services accessible, affordable and acceptable to all members of Fijian society, including those in remote areas….Therefore, in order to provide quality cost-effective health services to the outlying communities, the Government has developed a programme for the advanced education and deployment of a cadre of Nurse Practitioners" (Fiji School of Nursing, 2001, p.3). This commitment to PHC clearly established both the policy and practice framework within which the NPs were developed and has anchored their role firmly within the health workforce and health services.

The central role of the WHO in the Western Pacific

As has been shown, the geography of the Pacific region with its population scattered across thousands of islands, creates numerous challenges for the planning and delivery of efficient and effective health care services (Stark & Short, 1992). These and many other aspects of health and health care in the Western Pacific Region have been thoroughly described in the book published by the WHO to mark its 50 years of involvement in the region, from 1948-1998. This 42-chapter compendium chronicles key historical data, current conditions, and future challenges for the decades leading up to the year 2020. Chapter 9 of this text provides a broad summary of nursing's activities across the region, emphasising the large diversity of practice contexts, education and training, professional recognition, and regulation. It notes that there were (at the time of publication) over 3 million nurses and midwives in the Western pacific Region, and that their practice has "historically expanded or contracted in relation to the availability of other types of health workers, including doctors, medical assistants, laboratory technicians, pharmacists, health educators and even dentists" (Chapter 9, p. 1). The authors also make the important point that "there appears to be no direct correlation to a country's level of socioeconomic development and the *scope* of its nursing practice." (Chapter 9, p. 2, italics added). That is to say, in some low-income countries nurses may be highly utilised whilst in others the reverse is true. The same can apparently be said for high-income countries. The reasons for this are undoubtedly highly complex, yet nurses remain by far the most numerous member of the health care team and nursing remains the profession with the greatest potential capacity to initiate positive changes in health status. Improvements in nurses working conditions, career structure, remuneration, access to continuing education, and greater contribution to health planning and policy development are notable within the document, yet these remain as the very topics still requiring substantial improvement (WHO, 2000).

Clearly, the WHO is committed to supporting and strengthening nursing roles, particularly in developing countries, so that primary health care services can be delivered in those areas of greatest need. All communities need reasonable access to health care, however many lack the resources to train, retain and recruit enough doctors, particularly in small rural communities scattered across wide geographical areas separated by sea. A

major response to this workforce problem has been the implementation of mid-level practitioner roles in developing countries like Fiji, again because of a lack of doctors, a sparsely scattered population and economic constraints (WHO, 2001). The emergence of these roles demonstrate the changing skill mix required to address the transformation that is occurring within health systems, an issue taken up by Buchan & Dal Poz (2002). These authors conducted two reviews of publications that focussed on skill mix among health workers, the first between 1986 and 1996, the second from 1996-2000. The latter search produced more than twice the number of publications than for the previous decade, suggesting a growing interest in skill mix issues. Their findings were grouped into "reviews and meta-analyses, large scale ("macro") data surveys, single-site ("micro") examinations of roles and mix in nursing and other non-medical health professions; single-site ("micro") examinations of role overlap between doctors and other health professionals; and studies on introductions of new types of worker." (p. 576). The authors conclude that most of the published studies comprise descriptive accounts, "which add little in terms of use of methods or interpretation of results." (p. 578). Further, many of those that went beyond description were found to be methodologically weak, lacked appropriate evaluations of quality and cost, and used sample sizes that were too small to be useful. They note also that most of the studies were based in the USA, and the findings were therefore highly unlikely to be relevant to other countries and contexts. As a result, general conclusions or comparisons could not be made due to the many influences that shaped skill mix in any given setting, organization or health system. Variables such as resource availability, regulatory environments, culture, custom and practice were highlighted by the authors as factors shaping skill mix, making it difficult if not impossible to prescribe an ideal mix of health workers. From the available evidence, they concluded that in relation to doctor/nurse overlap, "there is unrealized scope, within the constraints of country - and system-specific regulations, for extending the use of nursing staff and for further development of care delivery led by nurses/midwives, for example in maternity units." (p. 579). The authors call for further robust research to develop reliable evidence that will better inform decision making in the important area of skill mix.

The advent of the NP role has heralded a major change in the skill mix of health professions, health organisations and health systems, in both developed and developing

countries. This initiative commenced during the 1970s and has gained rapid momentum since that time. Mid-level practitioners is the term used to describe health workers who have been trained to diagnose and treat common health problems; to provide initial care in emergencies; and to arrange for the safe transfer and referral of the seriously ill and injured (WHO, 2001). Mid-level practitioners play an important role in the implementation of WHO technical programs, including the syndromic approach to the treatment of sexually transmitted infections and the integrated management of childhood illness. Depending on the country and the level of training/education achieved, mid-level practitioners possess various titles such as nurse practitioner, medex, health extension officers, primary care provider (PCP), physician or medical assistant, or clinical officer. Whatever their title, experience has shown that they represent a cost-effective approach for providing basic health services in both industrialised and developing countries (WHO, 2001). In Vanuatu, for example, nurse practitioners have for many years reportedly played a vital role in the delivery of health services, although there are no published studies to support this claim. Nurse practitioners treat large numbers of patients in out-patient departments of national hospitals and are the main health providers in rural and remote health centres. The WHO has provided technical support for mid-level practitioner training in a number of Pacific island countries. In line with the Rarotonga Agreement, WHO has conducted a review of mid-level practitioner training and practice in the Pacific and has strongly supported the development of the nurse practitioner training program in Fiji (WHO 2001).

Fiji – its system of health care, and the health beliefs and practices of its people

Any discussion about the health of Fijian people must take into account the historical background that has shaped the development of Fiji society and culture, and its evolving identity as a nation in its own right. The health of Fijians, like all other people world wide, is a fundamental issue that cuts across the many social, political, economic, environmental, cultural, spiritual and personal dimensions that comprise their community.

Tourism is one of Fiji's greatest sources of revenue, and respected travel writers such as Stanley (2001), Jones & Pinheiro (2000) and Kay (1994) have published comprehensive texts on all aspects of Fijian history, life and culture. Travel oriented web sites also

abound with information about places to go and things to see in the Fijian islands, for example

http://www.southpacific.org/text/finding_fiji.html

http://www.tourismfiji.com/

and the Fiji Government's own comprehensive Fiji Visitors Bureau (FVB) site: http://www.fijifvb.gov.fj/

As travel guides, these texts inevitably present the best aspects to Fiji, rather than emphasise to any real extent its underlying economic and socio-cultural problems, which are substantial and remain well entrenched. Despite this, Kay (1994, p. 3) and others do describe (with not entirely covert relish, no pun intended) Fiji's cannibalistic and violent past with statements claiming that the victims of cannibalism:

> *"were not just randomly selected, but were almost always enemies taken during battles. Eating your enemy was the ultimate disgrace the victor could impose, and in the Fijian system of ancestor worship this became a lasting insult to the victims' families. This explains much of the sometimes extremely vicious infighting, internecine warfare and vengeance seeking that went on in pre-Christian times."*

Such descriptions reflect the violent and bloody practices that were commonplace in tribal Fijian communities prior to European exploration and the so-called 'Christianisation' of much of Fiji during the 18th and 19th centuries (Kay, 1994).

Understandably, only basic descriptions of health and health care are provided in such travel texts. Rudimentary first aid and travel health information is provided, alerting travellers to issues including environmental hazards such as heat stroke and motion sickness, infectious diseases such as diarrhoea, sexually transmitted diseases and HIV/AIDS, and insect-borne diseases such as dengue fever and filariasis (Jones & Pinheiro, 2000).

More comprehensive accounts of health and illness in Fiji are available, however, and authors such as Lowe (2001) have provided useful descriptions of health and disease in Fiji. He addresses major topics of:

- race, culture and research in Fiji
- the epidemiology of illness in Fiji

- environmental and socioeconomic influences on health
- cultural factors in health
- causes of illness in Fiji
- communicable and non-communicable diseases.

Lowe distinguishes between the health status of the two main ethnic groups in Fiji: the ethnic Melanesian/Polynesians, and the Indians. He highlights socio-cultural differences between these two groups in areas such as presentation to hospital with chest pain, citing older studies by Ram & Cornelius (1991) and Collins et al (1996) that suggest that "between 87% and 100% of patients who present to hospitals with myocardial infarction in Fiji are Indian."(Lowe, 2001 p. 3). It must be noted that these percentages are based on reported studies between 1964 and 1982, that substantial variations occurred across different regions of Fiji, and that women are underrepresented in these reports, variables that Lowe himself acknowledges.

Lowe also notes that not only are there marked differences in health and disease distribution between ethic and Indo-Fijians, but that major differences exist between male and female groups, and between those living in rural as opposed to urban areas. Citing Jorgenson & Taylor (1990) Lowe notes that "Many Fijians preferentially use traditional medicine rather than Western medicine for a large number of symptoms and diseases including many of the symptoms of heart disease."(p. 4). This phenomenon will be discussed in detail in chapter 5 of this thesis.

Nurse Practitioners in the Western Pacific

The search terms used were 'nurse practitioners Fiji' and 'nurse practitioners western pacific'. The results are summarised as follows:

- Blackwell Synergy – 8 matches.
- Cochrane central register of controlled trials - no hits.
- Cochrane database of systematic reviews – no hits.
- CINAHL – no results with either of these terms.
- Medline – One descriptive study by Usher & Lindsay (2003) illustrated elements of the NP role in Fiji, as outlined below. Two articles were found which related the roles of NPs to traditional healers and approaches to health in Hawaii.
- ProQuest 5000 – no articles found in either search.

- Ingenta – no articles found in either search
- Infotrac –One brief article was found by Wilson (2004), describing elective medical placement in Vanuatu. Three items were found for NPs and the Western pacific. Two are 1-page, localised descriptions of NP roles, by Lee (1989) and Stark and Short (1992). The other is an article by Smith (2001), a doctor, outlining the use of telemedicine in trauma care.
- FirstSearch – no articles found in either search

The eight results via Blackwell Synergy are all from journals produced by the Blackwell Publishing Company. Three, 1-page commentaries are unreferenced opinion pieces by Dr Neil Sharma, a doctor at the Fiji School of Medicine. Throughout his articles, he is openly critical of the political and central administrative processes in Fiji which, he claims, has led to a heavy price being paid "in terms of poor planning, inappropriate resource/finance management and a very high attrition rate of health service providers." (2002, p. 60). Little mention is made of NPs by Sharma, other than that they comprise one component of the primary care workforce in Fiji. Of the other five articles obtained, the evaluation study of a community based, nurse-managed clinic in New Zealand described by Clendon (2003), is the only one that provides some description of NPs, and their potential role within such settings. At the time of Clendon's study NPs were yet to be formally established as primary care providers in New Zealand, though the author anticipates that they were likely to be in place in such settings within 2-3 years.

Using fourth generation evaluation methodology described by Guba & Lincoln (1989), Clendon combined qualitative and quantitative data to generate a more comprehensive evaluation of the services offered by the Mana Health Clinic in Auckland. In so doing, she adds to the limited published nursing research that utilises fourth generation evaluation, an approach that in this case incorporated the 'voice' of users of the clinic as an important source of knowledge.

In the Medline search, Usher & Lindsay's (2003) article is notable in that it constitutes the only published, descriptive report of the roles of NPs in Fiji found in this search. Using a qualitative evaluation method as the study framework, the authors draw heavily upon an impact study conducted by Usher in 2001 (described later in this review). They

highlight the strengths of the NP role and the need for further research in areas such as scope of practice, career structure, access to further education and utilisation of NPs by the Fiji Ministry of Health. They note that the NP role "evolved in response to a chronic shortage of adequately prepared health workers to cover the needs of people located principally in rural and remote regions of Fiji" (p. 84). From the Government's perspective, at least, it was a necessary workforce strategy. While the authors briefly allude to NP roles that have developed in countries such as the UK and USA and constituting one element of advanced nursing practice, they do not explore definitions of NPs or advanced practice from a global perspective. They do, however, focus on the narratives provided by the many people interviewed as part of the original impact study, which highlighted the high degree of satisfaction with the NP role in Fiji, particularly by people in rural communities who otherwise would have little or no direct access to primary health care or health education. Importantly, they also identified issues that would assist the role to remain viable, including remuneration commensurate with their education and advanced scope of practice, the need for a career structure, and access to continuing education. In an otherwise barren landscape, this important article offers a small oasis that can nourish and nurture further research on NPs in Fiji. Indeed, it has been the catalyst for this Doctoral study, a component of which will be the publication of several articles that will at least begin to address the paucity of literature on this topic.

The other articles identified in the Medline search were those by Broad & Allison (2002) and Allison (1997), who reported on the interface between the western model of care provided by nurse practitioners in Hawaii and the traditional healing clinics (Lomi-Lomi) utilised by Indigenous people in that country. These localised, descriptive studies demonstrate the importance of cultural sensitivity in the planning and delivery of holistic health care, and acknowledge the legitimacy of non-Western health practices within an overall health care strategy. Broad and Allison note that the NPs, who mainly work within the curative/preventative model tended to see patients who presented for acute and sub-acute conditions such as infections, diabetes management, hypertension control, angina, congestive heart disease and asthma. The use of Hawaiian therapies, which focussed mainly on massage and spiritual healing, tended to be used more for chronic problems such as back and neck pain, and arthritic pain in the joints (Broad & Allison,

2002, p. 50). Given the earlier discussion regarding the increase in acceptance of traditional therapies by at least some within the medical orthodoxy, these reports add to the already substantial literature describing their use, and are important contributions in that regard.

The article yielded by the Infotrac search on NPs and Fiji did not really focus on these topics at all. Wilson's (2004) brief description of Vanuatu as a country to visit for an elective medical placement reads more like an excerpt from a travel guide. Along with descriptions of the climate and the best snorkelling sites, he at least provides a list of the hospitals and their contact details in Vanuatu, noting that nurse practitioners do much of the work in them. Given that the article appears in the student edition of the British Medical Journal it is perhaps not surprising to find a report of this nature. Lee's brief report (1989) provides scant description of NPs, other than to say that they have important roles in promoting health and preventing disease in the Republic of Korea, the Philippines and Vanuatu. In Korea, NPs appear to have the title of community health practitioners (CHP) who, once trained, are assigned to remote areas of the country where there are no other health professionals. Lee's article contains no references and unfortunately offers little other information of substance to the reader. Stark and Short (1992) recount their trip to visit the newly placed NPs in remote, scattered communities on the Cook Islands. At the time of writing, Dr Ruth Stark was the Nurse Educator/Administrator in the WHO's Western Pacific region and Mrs N. Ngapoko Short was the Director of Nursing in the Cook Islands. The new NPs (all women) were working as sole primary care providers on five of the eleven outer islands. Their roles included the assessment, diagnosis and treatment of common health problems, emergency care and midwifery. Radio contact was maintained with the doctors on the main island of Rarotonga, and patients could be transferred by sea or air to the hospital there if required. Like Fiji, the NP role appears to be highly effective in the provision of primary care in small rural and remote communities that could not support a doctor. As mentioned previously, the WHO has actively promoted this advanced nursing role as an efficient use of the existing health workforce, so that primary health care can be reasonably accessible to all. Stark (1997) has since outlined five reasons why nurses have been the preferred mid-level practitioner, namely:

- Nurses are already established in the workforce;
- Nurses are the largest category of health workers;
- Nurses are already there;
- Nurses are already providing a wide range of curative and preventive services in many countries, and
- Nurses are a flexible, multi-skilled, multi-purpose workforce.

Unfortunately, Stark's article is not research based and contains no references to support the above statements. She also does not specify in what countries nurses should be used in this way, but simply states that due to an inadequate and costly medical workforce nurses are the most logical health professional to address the health care needs of small rural communities. The training of such professionals should not be within expensive, lengthy, academic programs, claims Stark, suggesting that "what is needed are practical courses that give nurses working in underserved areas the competencies they need to enable them to provide the full range of primary health care services." (p. 30). Again, no evidence is provided to support this claim, which either suggests that a significant gap exists in the literature that describes and evaluates such courses, or that Stark has not chosen (or bothered) to look for and include it. Either way, despite Stark's seniority as regional adviser to the WHO in the Western Pacific, her report merely presents her view on the use of NPs in medically underserved areas and therefore can only reasonably be interpreted as such. Lastly, Smith's article entitled "Telemedicine and Trauma Care" (2001) outlines the current use of satellite and landline based technology to provide a diagnostic and consultative service between rural hospitals and tertiary care facilities. His reference to NPs is oblique, referring to them as likely to be present in a small rural hospital (in America). Likewise with his reference to the western pacific region – he refers to it only once in the context of several army medical facilities present in that region that are linked via telemedicine technology. From the perspective of this literature review, therefore, Smith's article is of no substantive value. It is however likely to be of interest to those involved in the use and development of such technologies which, due to their high infrastructure cost (currently at least) and technical inefficiencies are well outside the capacity of most countries in the western pacific region. Notwithstanding this, the Fiji School of Medicine and Fiji Government have in recent years become part of a

wider telehealth/telemedicine network, as reported by Pryor, Baravilala & Katoanga (2000). Clearly there is growing interest in the Pacific region regarding the use of such technology, prompting the conduct of a needs assessment, the results of which have been reported by Kerr, Dew & Abernethy (2002). Time will tell the extent to which this technology impacts on health care delivery and education within Fiji and the western pacific region, particularly in respect to the role and function of NPs.

Nurse practitioners and physician assistants (PAs)

Over the last 40 years, Physician assistants (PAs) and NPs in particular have experienced extraordinary growth in the US, again principally due to rapid changes in the structure and processes of the health system, the shortage of primary care physicians, and the need to increase access to health care for people in rural or other underserved areas (Fitzgerald, Jones, Lazar, McHugh & Wang, 1995; Anderson & Gillis, 1998; Lin, Hooker, Lenz & Hopkins; Mittmann, Cawley & Fenn 2002; Cawley, 2002). Indeed, PAs (also known as Medical Assistants) were trialled by the Fiji Government as a mid-level cadre of health professional to be deployed to remote areas. As will be shown later, they proved to be unsustainable and the NP model was subsequently introduced.

An abundant literature now exists that describes many aspects of the NP and PA roles, the majority of which are oriented toward NPs, and predominantly reflect the American context. Care must naturally be taken, however, when extrapolating the findings of descriptive accounts in one setting (such as America, for example), to a health system in another country (such as Fiji), as the findings are unlikely to be generalizable due to vastly different contexts and influences.

Reports on studies that demonstrate levels of safety, effectiveness and patient satisfaction with NPs equal to or greater than that afforded by physicians have been documented by Counselman, Graffeo and Hill (2000), cited in Mittman, Cawley & Fenn, (2002), Mundinger, Kane, Lenz, Totten, Tsai, Cleary, Friedewald, Siu & Shelanski (2000), and Larrabee, Ferri & Hartig (1997). Horrocks, Anderson & Salisbury (2002), conducted a systematic review of 11 randomised control trials and 23 observational studies sourced from a variety of data sources, including the Cochrane controlled trials register, Medline, CINAHL and Embase. They included studies that compared the care provided by primary care nurse practitioners and doctors to patients with undifferentiated health problems in a

primary care setting. From their review, they concluded that an "increasing availability of nurse practitioners in primary care is likely to lead to high levels of patient satisfaction and high quality care." (p. 819).

Considerably fewer articles were found which address patient satisfaction issues with PAs (Oliver, Conboy, Donahue, Daniels, & McKelvey (1986); Counselman, Graffeo & Hill (2000)). One reason for this could be that nurses are more likely to conduct qualitative research that explores issues such as patient satisfaction. Another could be that NPs might be motivated to conduct or be involved with research that demonstrates the value of their role. One caveat to this of course is that where the introduction of the NP role has been unsuccessful, it is less likely to be reported, which develops a bias in the literature that favours a positive view of the role. In regard to bias within this review, it is acknowledged that only publications written in English have been searched, which limits its scope to the extent that important articles from non-English speaking countries may have been overlooked.

Mittman, Cawley & Fenn (2002) note that at the time of publishing, there were more than 44,000 PAs in America, a figure that is projected to rise to 79,000 by 2015. These authors also delineate the roles of these two groups, stating that PAs are educated by physicians within medical schools using an abbreviated medical curriculum. They perform many of the activities of physicians including "examination, diagnosis, and (sic) carrying out investigations, as well as treatment and prescribing." (p. 485). They must be linked to a physician, and their level of autonomy in these roles is negotiated with the physician. NPs can perform similar functions as PAs, however Mittman, Cawley & Fenn (2002) note that they are not necessarily linked to a physician, they have tended to be educated in a specialty area, such as pediatrics, women's health or (more recently) family practice, their education is based on the nursing paradigm, they are regulated by professional nursing bodies and their regulatory body is also within nursing.

The American Academy of Pediatrics (AAP) Committee on Hospital care (1999) noted that during the 1990s the scope of practice of NPs and PAs increased to the extent that they were employed within mainstream hospital settings, contributing to inpatient, oupatient and post-hospital care (p. 1050). For example Dubaybo, Samson & Carlson (1991) describe the use of PAs in a critical care unit, acknowledging however that "The

original job of physician assistants (PAs) was to assist physicians in providing health care for outpatients in rural communities."(p. 89). The empirical study reported in 1998 by McCraig, Hooker, Sekscenski & Woodwell analysed ambulatory care visits to hospital outpatient departments over a 12-month period concluded that these clinicians "make an important contribution to ambulatory health care delivery in hospital outpatient departments." (p. 75).

Despite these 'success stories', the AAP has documented its scope of practice concerns regarding non-physician clinicians, principally NPs and PAs, and their role in providing paediatric care. The AAP's Committee on Pediatric Workforce policy statement (2003) emphatically reiterates the central role of the pediatrician as leader of the pediatric health care team, "because of their unique ability to manage, coordinate, and supervise the entire spectrum of pediatric care, from diagnosis through all stages of treatment, in all practice settings" (p. 427). The Committee further states that because the pediatrician has the most extensive education, s/he "possesses the clinical skills, medical knowledge, and other competencies necessary to provide accessible, continuous, comprehensive, family-centred, coordinated, compassionate and culturally effective paediatric care, 24 hours a day, 7 days a week." (p. 427). Paediatric NPs and PAs are particularly targeted by the authors as being the groups whose clinical practice needs to be coordinated by a paediatrician. One cannot interpret the content and intent of this policy statement by the AAP other than that it is endeavouring to [re] claim its role at the centre of the care of infants, children, adolescents, and young – which is indeed what the authors declare (p. 426). Such statements could be interpreted in many ways, and in one sense one cannot argue with their desire to provide the best quality care, however it seems utterly naive and utopian to believe that there will ever be enough paediatricians to oversee all the care of all children at all times and in all places, or that the quality care of children can only be provided by paediatricians. Broffman (1995), himself a paediatrician in the US, appears to present a more realistic and balanced view. He acknowledges the rapidly growing role that primary care teams are having and the legitimate contributions that PAs and NPs make within such teams. However, he argues that barriers exist to the further development of such teams, citing the "biases of physicians" and "the sense that no one

else is able to provide the same quality of care as the paediatrician" as being the foremost issues.

Generally speaking, there is support in the published literature for NPs and PAs. It is clear that while these two roles approach the patient encounter from different philosophical, clinical and relational perspectives, and follow different trajectories of care following the encounter, they do converge at the point of care, and appear to successfully do so in a variety of practice contexts. Both roles have grown rapidly, particularly the PA role in the United States, and are likely to continue this growth, given the substantial momentum that has been generated over recent decades. The greatest resistance to these roles comes from within orthodox medical circles, and from the nursing profession. In Australia, trials of PA models are pending within Queensland, and associated educational programs are being developed. Despite the absence of a formal domestic accreditation body, legislative framework or scope of practice it is clear that the maldistribution of doctors across the urban-remote continuum, increasing reliance upon overseas trained doctors and aging medical workforce provide clear imperatives for the development of PAs in Australia, particularly for rural and remote practice contexts (O'Connor & Hooker, 2007).

Nurse Practitioners in underserved areas

Many studies were found that described NP roles in underserved areas, though none were systematic reviews or randomised, controlled trials. Not surprisingly, the overwhelming majority of these were by American authors and focus on American contexts. The search terms 'nurse practitioner', and 'underserved' were used to search the English language databases mentioned earlier, within the same time period. An underserved area is generally accepted as one that has a reduced number of health professionals present and, as a result, offers a reduced range of services. Some studies used the term '*medically* underserved', suggesting that mid-level practitioners such as NPs or physician assistants are used in situations where there is no doctor (see, for example, Stark, 1997; Varnell, Pollock, Klotz, Green & Sportsman, 2002). Neale (1999, p. 252) reiterates the primary intent of the NP role: "The [NP] role was originally developed to meet a perceived shortage of primary care physicians, especially for underserved populations. Today, NPs work in various fields, such as geriatrics and women's and family health care, as well as

in various systems as private practice and health maintenance organizations." Rural and remote locations predominate as being underserved, largely because of their geographical isolation and sparse population distribution (Martin, 2000; Kippenbrock, Stacy, Tester & Richey, 2000; Fairbanks, Montoya & Viens, 2001). Other underserved areas identified were in urban or peri-urban locations that had high levels of poverty, violence and racial tension (Kippenbrock, Stacy, Tester & Richey, 2002) or contained vulnerable populations such as racial and ethnic minorities, adults with chronic mental illness, the elderly, the incarcerated or those requiring end of life care (Kuebler & Bruera, 2000; Puskar & Bernardo, 2002).

Outpost nurses functioning as primary care providers in Canada's underserved northern communities share many similarities with NPs, according to an interpretive study conducted by Tarlier, Johnson & Whyte (2003). These authors interviewed nine outpost nurses and, using Benner's model of interpretive phenomenology to analyse the clinical narratives provided by the participants, identified the following four themes:

1. Primary care competencies are fundamental to outpost practice,
2. Nurses evolve into the outpost role by learning community health competencies and adapting to context-specific practice issues,
3. Experienced outpost nurses build and maintain responsive relationships with communities, and
4. Experienced outpost nurses become comfortable with the autonomy and responsibility of practice (p. 180).

The title of outpost nurse appears to only be used in Canada, where the role is linked closely to that of NPs. Other studies focussed on community acceptance of NPs in medically underserved, rural areas (Baldwin, Sisk, Watts, McCubbin, Brockschmidt & Marion, 1998; Knudston, 2000).

Seivwright, a nurse, (1982) has articulated the roles of Primary Care NPs in Jamaica, while Broffman (1995) acknowledges the valuable role that NPs and Physician Assistants have in providing paediatric care in rural America. The provision of health care to migrant farm workers is seldom documented, yet Guasasco, Heuer & Lausch (2002), have described the important role that that nurse-managed clinics (which include NPs on staff) in rural North Dakota and Minnesota in the United States have in providing health

care to the many peripatetic Hispanic families that provide labour to the agricultural industry. In sub-Saharan Africa, the provision of palliative care in each of Uganda's 56 districts has been a major initiative since 1993. A team that includes NPs throughout Uganda's rural areas has provided a mobile, home-based palliative care service that prescribes and administers opioid pain relief (Morphine) and also psycho-social support to these sub-Saharan communities (Ramsay, 2001).

Nurse practitioners in Australia and New Zealand

As relatively near neighbours to Fiji in the Western Pacific region, it is important to highlight some of the literature that describes the NP role in Australia and New Zealand. Studies by Gardner, Carryer, Gardner & Dunn (2005) and Carryer, Gardner, Dunn & Gardner (2007) note that this is particularly pertinent given the legislation that has now been enacted which allows for mutual recognition of nursing qualifications between these two countries. Their interpretive studies sought to identify core elements of the NP role in both countries, which were found to be aggregated around the components of '*dynamic practice, professional efficacy and clinical leadership'* (2007, p. 1818, italics included). Notably, these three domains constitute the core, generic standards within the Australian Nursing and Midwifery (ANMC) standards used by regulatory authorities to 'determine the eligibility of nurse practitioners seeking authorisation as nurse practitioner in Australia and New Zealand' (ANMC, 2006, p. 3).

To locate early published data about NPs in Australia one has to go back to 1990 and the initial project established by the New South Wales Health Department to trial NP models of practice in three practice contexts: Area/District Health Services, General Practice services and Remote Area Services (Siegloff, 1995). Institution of the role in New South Wales (NSW) was a rocky path, characterised by resistance from the medical fraternity and also among nursing ranks, political and professional manoeuvring, and legal wrangling over core issues such as scope of practice, prescribing rights, access to the Pharmaceutical Benefits Scheme and Medicare provider numbers (Appel & Malcolm, 1999). Navigating a path through the nomenclature has also not been without its difficulties and conceptions of advanced nursing practice, extended practice and definition of the role and scope of practice of NPs have reportedly created confusion and ambiguity (Pearson & Peels, 2002; Gardner, 2004; Bryant-Lukosius & DiCenso, 2004;

Mantzoukas & Watkinson, 2007). An interpretive study recently conducted by Gardner, Chang & Duffield (2007) differentiated advanced practice nursing and nurse practitioner roles from an operational perspective. Legislative protection of the title of NP, scope and standards of practice, and *extended* versus *expanded* practice were found to be the main elements that delineated NPs from advanced practice nursing. As their study was limited to nine advanced practice nurses working in three acute care hospitals in south-east Queensland, further research is clearly required involving larger sample sizes and a broader range of practice settings in order to further validate their findings.

Despite early teething problems, NP models of practice have now become established in New South Wales across a number of practice settings, some of which have recently been evaluated (Middleton, Alnutt, Griffiths, McMaster, O'Connell & Hillege, 2007). The NSW project paved the way for NP pilot projects within all Australian States and the Australian Capital Territory (ACT). As these roles have become established, an increasing body of published literature has emerged describing various elements of these roles. For example, Offredy (2000) used a case study approach to compare the decision making practices of four NPs in across three Australian States (Victoria, South Australia and New South Wales). A trial of nurse practitioner services in the ACT reported by Gardner & Gardner (2005) highlighted the broad potential of the role within a defined scope of practice and proposed that NP models of care filled existing gaps in local health service provision.

Nurse Practitioner educational preparation in Australia

There is a paucity of literature pertaining to this area, and given the raft of Masters-level preparatory courses across Australian Universities such studies are urgently needed. One study by Gardner, Gardner & Proctor (2004) begins to address this gap, at least within one Australian context. The authors sampled four NPs working in the clinical specialties of military nursing, sexual health, mental health and wound care in the ACT, Australia. Importantly, their study identified the need for both generic and 'model-specific' education within three broad areas of study: clinical practice, clinical sciences and nursing studies. The importance of the clinical environment as a sphere of learning was highlighted, together with the vital role played by clinical mentors in facilitating 'purposeful learning' (p. 151). They noted that due to methodological limitations their

findings are not generalizable, although their findings clearly contribute new knowledge to the area of NP education. Given the gathering momentum of NP roles across the Australian health landscape, and increasing pressure upon Universities to respond to workforce trends, it will be vital to build a robust evidence base that informs curriculum development that is firmly grounded in the realities and needs of clinical practice.

Trans-Tasman collaborations

Important trans-Tasman research has recently emerged focussing upon the development of standards for NP practice and education in Australia and New Zealand (Gardner, Dunn, Carryer & Gardner, 2006), and their scope of practice using the construct of 'capability' (Gardner, Hase, Gardner, Dunn & Carryer, 2008). The latter study, in particular, identified that competency statements alone were insufficient in describing the multiple roles of NPs, and that 'both competence and capability need to be considered in understanding the complex role of the nurse practitioner' (p. 250).

The establishment of new, collaborative relationships between NPs, doctors and allied health professionals has been a hallmark of the journey undertaken by NPs as they have become integrated within the Australian and New Zealand health workforces. Exploratory studies conducted in New South Wales have sought to identify the nature of collaborative relationships between General Practitioners and NPs (Whitecross, 1999), and elucidate the dissatisfaction experienced by NPs when working with GPs and allied health groups (Wilson, Coulon, Hillege & Swann, 2005). These latter authors recommended that a national study be undertaken to 'explore the contemporary challenges embedded in health care partnerships and the forces that facilitate or negate collaboration' (p. 27), and this constitutes a clear gap in the published literature within Australia and New Zealand currently. Bailey, Jones and Way (2006), in their Canadian study exploring the experiences of nurse practitioners and family physicians working in collaborative practice at four Canadian rural primary care agencies, found that without the implementation of formal, robust educative strategies to support interprofessional collaboration, such relationships developed poorly.

The Fiji context - story telling and publishing

One of the aims of this study is to explore the interprofessional relationships between NPs and other members of the healthcare team in Fiji, particularly doctors. Using the

search terms ‘interprofessional collaboration’, ‘nurse practitioner’ and ‘Fiji’, the databases mentioned previously were scanned. Unfortunately this search yielded no results from any of the selected databases, nor were any results found using the Google Scholar search engine. Without such data it is impossible for anyone outside this network to gain any insight into the ways in which NPs interact professionally with other members of the health care team in Fiji. Gaining such insights is important for a number of reasons. First, NPs in Fiji operate within a wide range of practice contexts, and it is reasonable to assume that their roles and interprofessional relationships will differ accordingly. For example, in rural or isolated areas where the NP is the only health professional, their interprofessional relationships will be very different to that of a NP working in the accident and emergency department or one of the wards in the major hospital. Decision making about patient care is also likely to be heavily influenced by factors such as diagnosis, level of acuity, access to human and material resources and capacity of the patient to comply with a treatment regimen. Second, the degree to which collaboration occurs is likely to be linked to issues such as the efficiency, effectiveness and quality of health care, and patient and staff satisfaction. Lastly, from a critical perspective the dynamics of interprofessional relations are intrinsically important to explore, particularly those that focus on expressions of power such as participation in decision making.

Clearly, this gap in the published literature is important not only for the Fiji context but across the Western Pacific region, where NPs are increasingly being used within the health workforce. The burgeoning body of literature referred to above which describes developments in Australia is important, yet there is much that can be gained from looking beyond these horizons to countries such as Fiji, in order to tap into previously unexplored synergies and thus strengthen the international flavour that such collaborative studies might bring.

Educational preparation of the NPs in Fiji is an important issue taken up later in this thesis. Usher, Rabuka, Nadakuitavuki, Tollefson & Luck (2004) have chronicled the development of nurse education in Fiji, including a brief description of the education program for NPs conducted by the Fiji School of Nursing. More recently, Foster, Usher, Baker, Gadai & Ali (2008) have extended earlier work by Aganhwa (2004), in their

exploration of the attitudes of mental health workers toward mental health and their clients in Fiji. These former authors highlight the vital role that education plays in the attitudinal development of mental health workers and suggest that such knowledge is vital in informing future mental health education programs in Fiji.

As noted, there is a distinct paucity of published literature *about* and more particularly *by* NPs in Fiji. The basis for this is unclear; what is clear, however, is that the majority of these nurses do not write about or research their practice, or collaborate with others to do so. One could postulate that this reflects a professional culture that is not oriented toward formal inquiry or developing an evidence-base to practice, or that it represents a lack of opportunity to access formal research training and the support required to publish in relevant, scholarly journals. This raises important ontological and epistemological issues about knowledge development through inquiry and reflection, and utilisation of an evidence-base to practice, for example. Knowledge development through *informal* networks must not be ignored or disregarded, however, particularly in countries like Fiji where the relatively small cohort of NPs means that they are more likely to know each other and communicate about aspects of their practice. While these issues are outside the scope of this study to explore, they remain potentially important areas for research.

The lack of published data by NPs in Fiji may be a reflection of knowledge transfer that has historically been more oriented toward an oral tradition, rather than one that is written. Story telling (*I talanoa*) is a fundamental aspect of traditional Fijian society and, as Katz (1993) points out, storytellers are committed to faithfully passing on what they have been told and what they know from their own experience. More pragmatically, it may be that conducting formal inquiry into their practice and 'getting published' is simply not important, or a required part of their role.

Due to economic constraints and a lack of technological infrastructure, access to nursing journals (either electronically or in print) is not possible for the majority of nurses in Fiji, which reinforces the status quo and severely limits any opportunity to initiate change based on sound research and evidence. This in turn keeps the nurses disempowered and severely limits their ability as a group to embrace contemporary nursing practices, and contribute to the development of the NP role in Fiji. For those teaching the NP program at the Fiji School of Nursing, the use of published research is also a concern. The School

has dedicated computers linked via the Internet to the James Cook University (JCU) website, which in turn enables access to the many JCU library databases. The extent to which these are accessed and material incorporated into the NP course is unknown. At the philosophical level, this raises important ontological and epistemological issues about knowledge development through systematic inquiry, reflection, utilisation of an evidence-base to practice, and evaluation processes. At the practical or operational level, descriptions of practice relationships, issues relating to staff mix and indicators of cost and quality go unreported, at least in the published literature. Pedagogically, the important role that research has in underpinning the curriculum and the teaching and learning processes utilised throughout the course is an important consideration and, once again, its extent is unknown.

In summary, there are limited published studies available into the professional world of NPs in Fiji, particularly from their perspective. This distinct lack of information by NPs in Fiji and the Western Pacific region is of concern for a number of reasons. It suggests that the growing NP workforce in this region do not as yet have a 'voice' by which it can be heard *(vaka-rogo–ya – to cause to be heard, or made known)*, which in turn means that their practice and professional identity remain hidden from sight *(tabogo)*. Further, the types of knowledge (including tacit knowledge and that based on experience, reflection, research and evidence) utilised by these NPs are yet to be explicated *(vaka-ta kila – to show, make known, reveal)*. Given the global development of the NP role, there is much that the Fijian NPs can contribute to what little is known about the role and function of NPs in developing countries. Without appropriate support and nurturing of a culture that values and rewards inquiry and publication, however, NPs in Fiji are unlikely to have the opportunity to acquire these skills, and thus begin to address the paucity of data that currently exists. Knowledge development through *informal* networks must not be ignored or disregarded, however, particularly in countries like Fiji where the relatively small cohort of NPs (27 at the time of writing) means that they are more likely to know each other and communicate about aspects of their practice. The extent to which this actually occurs is unknown.

Notwithstanding the dearth of published nursing literature about NPs in Fiji, reports are available that describe important aspects of their role. For example, Downes (2001) and

Usher (2001) have conducted evaluations of NPs in Fiji. Downes, a nurse consultant to the WHO Regional Office for the Western Pacific Region from Emory University in the United States, assisted in finalising the NP curriculum in Fiji and evaluating the first cohorts of graduates. Downes states that the NP program in Fiji "was developed in response to expressed needs and difficulties faced in staffing health centres with Medical Officers and Assistants" (Downes, 2001, p. 1). Regarding the background to the development of the NP role in Fiji, she notes the commitment by the Fiji Government to primary health care, and the failure of Medical Assistants and other mid-level practitioner roles to adequately meet workforce needs as being key factors. She cites also the recruitment difficulties that the Fiji Government was experiencing during the 1990s in regard to filling physician vacancies, particularly at health centres in rural areas and the concurrent, proactive steps the Division of Nursing in Fiji was taking to strengthen the nursing sector through the development of an expanded role. Usher's qualitative, explorative study (at that time as consultant to the WHO, Regional Office of the Western Pacific) extended Downes' work, and involved individual interviews with all of the NPs employed at that time (18), interviews with other key stakeholders (54) as well as three focus group sessions with community members. Her findings highlighted the broad scope of practice of Fijian NPs, the high level of community satisfaction that exists with the role, the urgent need to upgrade their education, the need for a career structure, and the need to review NP protocols (Usher, 2001). Together, these reports to the WHO and Fiji Government provide a useful overview of the current status and future needs of NPs in Fiji. More recently, Usher & Lindsay (2003) have published the results of an impact study conducted by Usher in 2001, drawing attention to the strengths of the role and the need for further research in areas such as scope of practice, career structure, access to further education and utilisation of NPs by the Fiji Ministry of Health. The turmoil that has characterised the socio-political landscape of Fiji over the past two decades has been widely documented, and clear links exist between these processes and the resultant emigration of many professional groups, including doctors. The emergence of the NP role is a direct consequence of this acute shortage of medical officers. Nurse Practitioners are characteristically located in underserved areas, where the absence of doctors is most acute. In Fiji, the NP role was established to meet the dire shortage of primary care

provision in these areas. Descriptive studies by Usher and Lindsay comprised the only sources of published data on the NP role in Fiji. A series of mission reports by WHO consultants chronicle the implementation of the role, curriculum development, legislative framework and scope of practice. Interprofessional collaboration has been highlighted as an important factor for the successful implementation of new roles, particularly those that challenge professional boundaries and blend knowledge and skills from several professional groups.

Chapter summary

A broad range of issues have been raised throughout this literature review which collectively provide important, published insights into the spheres of influence that impact upon NPs. Approaches to health and illness were conceptualised from both western and traditional approaches, and it was shown that there is a growing corpus of literature describing the interface of these two approaches in countries like Fiji. The emergence of NPs has been a global phenomenon, and across the Western Pacific region a variety of 'mid-level' practitioner roles have emerged, which include the NP in countries like Fiji. Other such roles include Physician Assistants (PA) and the United States, in particular, has embraced the PA role. The literature describing the development of the NP role in the author's country, Australia, has been presented and, not surprisingly, these studies have predominantly focussed upon the foundational areas of NP role definition, competency and scope of practice development, situating NP roles against advanced nursing practice, exploring interprofessional collaboration, evaluating NP models of care and describing the many clinical specialties and contexts of practice in which NPs are beginning to be employed. The absence of any published data by the NPs in Fiji is particularly notable, and a number of reasons for this were proposed. Possibilities for multi-site, collaborative research with colleagues from Fiji and New Zealand thus offers a potentially fruitful area of future research. In particular, the following topics are some important gaps in the existing literature relating to the NPs in Fiji:

- the model of care provided by the NPs in Fiji
- integration of NP-led models of care within existing health services
- educational preparation and professional development

- patient outcomes within NP-led clinical contexts
- scope of practice and expanding contexts of practice: rural and remote health centre, peri-urban health centre, regional/ urban hospital
- evolving specialist and primary care roles
- Developing an evidence base for their practice.

As NPs roles evolve across Australia, New Zealand and the Western Pacific much can be learned from the growing body of published literature related to nurse practitioners. Many gaps in the research exist and several important areas have been proposed for future research that focuses upon the development of the role across the region. A significant challenge exists for NPs in countries like Fiji who have few opportunities to access and limited capacity to interpret and apply research data to their practice. Furthermore, they are unlikely to be involved in research unless it is sponsored and facilitated by external groups or individuals. Thus, it behoves researchers from countries like Australia to establish research oriented partnerships with nursing and midwifery colleagues in these countries. The broad review provided here has contextualised the scope and intent of this study within the existing landscape of research, and further set the scene for the chapters that follow.

CHAPTER 3: METHODOLOGY, METHOD AND INTERPRETIVE FRAMEWORK

Introduction

The principle goal of this study is to critically analyse and thus gain a better understanding of the professional world of nurse practitioners in Fiji, and this chapter will discuss the interpretive framework, methodological approach and method used to achieve this. Creswell (1998) proposes that as a researcher, I bring to my study a 'basic set of beliefs or assumptions', that are divided into three broad areas, or sets of claims (p. 74). Philosophically, these relate to ontological claims about the nature of knowledge and how the nature of reality is perceived; epistemological claims about how knowledge is known and my relationship with that being researched, and axiological claims regarding the role of values, or ethics within the study. Collectively, these contribute to the metaphysical aspects contained within what Guba & Lincoln (2005, p. 193) call the interpretive framework, or 'alternative inquiry paradigm'. Linked to this are the research methods used within the study, or procedures employed to gather and analyse data, the methodology or process of research that guided the choice and use of these methods, and the theoretical perspective (philosophical stance) that underpinned the methodology.

Critical epistemological issues

Epistemology has been defined as a theory of knowledge, or 'a way of understanding and explaining how we know what we know' (Crotty, 2003, p. 3) and, because we gather knowledge in different ways, there are a variety of epistemologies. Knowledge claims in social research can be made from a variety of philosophical perspectives, in which are embedded assumptions pertaining to what constitutes knowledge. Within this study, it required me to ask: "What is the relationship between the inquirer and the known?" and, "What theory of knowledge is contained within the theoretical perspective and thus in the methodology?" (Lincoln & Guba, 2005, p. 22). Critical social constructionism embraces the influences of culture on the way individuals perceive (see, feel and interact with) the world, yet is suspicious of the reification that can occur as we identify and interpret phenomena and unquestioningly accept them as simply 'the way things are'. Indeed, when viewed through a critical lens, the meanings ascribed to various social activities are construed as being produced and maintained in order to support hegemonic interests;

such interest, notes Crotty (2003, p. 59-60), 'resists moves towards greater equity, and harbours oppression, manipulation and other modes of injustice and unfreedom.'

The 'critical' elements of the study were linked to aspects of political theology, because as a Christian and a critical researcher my value orientation and world view (*weltanschauung*) resonate with the social justice principles, political activism and Christian ethos evident within this movement. Arens (1997) proposes that political theology and critical theory both share a fundamental criticism of the 'oppressive tendencies of modernity', and 'dehumanizing structures of power and domination" (p. 238).

There are, I believe, several strong parallels evident between elements of political theology and the Fijian context, given its status as a developing country, profound cultural and socio-political struggles and strong Judeo-Christian influences, particularly among Indigenous Fijians. Of importance to this thesis, therefore, are the ways in which aspects of critical, liberative praxis are actualised within contemporary Fijian culture and, more specifically, by Nurse Practitioners. Within this study, I have suggested that the practice world experienced by the NPs reinforces, and is reinforced by, the powerful historico-cultural, political and religious ethos that is deeply interwoven throughout much of contemporary Fijian society.

Kincheloe and McLaren (2005, p. 304) define a criticalist as 'a researcher or theorist who attempts to use her or his work as a form of social of cultural criticism and who accepts certain basic assumptions." These assumptions are worth stating here, as they provide a valuable foundation for further discussion around the use of critical theory as the methodology utilised within this study. These assumptions are that:

1. All thought is fundamentally mediated by power relations that are historically constituted:

In the context of this study, it is accepted that issues of power and power relations, in whatever form they may take, have consciously or otherwise permeated the thinking surrounding the development of the Nurse Practitioner role within Fiji. Such relations have been maintained through combinations of political, professional, educational, cultural, religious and economic processes, and are embedded historically within the provision of health care and the practice of nursing within Fijian society.

2. Facts can never be isolated from the domain of values or removed from some form of ideological inscription:

No data concerning the Nurse Practitioners in this (or any other) study is value free; on the contrary, this study has been approached on the understanding that all communications are value laden. These include, of course, my own personal values as well as those of the participants who constitute the case. Ideological influences, mediated through communicative acts, artefacts and symbols, are always present and pervasive and thus constantly exert influence on the cognitive, verbal, written, interpersonal and visual processes and products concerning Nurse Practitioners in Fiji.

3. The relationship between concept and object and between signifier and signified is never stable or fixed and is often mediated by the social relations of capitalist production and consumption:

As I approached this study of Nurse Practitioners in Fiji, I did so on the premise that, *inter alia*, political and economic expediency were fundamental to the decision making undertaken by those responsible for the initial and ongoing implementation of the role. As will be discussed later, the Nurse Practitioner placed in a rural or remote area may be the most senior health professional and the Fijian people, as consumers, have little choice but to rely heavily on that NP for their health care.

4. Language is central to the formation of subjectivity (conscious and unconscious awareness):

Language in all its forms assists the individual to interpret the world, for example by decoding words and gestures, and communicating subjective experiences. To the critical researcher, language and its use are perceived as a means by which hegemonic interests are introduced and reinforced, primarily to maintain power. Examples within this study include the language used by the print media to report issues pertaining to nursing, health and health care; the language used by the civil service within which all NPs are employed; the language employed by the NPs as they communicate with their nursing, medical and allied health colleagues, and the language NPs used to communicate with their patients. The use of Critical Discourse Analysis (CDA) as the method by which data was analysed further reinforces the central role that language and social processes play within this study.

5. Certain groups in any society and particular societies are privileged over others and, although the reasons for this privileging may vary widely, the oppression that characterizes contemporary societies is most forcefully produced when subordinates accept their social status as natural, necessary, or inevitable:

Oppression and domination are central themes within critical research, and thus within this study. As a critical researcher, I aim to uncover and raise conscious awareness of the social forces which serve to maintain the subordination and oppression that I assume exists, even though it may not be recognised by the Nurse Practitioners themselves. Moreover, I contend that the concept of 'service' which historically, at least, has characterised the nursing ethos, has been exploited and normalised under the rubric of religious duty, cultural expectation and personal and professional responsibility, to the extent that it is now inextricably embedded within the role and value system of the Nurse Practitioners. I suggest also that the Fijian ethos of service can be likened to the Aristotelian concept of praxis, which was guided by a moral disposition to act truly and rightly, and a concern to further human well-being and the good life. This is what the Greeks called phronesis, or practical wisdom.

6. Oppression has many faces and that focusing on only one at the expense of others (e.g., class oppression versus racism) often elides the interconnectedness among them:

Contemporary Fijian society is characterised by a complex interplay of cultural, religious and socio-political forces, many of which are historically linked to traditional tribal relationships, British colonisation and the subsequent importation of Indian workers to develop the burgeoning sugar industry. During this era, a growing missionary presence and the resultant conversion to Christianity of many Indigenous Fijians led to the establishment of Churches throughout the country. Indians, who now constitute approximately 43% of the overall population, also contribute to a strong religious presence in Fijian society, yet they remain an oppressed group with little hope of ever gaining equality with Indigenous Fijians. The Church exerts a powerful influence on many aspects of Fijian life, including its politics, social life, cross and intra-cultural relationships, values, beliefs and aspirations. It is recognised here that such forces are invariably oppressive in some way, and that as a critical researcher I must not only be

alert to them, but also seek to raise the consciousness of those who at the same time both constitute and are subjected by them.

7. Mainstream research practices are generally, although almost always unwittingly, implicated in the reproduction of systems of class, race, and gender oppression.

As a Christian, male, nurse academic residing in a wealthy, industrialised country (Australia), I recognise that bringing a critical focus to this study of Nurse Practitioners in Fiji will inevitably raise a wide variety of issues, as it involves confronting the oppression found within the types of systems that Kincheloe and McLaren mention above. Such critique can be based on a diverse range of intentions and result in myriad outcomes, however as a critical researcher the challenge for me throughout this study is to limit wherever possible any oppressive influences that I might bring to those involved. Critical research is therefore a risky business for all concerned, yet it remains a powerful medium for change.

(Kincheloe and McLaren 2005, p. 304, italics and bold type added)

Many of the above points are clearly epistemological in nature, and Carspecken (1996) and others have endeavoured to articulate these assumptions, to a greater or lesser extent, within their own theoretical orientations. Carspecken (1996), who claims to be a 'criticalist', argues strongly that the core elements, or principles, of a critical research methodology are epistemological in nature, and do not rely on the 'value orientation' of critical researchers, though he is quick to note that such value orientations are nevertheless important. Indeed, he proposes that the motivation of critical researchers is highly 'value-driven', to the extent that they are compelled to engage in critical research by a personal desire to better 'the oppressed and downtrodden.' (p. 6). He is also quick to stress, however, that critical epistemology does not provide a 'recipe' for the emancipation of such groups; rather, it provides 'principles for conducting valid inquiries into any area of human existence.' (Carspecken, 1996, p. 8). The value orientations of researchers, therefore, should not bias, or distort the research process; and their validity claims must meet democratic principles in order to reflect a careful consideration of 'the notion of truth' (p. 8). It is this focus on validity that is of concern to critical epistemology.

Ontological issues

Ontology is 'the study of being. It is concerned with 'what is', with the nature of existence, with the structure of reality as such.' (Crotty 2003, p. 10), and is linked very closely to the epistemological concerns mentioned above. For the purposes of this study, however, ontological concerns will be broadly addressed within the critical theoretical perspective described later.

Axiological issues

For the purposes of this study, my knowledge claim position is based on an advocacy/participatory perspective which, as Creswell (2003) notes, is political in its orientation, contains an action agenda in partnership with the participants, and addresses social issues of 'empowerment, inequality, oppression, domination, suppression and alienation.' (p. 10). As a critical researcher, therefore, I endeavoured to go beyond interpretive and constructivist stances and address issues of power and justice and examine the elements that construct the social system within which the Nurse Practitioners are situated.

Critical social research

Critical inquiry is a theoretical perspective which holds that "no aspect of social phenomena can be fully understood exclusive of the historical, cultural, economic and political context in which it is situated" (Jackson, Clare & Mannix, 2003, p. 213). Critical research, states Kincheloe & McLaren (2005, p. 305) "can best be understood in the context of the empowerment of individuals. Inquiry that aspires to the name "critical' must be connected to an attempt to confront the injustice of a particular society or public sphere within the society. Research thus becomes a transformative endeavour that is overtly "political" and unafraid to embrace a relationship with emancipatory consciousness." It is thus concerned with challenging issues of power, hegemony, oppression, domination and social justice and seeks to initiate action and bring about change. Concerns such as these stimulate critical researchers to question current ideologies, interrogate commonly held beliefs, values and assumptions and challenge conventional social structures (Crotty, 1998).

The critical theory 'tradition'

Critical theory is considered by many to have its origins in Marxist criticism (critique) of social forces/existing conditions, and the term is commonly linked to Max Horkheimer and the Institute for Social Research (later given the title 'Frankfurt School'), which was established in Germany in 1924 (Arens, 1997). Bronner (2002) proposes, however, that earlier 'unorthodox thinkers', principally Karl Korsch, Georg Lukacs and Ernst Bloch who were linked to left wing, communist ideals, set the scene for the later emergence of critical theory. He argues that the philosophical works published by these writers represented a radical departure from mainstream thought at that time, and 'stood opposed to mechanistic materialism, economic determinism, and all ahistorical forms of interpretation.' (p. 6). It was against this backdrop of post Russian Revolution optimism that the Institute for Social Research was established.

Critical theory emerged in Germany in the decade following the First World War. The likes of Max Horkheimer, Theodore Adorno, Erich Fromm and Herbert Marcuse all drew heavily from Marxist writers such as Lenin, Trotsky, Luxemburg and Bukharin (Crotty, 1998). Its development was deeply influenced by the events surrounding the War – the collapse of the international labour movement, the hardening of Soviet dictatorship, and the economic devastation that led to fascism. Thus, critical theory was, at least originally, applied to a capitalist ideology wherein the working class, or proletariat, was kept oppressed by the bourgeois upper class. The critical tradition aimed to uncover, through the use of reason, the hegemonic interests and power structures within a society that maintain the status quo of inequity, poverty, oppression, manipulation and other modes of injustice (Crotty, 1998). Such examination was intended to generate knowledge and understanding that has the potential to bring about societal change, and enlightenment and emancipation to those who have been de-humanized by such forces. By employing reason, or rationality, notes Blaikie (1993), early critical theorists such as Max Horkheimer and Herbert Marcuse and later Jurgen Habermas, postulated that human beings could challenge the nature of societies. They regarded human beings as "free, autonomous agents who are able to create and control their own lives as long as their society lacks any form of alienation." (Blaikie, 1993 p. 52). Thus, emancipation, egalitarianism, liberation, happiness and rationality versus oppressive social and

economic conditions all became fundamental tenets of the critical perspective. Kincheloe & McLaren (2003, p. 436-7), in their description of a reconceptualized critical [social] theory, define it as "concerned in particular with issues of power and justice and the ways that the economy, matters of race, class, and gender, ideologies, discourses, education, religion and other social institutions, and cultural dynamics interact to construct a social system."(pp. 436-7).

A major focus of critical theory relates to ways that cultural institutions such as the media and religion are used to shape identities, and dictate what is accepted as true, normal, or acceptable within a particular culture, offering advantage to some, and marginalizing others. Critical theorists constantly concern themselves with the mechanics of this process of privilege and marginalization, and are often drawn to consider possible action against it. Every action brings into play different contexts and opens up new ways of understanding, however, requiring endless cycles of reflection and action that are intended to move society toward a more just and free state (Crotty, 1998). Contemporary critical inquiry is therefore a form of praxis, offering the opportunity for self-reflection and deeper understanding on the part of the researched, while generating empirically grounded theoretical knowledge.

In summary, critical theory may be characterised as possessing three broad theoretical traits: it rejects notions of pure reason and pure theory and by so doing is critical of idealism; it is critical of positivism, and insists that inquiry into current conditions take into account historical, social, political and economic conditions and lastly, it is critical of capitalism, and seeks to overcome it by liberation and emancipation (Arens, 1997).

What will using this approach mean?

Within this study, I recognise that advocacy borne of critical inquiry is concerned with seeking the goals of enlightenment, empowerment and emancipation, and the ways in which different forms of power shape consciousness, whilst collaboratively advancing an agenda for change. One aspect of this position is assisting Nurse Practitioners in Fiji to have a voice for change. Critical inquiry thus aspires to be transformative, is unashamedly political and aims to "expose the contradictions of the world of appearances accepted by the dominant culture as natural and inviolable." (Kincheloe & McLaren, 2003, pp. 453-4). With these goals in mind, I acknowledge here the caveat provided by

Kincheloe and McLaren (2003), that one can never be completely emancipated from their socio-political origins, yet I remain convinced that the critical approach is an effective way for me to explore the world of nurse practitioners in Fiji. Utilising a critical approach also involved consideration of the ways in which social priorities, such as the provision of an acceptable level of health care in remote areas of Fiji, are identified, as well as appraisal of the range of factors that led to the development of the nurse practitioner role in Fiji, and the ways in which this group of nurses are utilised by the Government. Importantly, this critique also involved contextual examination of the broad social status of the profession of nursing in Fiji, and the social institutions and conditions that inform, shape influence the role. Related to these are issues of class structure and socio-political, historical, religious, cultural and economic influences, and these have been examined in terms of their roles as social phenomena. The critical approach also enabled me to explore the effects of gender, culture, ethnicity, religion, politics and history in terms of their role as social events that have shaped the NP role. Issues of inter-professional domination, power, access to and utilisation of resources by the nurse practitioners and their perceived legitimacy of knowledge are important matters that are also explored within this study. It is posited here that by critically examining these factors, a richer understanding can be gained by both the researcher and the researched, leading to opportunities for emancipatory action. The critical approach used within this study raised a number of important questions for ongoing consideration and reflection, including:

- What might enlightenment, emancipation and empowerment mean for NPs in Fiji?
- Do NPs serve to ameliorate the effects of inequity, poor access to and low levels of health care experienced by people in remote areas of Fiji, and are they a cheaper substitute for unavailable numbers of doctors in rural and remote areas?
- Were NPs put in place as a means by which to legitimise the prioritization of investment in health and the healthcare workforce, and the systems which sustain them?
- Is there evidence of distorted language use within the health workforce in Fiji?
- What evidence is there of hegemonic struggle, dominance, and the use of power within the professional world of the NPs?

- What processes or mechanisms are available to the NPs so that their role *vis a vis* the rest of the health workforce is maintained, and further recognized, legitimized or rewarded?
- How does the strong cultural, religious, economic and political divide that (reportedly) exists between the Indo-Fijians and the native Fijians create forms of oppression that in turn impacts on health care and, more particularly, the roles that members of the health care team have, particularly Nurse Practitioners?
- Given the breadth of the NP role, what discourses inform and, reflexively, are shaped by this role?

Critical questions such as these shaped my thinking throughout the data analysis and discussion chapters, and helped me maintain a critical edge throughout the thesis.

Data analysis

The social practices in which all people engage daily constitute (and are constituted by) patterns of access to discourse and communicative events. Many critical researchers have explored the social practices of language and discourse and the ways in which they exert power within the world and, indeed, serve to construct it (Phillips & Jorgensen, 2002). In this context, discursive patterns and practices ascribe meaning to, and thus shape, the social world. As a critical researcher, I am concerned with investigating power relations in society with a view to possibilities for change, and critical discourse analysis (CDA) was used as the technique for analysing the research findings. As Wodak (2001, p. 2) states, 'this analytical approach aims to investigate critically social inequality as it is expressed, signalled, constituted, legitimized and so on by language use (or in discourse).' CDA is intended to contribute to addressing injustice and inequality in society (Phillips & Jorgensen, 2002). These authors note that CDA "provides theories and methods for the empirical study of relations between discourse and social and cultural developments in different social domains." (p. 60). The aim of CDA as explanatory critique is to "promote more egalitarian and liberal discourses and thereby to further democratization." (Phillips & Jorgensen, 2002, p. 88). Thus, the use of CDA enabled me to not only explore and describe the various social processes and structures which led to the production of 'texts' relating to Nurse Practitioners in Fiji, but also how the NPs, as

'social historical objects', create meaning through interaction with these texts (Wodak, 2001).

Discourse and Fairclough's Critical Discourse Analysis

There are many different definitions of discourse and Fairclough (1992), too, regards discourse in a number of different ways. In its most abstract sense, he regards it as 'spoken or written language use' within broader semiotic activities which form part of irreducible social practices and processes (p. 62). Social life is theoretically viewed, and may be therefore analysed, as interconnected networks of social practices, all of which have semiotic elements. Discourse is thus constituted by social structures and is also, at once, constitutive of them (Phillips & Jorgensen, 2001). A practice is a relatively permanent way of acting socially within a structured network of practices, however not all social practice is considered by Fairclough to be discourse. As Phillips and Jorgensen (2001) note, Fairclough limits discourse to mean "semiotic systems such as language and images (p. 67). His conception of discourse implies an action orientation and also makes the claim that a dialectical relationship exists between discourse and other elements of social life, which may have both constructive and transformative effects on other elements. He also understands discourse to be the kind of language used within a specific field, for example medical or political discourse. Lastly, he uses the term as "a way of speaking which gives meaning to experiences from a particular perspective", for example feminist discourse or Marxist discourse (Phillips & Jorgensen, 2001 p. 67). What distinguishes critical discourse analysis (CDA) from other forms of linguistic or discursive analysis is its premise that there is unequal access to linguistic and social resources by people within social life, and that these resources are controlled institutionally. This inequality produces and maintains disparate power relations and ensures the presence of hegemonic struggles over power. Importantly, dominant discourses can, or should be, criticised and problematised through analysis, identifying the presence of contradictions and assumptions, and examining both what is said and what is not said and seeking to uncover what assumed truths are present within the discourse. As with all critical social science, the problem oriented focus of CDA is on emancipation from various forms of oppression, and investigation of ways in which social and political domination are reproduced through text and talk. At the heart of

CDA, therefore, is analysis of the ways in which "discourse structures enact, confirm, legitimate, reproduce, or challenge relations of power and dominance in society" (Van Dijk, 2001, p. 353).

Fairclough's framework endeavours to draw together three traditions, namely detailed textual analysis, together with both macro and micro-sociological analyses of social practice. Any discursive event is seen by Fairclough as being simultaneously a piece of text, an instance of discursive practice, and an instance of social practice' (Fairclough, 1992, p. 4). Analysis of any communicative event, he argues, should thus consider the linguistic features of the text, the discursive practices used to produce and consume the text, and the wider social practice in which the communicative event is situated (Phillips and Jorgensen, 2002).

To this end, Fairclough has articulated a three-dimensional framework for studying discourse, "where the aim is to map three separate forms of analysis onto one another: analysis of (spoken or written) language texts, analysis of discourse practice (processes of text production, distribution and consumption) and analysis of discursive events as instances of sociocultural practice" (Fairclough, 1995, p. 2). Every instance of language is thus perceived as a communicative event consisting of 3 dimensions:

1) Text

2) Discursive practice - processes related to the production and 'consumption' of the text, and

3) Social practice to which the communicative event belongs.

Fairclough (1995, p. 98) has diagrammatically represented these dimensions of discourse as follows:

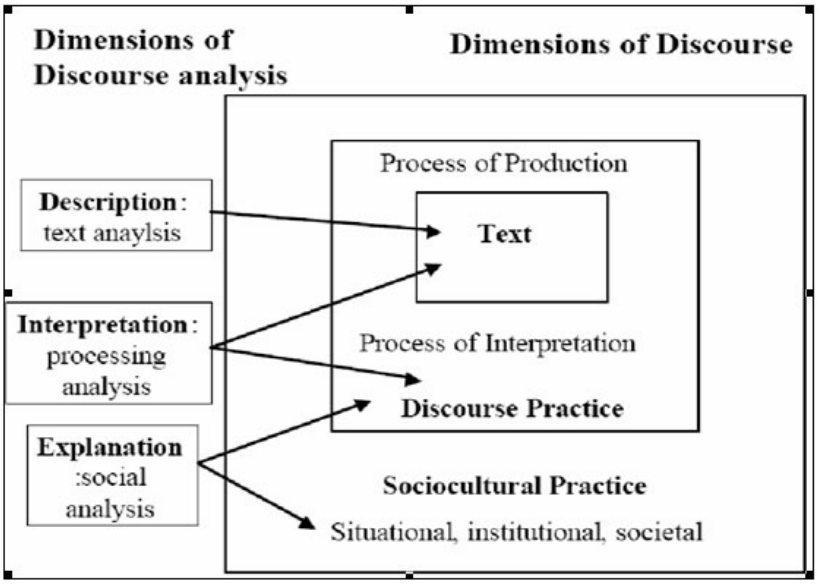

Figure 2 Fairclough's three dimensional framework for critical discourse analysis

The semiotic aspects of these social practices constitute what Fairclough calls 'genres' and 'styles', (Meyer, 2001, p. 22). The configuration of such social practices constitute a social order, or what Fairclough (borrowing from Foucault) calls an 'order of discourse' in which discursive practices are produced and consumed (interpreted). For example, orders of discourse are present within the media, a health service or an individual hospital (Phillips & Jorgensen, 2002). Orders of discourse are defined as "the sum of all the genres and discourses which are used within a specific social domain" (Phillips & Jorgensen, 2002, p. 72).

Interdiscursivity and intertextuality are also key concepts within Fairclough's approach to CDA. The former, notes Phillips & Jorgenson (2002, p. 73), "occurs when different discourses and genres are articulated together in a communicative event." By creatively mixing discursive practices, new articulations of discourses emerge, resulting in change at both the discursive and broader socio-cultural level. Interdiscursivity is a form of intertextuality, the latter being "the condition whereby all communicative events draw on earlier events." Phillips & Jorgensen (2002, p. 73). Thus, history impacts on the process of intertextuality within and between texts, as elements of them are incorporated, modified, linked and reshaped to form new texts over time. Change is manifested by this

process with, at least for Fairclough, one important caveat: such practices are limited by hegemonic relations and hegemonic struggle. Elements of Fairclough's 'critical' approach draw on the primary contributions that Karl Marx, Antonio Gramsci, Louis Althusser, Jürgen Habermas, Michel Foucault and Pierre Bourdieu have made, in order to examine ideologies and power relations involved in discourse. He notes that "language connects with the social through being the primary domain of ideology, and through being both a site of, and a stake in, struggles for power" (Fairclough,1989, p. 15). A core role of CDA, therefore, is to bring into focus what Fairclough calls 'opaque relationships of causality' between discursive practices and society in general (Fairclough, 1995, p. 132).

Fairclough's conception of hegemony and ideology resonates strongly with, and indeed draws on, that of Antonio Gramsci. For example, he endeavors to locate the relationship between discursive and social practices "within a Gramscian conceptualization of power and power struggle in terms of hegemony." (Fairclough, 1992, p. 100). Moreover, he draws on Gramsci's notion that people in social groups have different and competing ideologies which, via 'negotiations of meaning', create a collective 'common-sense' shared by members of that group. Located thus, these relationships and the associated concepts of consensus, meaning and resistance and how they contribute to the "reproduction and transformation of the order of discourse" (Phillips and Jorgensen 2001, p. 76), are able to be analysed. For Fairclough, ideologies are viewed as "domination-related constructions of a practice which are determined by specifically discursive relations between that practice and other practices." (Chouliaraki & Fairclough, 1999, p. 27). A critical policy analysis framework, such as that described by Considine (1994) was also used to analyse policy documents, as it endeavours to explore the relationship between policy texts and their historical, political, social and cultural contexts. Using critical policy analysis within a CDA framework offers the opportunity to investigate the relationship of language to other social processes, and explore how language works within power relations.

Strategy/Methods of Inquiry

Definitions of qualitative research abound, however I identify with that proposed by Denzin & Lincoln (2003, p. 4), who state that "…Qualitative research is a situated

activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world." Qualitative research researchers, therefore, "stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry." Denzin & Lincoln (2003, p. 13). It is thus holistic, humanistic and requires that I, as the researcher acknowledge, in a reflexive way, the biases, values and interests that I bring to the study (Creswell, 2003). These incorporate etic and emic issues (Stake 1995), the former comprising what I, the researcher bring to the study as an outsider and the latter being the issues for those 'inside' the case. For example, as a nurse academic in Australia, my perception of the Nurse Practitioner role in Australia has been heavily influenced by the ways in which the role has been developed and implemented across a variety of practice contexts, the response to the role by various professional and political groups, the way in which the role is regulated and the educational preparation required for the role. These are etic issues and I acknowledge them here as influences on my thinking about advanced nursing roles and the NP role in particular. Inevitably, there are parallels one could draw between the Australian and Fijian Nurse Practitioner 'experience', however this study focuses on the discourse associated with the NP role as it exists within the Fijian context, and within it the emic issues of the participants. Laverack & Brown (2003) have described their experiences of conducting qualitative research in traditional Fijian communities, and stressed the importance of modifying Western research approaches "to accommodate different cross-cultural styles of facilitation, group dynamics, spatial arrangements, gender issues, protocol, patterns of participation and perceptions of time." (p. 333). They proposed that taking these factors into account positively influenced the success of cross-cultural, qualitative research that involved processes such as workshops and group discussions.

A qualitative, exploratory approach drawing on the case study methods developed by Yin (2003) and Stake (1995) informs this component of the study design. Bergen & While (2002, p. 926) note that case study research "has become an accepted vehicle for conducting research in a number of disciplines" citing education, experimental psychology, nursing, anthropology and sociology among those out of which publications have come promoting and describing its use. Case study method was used to identify the

topic of study, and inform the sources of data and data collection methods, and the techniques described by Stake (1995) and to a lesser extent Yin (2003), were drawn upon to guide these elements. Whilst Creswell (1998) locates case study research among other major traditions of qualitative inquiry, Yin (2003, p. 14) argues that '… the case study strategy should not be confused with "qualitative research"', as case studies may comprise a variety of evidence sources. With this important distinction in mind, this case study is essentially qualitative in its orientation because of its focus on the experiences of the study participants, the contextual elements surrounding the development of the Nurse Practitioner role, and its emphasis on achieving understanding. As Munhall (2001) notes, such understanding leads to new perspectives and opportunities for action and change, these being a key goal of critical research.

Yin (2003, p. 13) provides a technical definition of a case study, stating that "A case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident." He further proposes that case studies constitute a 'comprehensive research strategy' that addresses the components of design, data collection and analysis. (p. 14). Case studies focus on what Creswell (1998) and Stake (1995) call 'bounded systems'; that is, the case is bounded by time and place. As mentioned, Nurse Practitioners in Fiji constitute the case in this study and my goal therefore was to gain a deep understanding of the unique nature of their role. This is what Stake refers to as 'particularization' (1995, p. 8). Zucker (2001, page unnumbered), notes that "Stake (1995) emphasize [sic] that the number and type of case study depend on the purpose of the inquiry: an instrumental case study is used to provide insight into an issue; an intrinsic case study is undertaken to gain a deeper understanding of the case; and the collective case study is the study of a number of cases in order to inquire into a particular phenomenon." My study was intrinsic in its orientation rather than being instrumental, to the extent that I was primarily interested in the distinctive character of the Nurse Practitioner role, as opposed to exploring it in order to illustrate an issue or generalize to other contexts, times or situations (Creswell, 1998).

Ethical and Participant Welfare Issues

As required under JCU and National Health and Medical Research Council (NHMRC) guidelines, the study followed the required process of obtaining informed consent, and signing a consent form by all participants (Appendix A). Ethical approval to conduct this study was gained from the James Cook University (JCU) Human Ethics Committee. At the time of conducting this study, Fiji did not have a research ethics committee, so a letter was sent to the former Permanent Secretary for Health in Fiji, Mr Luke Rokovada, outlining the study, my role as researcher, who the proposed participants would be and the time frame for the study (Appendix C). A separate letter was also sent to the CEO of the Ministry of Health requesting access to available documentation related to the NPs.

Once permission was gained to conduct the study, negotiations were held with senior nursing staff at the Fiji School of Nursing to identify where in Fiji the Nurse Practitioners and other key stakeholders were, so that they could be sent information sheets about the study (Appendix B). Purposive sampling was used to select the participants in the study, in order to recruit a range of key stakeholders. Following individual consent by the participants, I gained access to the setting and the participants by travelling to Fiji, making appointments to meet with them, and then conducting the interviews in their workplaces.

Face to face, semi-structured interviews were conducted with each of the participants over a two week period, and a combination of male and female Nurse Practitioners were interviewed. The participants were located on the islands of Viti Levu, Vanua Levu and Taveuni. The semi-structured interviews used a conversational style to help the respondents “tell their story”, which provided a richer data set (Minichiello, Aroni, Timewell & Alexander, 1995). The interviews were focussed, however, given the time frame of approximately one hour for each. Issues regarding language, gender and culture were clarified with each participant prior to commencing the interview. Participants were informed that during the interviews they could leave at any time, have the session temporarily suspended, the recording stopped, or the session terminated. They could also choose not to answer one or more questions if they wished. Verbal consent will also be gained before commencing each interview. Participants were informed that all information gained will be treated confidentially. Interviews and discussions were held in

a safe, non-threatening and comfortable place where they cannot be observed or overheard, and where interruptions were unlikely. Individual interviews were subsequently conducted with nineteen participants, comprising:

- 9 NPs (2 male, 7 female) from a range of practice settings, including remote and peri-urban health centres, Community Mental Health, STD/HIV/AIDS community outreach, Accident and Emergency department and Paediatric outpatients at the Colonial War memorial Hospital, Suva.
- 2 doctors that work with Nurse Practitioners in rural settings;
- The Principal of the Fiji School of Nursing (FSN);
- The Dean of the Fiji School of Medicine (FSM);
- 2 tutors that teach in the NP program at the FSN, who have completed the NP program and practised in that role;
- The Director of Nursing Services at the Fiji Ministry of Health;
- The Chief Executive Officer of the Ministry of Health;
- The Chairman/CEO of Health within the Ministry of Health, and
- The General Secretary of the Fiji Nurses Association.

This is a Category 1 study, as described within the Ethics Application, and participants were not expected to suffer any physical or psychological distress as a result of being involved. As a support measure, however, the Principal of the Fiji School of Nursing Mrs Iloi Rabuka agreed to provide support to any participant it be required. Her support was not required throughout the study.

Apart from the interviews, other forms of data were also gathered over a two-year period, and these included legislative and policy documents from the Ministry of Health, Fiji School of Nursing, Fiji School of Medicine and Fiji Nurses Association, reports by external agencies such as the World Health Organization, and newspaper articles and Hansard records. Collectively, these multiple sources of data constituted a methodological, triangulatory function by which I developed what Creswell (1998, p. 203) describes as rich, thick description that also served to verify the validity of the case and enable more confident analysis and interpretation.

My role as researcher

True to the critical paradigm, designing the study, collecting and analysing data and reporting the findings involved ongoing processes of critical (self) reflection and analysis. As a critical researcher, I recognise that I am not outside the discourse – I bring to my analysis my own assumptions, norms, beliefs, and values and these are themselves an historical outcome of discourse. In addition, I must consider how I can convey my results in a way that is not only accessible to those being researched, but can also be used by others to contribute to a more equal distribution of power. I also recognise that any possible bias I may have is not based on truth but represents a position that in turn is the result of a discursive process. As Kincheloe & McLaren (2005, p. 305) state, as a critical researcher, I must "try to become aware of the ideological imperatives and epistemological presuppositions" that inform my research, as well as my own "subjective, intersubjective, and normative reference claims." As a Christian, I regard my conceptions of the world to be aligned with a number of the central tenets of critical theory, but underpinned by a strong political theological base. I understand that in the context of this study, at least, critical theory assisted me to construct ways in which to explore and better understand the world of the NPs in Fiji. As it will later be shown, for many of these NPs a strong cultural and Christian ethos constitute seamless influences between their professional and personal worlds, such that their nursing practice is understood by them to be part of their Christian and cultural 'service', and which reflexively contributes to their resilience.

Rigour, validity and generalizability

This study utilized a qualitative, critical interpretivist approach and thus issues of rigour, validity and generalisability are conceptualized differently than within positivist research. The position used within this study is similar to that proposed by Janesick (1994), and Merriam (1998), who argue that validity in qualitative research is concerned with whether the work presents a recognisable description or credible explanation of phenomena. Cresswell (1994) asserts that, by providing clear statements about the researcher's central assumptions, biases and values, as I have endeavoured to do within this chapter, and information on the selection of the data interpreted, the possibilities for replication in similar contexts are enhanced.

Chapter summary

Critical inquiry informs the methodology used within this study, given its focus on issues of power, justice, and the ways that the economy, matters of race, class, gender, ideologies, discourses, education, religion and other social institutions, and cultural dynamics interact to construct a social system (Kincheloe & McLaren, 2003). This theoretical lens made it possible to identify the forces which acted in an oppressive and disempowering way on NPs, and opened up possibilities for change by which to ameliorate these forces.

A case study approach enabled the NPs in Fiji to be constituted as 'the case'. Case study method was used to guide selection of the various data sources, and support an in-depth analysis of the professional world of the NPs.

Fairclough's approach to critical discourse analysis provided the interpretive framework by which the data was examined. The three dimensions of Description, involving textual analysis; Processing, involving interpretation of inter-discursive practices, and Social analysis, involving situational, institutional and societal levels of social organisation, guided the linguistic analysis of the texts, the processes of production and consumption of the above texts, and explanation of the relationships between discursive and social practices. Applying Fairclough's framework enabled important links to be made between the current socio-political situation in Fiji, the health workforce, the emergence of the NP role and its associated discourses. Linguistic analysis, though a lesser focus, provided important insights into the features of texts which comprised my data sets, which included interview transcripts, government documents, WHO reports and newspaper articles.

CHAPTER 4: NURSE PRACTITIONERS: RELATIONS OF POWER AND EXPLOITATION

Introduction

This is the first of three chapters in which Fairclough's model of critical discourse analysis (CDA, described previously) is used to examine three major themes that emerged from the texts employed within this study. The three *dimensions* of discourse within Fairclough's model: sociocultural, discourse practice and textual, are analysed simultaneously using the associated dimensions of discourse *analysis*, i.e.

- description - text analysis;
- interpretation – processing analysis, and
- explanation – social analysis (Fairclough, 1995).

The analyses constitute what Janks (1997) terms "the interdependence of these dimensions and the intricate moving backwards and forwards between the different types of analysis which this interdependence necessitates" (pp. 1-2). At the level of textual analysis, a highly detailed description of the linguistic elements of the above texts has not been undertaken; rather, the analysis focuses on a more thematic approach. As noted by Smith (2007), this is a valid method within CDA given that an aim of this study is to identify the key themes evident within the texts *vis a vis* the overall topic under investigation.

A fundamental premise of the critical approach used throughout this study is that asymmetrical power relations characterise the interactions between the NPs and their communities and 'patients', NPs and their medical, nursing and allied health colleagues, and NPs and the Government. Critical analysis of the discourses associated with these relations assumed that they function ideologically, such that they "appear given, commonsensical and 'natural'" (Luke, 1997; Janks & Ivanic, 1992). By so doing, they help secure what Gramsci (1971) called a hegemonic relationship, characterised by domination, exploitation and subordination.

The analyses presented in the following chapters will identify these relationships and their impact on the professional world of the NPs. Commencing with a more 'macro' perspective serves to situate the NPs within the wider socio-cultural field of health care

within the Western Pacific Region and Fiji, and recognises that forces outside the country also powerfully shape health and the health workforce within it. The opening sections aim to contextualise these relationships, and lay the foundation for a deeper analysis of the discursive practices and processes that shape the role and function of the NPs.

Primary Health Care and the WHO: its influence on health services in Fiji

The World Health Organization (WHO), via its regional office in the Western Pacific, has for many years been hugely influential across a broad range of health issues in Fiji, as it has for all countries within the region, particularly the poorer and less developed. Its main purpose is to "lead the regional response to public health issues on all fronts - medical, technical, socio-economic, cultural, legal and political - towards the achievement of WHO's global health mission" (http://www.wpro.who.int/about/about.htm). By self-declaring its leader status across the major spheres of power and influence within the public health domain, WHO has positioned itself as the hub around which many other related activities revolve, from a regional to a global level. Furthermore, the web site of the World Health Organization Regional Office for the Western Pacific declares that the Regional Office acts as 'the health conscience of the region', suggesting it also possesses an ethical mandate on top of its already far reaching statement of purpose. In the context of this study, a number of policy documents and mission reports (some of which were cited earlier) produced by the WHO were examined and will be discussed in relation to the health sector in Fiji and, more specifically, the development of the NP role.

Over the past fifty years, the Fiji Government has endeavoured to improve access to primary health services by Fijians who inhabit the rural areas on the two main islands of Viti Levu and Vanua Levu, as well as those on the many outer islands that comprise the Fiji archipelago. This has largely been in response to the adoption of the principles of comprehensive Primary Health Care (PHC) espoused within the Alma-Ata declaration of 1978, which had been actively promoted through the 1980s to the year 2000 by the World Health Organization. The original vision of improved health for all people has since adopted a more focussed approach, under the rubric of Selective Primary Health Care. Considerable debate and controversy have accompanied this shift, with many suggesting that the original goals have been watered down and even lost (Cueto, 2004). As Hall and

Taylor (2003, p. 19) note, "The "World Health Report 2000, Health Systems: Improving Performance" marked the end of WHO's use of PHC as the means for the delivery of healthcare services in resource-poor countries." While it is outside the scope of this study to explore these changes in any detail, it is important to recognise the impact that they have had on the ways in which health services are organised in developing countries like Fiji.

Health service organisation in Fiji

Since the 1960's, over 900 village clinics, 124 nursing stations and 75 health centres have been established throughout remote, rural and peri-urban areas of Fiji. These primary care centres constitute a network that feed into 19 sub-divisional medical centres, 7 sub-divisional and 3 divisional hospitals that provide secondary and tertiary levels of care, as well as the 3 specialty hospitals that cater for tuberculosis, leprosy and mental health patients. One private hospital, located in the capital Suva, provides a full range of services as an alternative to public health system (Sharma, 2002; Fiji Government, 2005). Creation of this decentralised model of health care, constituting several tiers of service capability across the remote-urban continuum, is not dissimilar to that seen in many other countries such as Australia, Africa, the United States and Canada, which also have a widely dispersed population across a large and varying geographical area.

The influence of global health workforce trends

There is increasing evidence of a burgeoning global health workforce crisis, with both developed and developing countries experiencing shortages, particularly in the medical and nursing arenas (O'Connor & Hooker, 2007). Estimates by the WHO indicate that the workforce shortage now exceeds 4.5 million, and is growing (WHO, 2006). Furthermore, there is inequitable distribution of health workers *across* countries and also an imbalance *within* countries, with rural and remote locations being the most disadvantaged (WHO, 2006). Political instability has been noted to further exacerbate this problem and this has been evident in Fiji following the coups of 1987, 2000 and 2006, following which many tens of thousands of professionals, including doctors, left its shores for more secure positions overseas (Baravilala & Moulds, 2004). The economic implications of this for Fiji are, not surprisingly, substantial, and have been poorly quantified to date (Reddy, Mohanty & Naidu, 2004). Importantly, it was this political upheaval and subsequent

migration of many medical officers that dramatically accelerated the need to urgently introduce the NP role into remote areas where the medical shortage was most acute. Brown & Connell (2004), in their study on the international migration of skilled health professionals (SHP) from Fiji, Samoa and Tonga, have suggested that "In the health arena the significance of human resources is doubled; SHPs directly improve the quality of life for others, who are then able to contribute more to the wider society. Conversely the lack of availability of skilled health workers has harmful ramifications for the rest of society." (p. 2193).

The WHO has also noted with alarm the negative impact that the global health workforce shortage is having on the health of people, particularly in poorer countries. A variety of strategies have been employed to address the shortage and maldistribution of the medical workforce, in particular, including the development of new categories of health worker such as NPs (WHO, 2001; Australian Government, 2005). Other strategies have included the importation of medical graduates from overseas, increasing the number of medical schools and boosting the number of medical graduates from Medical Schools (O'Connor & Hooker, 2007). Despite these initiatives, there remain significant short and long term concerns regarding the global health workforce which have inevitably prompted the Fiji Government to experiment with a variety of mid-level practitioners.

The Medical workforce in remote areas of Fiji – problems and early solutions

The Fiji Government sought to address the chronic medical workforce shortage in rural centres by commencing the training of Medical Assistants 1978, which was a WHO supported initiative. While they reportedly made an "important contribution to primary health care delivery" (Stark, 1997), they ultimately proved to be unsustainable. The reasons for this are unclear, although factors such as little opportunity for career mobility or advancement have been cited (Downes, 1998). In 1991, this program was replaced by a different model of health worker called a Primary Care Practitioner (PCP) who underwent a 3-year, community based training program at the Fiji School of Medicine, again with a view to providing primary care services at the remote health centre level. Once again, this group proved to be unsustainable, once again due to a perceived lack of status and limited career mobility or advancement opportunities (Downes, 1998). It is important to note that throughout this time nurses in remote posts were working well

outside their scope of practice, performing activities for which they had inadequate educational preparation and clinical supervision, and thus little or no legal cover. How such practices became naturalized for these nurses is unclear, but it is reasonable to assume that they were partially filling the practice vacuum created by the absence of medical officers. Given the failure of the MA and PCP models, a mounting crisis in health care provision in remote centres, and the potential ethico-legal minefield that existed due to nurses working outside their scope of practice, the Ministry of Health was clearly under pressure from a number of quarters to urgently address the need to develop a sustainable cadre of health worker that would be legally empowered to provide comprehensive care in rural and remote areas. As a senior Government Minister stated during interview:

> *'And for us I think if that is no a very ah the… we cannot call it a short-term and long-term solution to addressing our problem of ah doctors ah because we forty, nearly forty percent of our current ah doctors total doctors here in Fiji are expatriate, yeah. And ah somewhere along the line we have to gradually decrease those. Yeah. And um and ah the nurse practitioners…the because of er of ah our we cannot control our the moving of our people we need to, to assist… to… make sure that nurse practitioners ah programs continues and those in trying to meet our needs, ah maybe not on specialised areas which we hope F. S. M. will conduct… and then we do not control the end part of our system we know the numbers that we can take I mean I'm thinking broadly of our like Fiji School of Nursing and ah F. S. M. we take in fifty every year in doctors training and we take in right ah now about two hundred so we know exactly the number, we can control this is one but the end part of it, we have no control on this, yes so unless we sort of er have a control on those, no? Then we can at least stabilize ah the movement of our people, eh? But that is a long way down the line and I do not know when it's going to happen but for nurse practitioner there is going to be a need now, a need in the future for them, yeah because they meet the criteria of ah, no? rural outer station, of our people of our personnel that we send there eh? And because of their nursing experience, I mean it's like ah killing two, two bird*

with one stone. You have a doctor and nurse here so if there is any need for nursing kind of, ahh, work they will be able to handle those and even some, excuse me (coughs) the doctor's ah role, satisfy the doctor' s role in the rural community, yeah.'

(Phillip, p. 3-4, 74-94)

This response highlighted the intention of the Ministry of Health to substitute vacant medical positions in remote areas with NPs. The interviewee spoke of global market forces that were causing increased migration as medical graduates moved to 'greener pastures' after a few years. He lamented the lack of 'control' that the Government had on the end product (medical graduates) of Government investment, but that the NPs were produced locally 'for the local market' in a relatively short time in comparison to doctors and were 'putting on doctor's coat', suggesting they were in fact replacing them, in remote areas at least. He also spoke of NPs 'killing two bird with one stone' in that they not only possessed extensive nursing and midwifery skills, but these were combined with basic primary curative skills normally taught to doctors, to produce a practitioner with a very broad range of knowledge and expertise.

Identifying social and discursive processes

There appear to be several orders of discourse being drawn on in the above excerpt. First is that associated with the global labour market, and the acute need of the Government to assert its power and control over the health workforce in an epoch of widespread shortage, increasing mobility and intense competition. With over 40% of the medical workforce comprising costly expatriates, there can be no doubt that the Fiji Government had been desperately seeking a cost effective and sustainable solution to the provision of primary medical care to its many remote communities. To this end, there is clear evidence of political power being wielded as the Government asserts its control over nursing, as evidenced by the above respondent stating that 'we' have a program that is tailor made to 'our' needs. It is unclear whether the 'we' he is referring to is the Government alone or includes the medical profession. A senior official in the Ministry of Health highlighted the relative costs associated with medical and NP training:

> *'It is cost effective and meeting our lower-level ah kind of um medical er you know work that needs to be done in rural areas and er like you said the cost for six years is, is over two hundred thousand training one doctor and for nurse practitioner we trained them for one year, one year six months and the cost is a, is a big factor in maintaining the nurse practitioner program and secondly like you said we have ah somehow control this because their qualification is only recognised locally and that is a big plus for us in maintaining them in the system, uh?'*
>
> (Phillip, p. 4, 101-107)

Economic discourse is also evident, as the inevitable effects of globalisation were felt and Fiji endeavoured to improve its standing on a shaky financial platform made more perilous by continued political instability, the withdrawal of foreign aid, reduced investment and tourism, and expulsion from the Commonwealth. Wealthier countries were seen as competing and superior bases of power and influence, able to lure Fiji's valuable human resources, notably doctors and to a much lesser extent nurses, with offers of better salaries and conditions, which Fiji is unable to match. This circular process sees Fiji continuing to produce expensive medical graduates every 6 years, many of whom eventually enter the global market and potentially become lost assets to Fiji's workforce, the important economic contribution of remittances back into Fiji by these and many other groups not withstanding. Another senior Government official that I interviewed reinforced this scenario, stating that the main impetus for the introduction of NPs was the 'continued wastage' of doctors, who were prepared locally at the Fiji School of Medicine but then after a few years went overseas to practice.

Rural medical practice perceived to be a waste of resources

A senior medical officer I interviewed also reinforced the view that rural/remote medical practice was a waste of resources, and that it was more appropriate to place doctors where they were needed most, namely in larger hospitals and health centres. He stated that:

> *'Take for instance in ah rural health centres ah and I think also from maybe anecdotal ah reports of MBBS graduates going to the health centres and after serving one or two years, coming back and telling their supervisors that it was*

> *a waste of time, you know training for full six years, going to the health centre and see only maybe 10 patients and maybe out of those 10 patients you are doing five dental extractions because you do dental extractions too, so (short laugh) whether it's worth it or not…'*
>
> (Paul, p. 2, 45-51)

This suggested that using the common primary medical care model whereby doctors passively engage with their patients via consultation was perceived as a poor use of scarce medical resources in rural health centres. Furthermore, the work was viewed as being repetitive, slow, and outside that normally engaged in by doctors. When coupled with professional isolation, reduced availability of many basic diagnostic and treatment facilities, an inability to specialise, reduced opportunities for continuing professional education, long hours and limited social infrastructure such as secondary schooling, it is little wonder that there continue to be many medical vacancies in rural health centres. Importantly, many of these factors are no less real or relevant to the NPs, and it is suggested here that the privileged position of doctors, together with their maldistribution in favour of urban and peri-urban areas and overall short supply, has directly contributed to the ongoing vacancies in rural health centres. An important corollary of this lack of enthusiasm by doctors to practice in remote locations is that it has largely prevented the 'turf war' that has been appeared within the discourse of segments of the medical fraternity following the introduction of NPs in neighbouring countries such as Australia and New Zealand. Such tensions stem from entrenched and previously immutable relations between the medical and nursing professions which, from a critical standpoint, have contributed to the historical development of markedly unequal power relations, domination and oppression (Fulton, 1997; Blue & Fitzgerald, 2002).

The WHO Missions – laying the foundation for implementation of the NP role

In response to the growing medical workforce crisis in remote areas, a series of six WHO Missions were conducted between December 1997 and December 2001, the reports from which described the establishment, implementation and evaluation of the NP program. Dr Ruth Stark, a Registered Nurse who at the time held the position of Regional Adviser in Nursing for the World Health Organization in the Western Pacific Region, based in

Manila, was requested by the Fiji Ministry of Health in 1997 to conduct an initial mission, the objective of which was to "provide technical support to the Ministry of Health for the development of a mid-level practitioner program", as the Ministry was "planning to train nurses as mid-level practitioners to staff the rural health centres where there are no doctors" (Stark, 1997 p.31). She noted that **prior** to the establishment of the MA and PCP models of health care worker, "it was proposed to give advanced training to nurses so that they would have the clinical primary skills needed for working in remote areas." (1997, p. 31). For reasons that are unclear, this was rejected by the Government in favour of the medically oriented models that subsequently proved to be unsustainable.

In order to address the continuing vacancies and associated lack of primary care health services available in remote areas, the Fiji Nurses and Midwives Board in December 1996 *re*submitted a paper to the Ministry of Health (MOH) recommending that nurses be trained as a new cadre of mid-level primary care practitioner. Stark noted that on this occasion the recommendation was 'enthusiastically endorsed' by the MOH, and in April 1997 a National Health Conference formally ratified the introduction of nurse practitioner, stating that "The Conference accepts the need for the introduction of a nurse practitioner cadre to fulfil the country's mid-level practitioner workforce requirements and that appropriate training and legislation be put in place as soon as possible." (Stark, 1997, p. 32). Stark's report included the recommendation that a NP tutor from overseas be recruited to assist with initial curriculum development and mentoring of tutors at the Fiji School of Nursing, and that a career structure be developed and submitted to the Public Service Commission for ratification. Elizabeth Downes, a Nurse Practitioner and educator was subsequently recruited from the United States to assist with formulation of the curriculum, organise teaching of the new course at the Fiji School of Nursing, and evaluate each stage of its implementation.

The initial report produced in 1997 by Dr Ruth Stark included support for the proposal by the Fiji Nurse Practitioner Steering Committee that the preparatory course, entitled the Advanced Diploma in Clinical Primary Health Care, comprise 13 months of full time study. It is unknown how often this Committee met, and any minutes from its meetings have been unobtainable, so there is no way of examining the decision making processes that were used, or the outcomes of the meetings. Given the nature of the role being

developed, however, it is not surprising that key Government officials and Medical Officers were heavily involved in those early stages. Indeed, the Steering Committee was chaired by a Medical Officer who held the position of Director, Primary and Preventive Health Services and several other medical doctors were also members, along with the Director of Nursing Services and the Principal of the Fiji School of Nursing. Further, an indigenous Medical Director for the nurse practitioner program was recruited, ostensibly to 'support the clinical training' of the NPs (Stark, 1997, p. 2). In reality, this latter position appears to have included responsibility for liaising with medical practitioners in order to facilitate clinical practicums and supervision for the NP students, the delivery of lectures, and the coordination of workshops on the insertion of intra-uterine contraceptive devices, and the conduct of PAP smears, male circumcision and limited dental procedures, particularly tooth extraction. It is clear that the role was designed to be heavily oriented toward primary medical care, and this was reinforced by Stark in her report when she stated that in Fiji "A nurse practitioner is a graduate nurse midwife with advanced clinical training in the diagnosis and treatment of common health problems.", and that "In Fiji, the primary purpose of training nurse practitioners is to staff vacant health centres. Thus, the focus of the training should be to prepare nurse practitioners to provide basic curative primary health care services." (1997, p. 3). The words 'basic curative', 'diagnosis', 'treatment', 'management', and 'referral' are used by Stark to describe the role of the NP and together with the types of activities in which the NPs would engage, strongly reflect the predominantly medical nature of the role and associated medical discourse being drawn on. Members of the medical profession in Fiji have maintained close control over the NP program in a number of key areas. These include conducting lectures within the Course, supervising the students and graduates in clinical areas, providing advice regarding their deployment throughout the various sub-divisions, contributing to the selection of students and lobbying Government to continue the education of NPs to staff remote Health Centres. Such control effectively serves to reinforce the domination of medicine over the core components of this nursing program, which reflects the wider inequality of power relations between the two professions.

The WHO consultancy process to establish the NP role in Fiji also involved academics from Australia and the US, together with the WHO regional nurse educator. In addition,

two Masters of Nursing students, Haddad and Williams, from Emory University in Atlanta, Georgia, conducted an evaluation of seven of the fist nine NP graduates between November 2000 and January 2001 which formed one phase of a mission conducted by WHO consultant Elizabeth Downes, an academic also from Emory University, who undertook the majority of missions to establish and evaluate the NP program in Fiji over a 4 year period. Professor Kim Usher, from the School of Nursing Sciences at James Cook University in Townsville, Queensland, also conducted a two-week review of the impact of NP services during November/December 2001, which raised a number of important issues relevant to this study. Unlike her predecessors, Usher had not been involved in the development and implementation of the program, and thus was arguably less encumbered by a sense of ownership and responsibility than Downes, in particular, who had developed a very close relationship with the key stakeholders and the course curriculum. Like her predecessors, Usher interviewed many of the NPs and observed them at work, and held meetings with senior Government officials, Elizabeth Downes and other key stakeholders involved with the delivery of the Course (Usher, 2001). Usher identified that many of the concerns raised earlier by Downes (2000) still existed, and that for the NP role to be sustainable many changes would need to be implemented. Her major concerns focussed on:

- inadequate remuneration commensurate with their expanded role;
- indiscriminate deployment of NPs from Health Centres to major hospitals;
- a lack of a formally identified career pathway;
- the need for greater clinical mentorship, and
- providing the NPs with opportunities for continuing professional education.

(Usher, 2001)

These concerns are clearly substantial, and no doubt contributed to the continued feelings of exploitation and disempowerment expressed by the NPs interviewed in this study.

Despite the problems raised by the WHO consultants, they found that there was a positive perception of the NPs among people in remote areas, some of whom stated that they preferred the NP to a doctor, because ‘they combine what is expected of a doctor and a nurse’ (Usher, 2001, p. 3). Usher noted the difficulty in quantifying the impact of the NPs

on the health of people in remote areas, although given the anecdotal evidence, their broad scope of practice, and the fact that if they were not there people would either not receive care or have to travel long distances to access a doctor, it was concluded that the impact was positive.

Discursive analysis of the Mission Reports

The series of six Mission Reports produced by the consultants between 1997 and 2001 generally followed a consistent, standardized approach in terms of their format and layout. The exception was that provided by Haddad and Williams, which included many excerpts from their interviews with community members served by NPs, as well as the NPs themselves. Their mission was intended to review and evaluate the NPs and the NP program, in particular to describe the "community acceptance and practice patterns of Fiji's first class of nurse practitioners." (Haddad & Williams, 2000, p. iii). They noted in their report that the review was partly funded by a Fellowship from the Rollins School of Public Health at Emory University. These two students used their experiences as part fulfilment of the public health component of their dual Master of Science in Nursing/Master of Public Health (MSN/MPH) degree. As such, their review primarily served to achieve this purpose although this is not stated anywhere in their report. Not surprisingly, the general layout of their report and the language used within it was noticeably different to the other WHO Mission reports. It was cited by Downes (2001) and a copy (excluding annexes) appended to her WHO Mission Report MR/2001/0854. Their document was entitled: "Achieving Health For All through Community Partnerships: the key roles of Nurse Practitioners in Fiji". A 'suggested reading guide for stakeholders' for the various sections of their report was provided in table form, which was not consistent with the style generally used in WHO Mission Reports. Downes suggested that 'Multiple audiences may use this report' (p. iii), and it was sent to the Ministry of Health, The Medical Director of the NP program and 'key persons at the Fiji school of Nursing' (Downes, 2001, p. 2). The 'Context', 'Objectives' and 'Methods and Conceptual Framework' sections of the report all contained a number of in-text references from diverse sources including published articles from a range of different journal types, Fiji Ministry of Health data, WHO Mission reports by Elizabeth Downes, *Fiji Post* newspaper articles, WHO publications, books, and a memorandum from the Fiji

Public Service Commission. A reference list was also provided at the conclusion of each section, which also is not a style typically used in WHO Mission Reports, but is more in keeping with a formal piece of academic writing. Fairclough (1992, p. 233) refers to this as the 'manifest intertextuality' of a text, or the way in which other texts were used, or drawn on in its formulation. Relevant findings were also reportedly made available to the NPs who were interviewed and to their respective communities, but it was not stated whether any follow up occurred with either of these groups in order to gather feedback.

Applying Fairclough's framework

At the level of discursive practice, there are a number of points to make at this juncture. In terms of the distribution of the text, this document has entered into what Fairclough (1992, p. 232) calls an 'intertextual chain', whereby it becomes transformed by its various consumers into other text types and is thus linked to different discourses, such as those associated with government policy formulation, education and training, and health workforce development. For example, the data gathered was used by the two students in their Masters theses, was referred to by successive WHO reviewers of the Fiji NP program, and it has been drawn on as part of this thesis. It may also be used by key stakeholders in Fiji to guide curricular modifications, or bring about a change in government policy in areas raised by the reviewers.

The reviewers drew on a variety of discourses and genres, including those associated with health care, education and training, quality improvement, nursing, health planning and workforce development, evaluation, and qualitative and quantitative research, and interwove them in the creation of their report. This is an example of what Fairclough (1992) refers to as interdiscursivity, wherein "different discourses and genres are articulated together in a communicative event" (Phillips & Jorgensen, 2002, p. 73). A heteroglossic blend of styles was used throughout the document, with the initial sections citing a number of references which, as suggested above, indicates a more formal academic style. The authors used both qualitative and quantitative approaches to gather their data, incorporating interviews with NPs, community members and the caregivers of children seen by the NPs, observation of NPs during clinical encounters, document analysis/audit as well as a formal 'stock take' of the health centres visited which was intended to 'quantify and describe resources available to NPs and communities' (Haddad

& Williams, 2000, p. 10). A core component of their review focussed on describing the quality of care provided by NPs, with stated objectives being to 'assess community satisfaction with NPs', 'assess effectiveness of patient education by NPs' and 'Determine competency of NPs in the case management of selected primary care problems.' (Haddad & Williams, 2000, p. 9). Collectively, these processes appear quite rigorous and the NPs being evaluated may have justifiably felt that their professional practice and the context in which they worked were being thoroughly scrutinised for their quality, efficiency and effectiveness. Given that the two reviewers were previously unknown to the participants, yet came with the authorization of the Ministry of Health and were joined by Elizabeth Downes and, for two visits, the Medical Director of the NP program, the participants seemingly had little choice but to contribute to the review process. Surprisingly, there was no mention in their report that formal consent was gained to interview any of the participants, and no consent form was mentioned or included as an annex. From a critical perspective, these factors may be interpreted as representing and reinforcing unequal power relations between the researchers and the researched. Furthermore, their findings may conceivably be used by key stakeholders as a resource in 'cultural and social engineering' in order to impose change wherein research is incorporated into bureaucratic and managerial agendas, thus becoming a manifestation of what Fairclough terms the 'technologisation' of discourse (1992, p. 239). A sweeping solution offered by Fairclough to this burgeoning trend of technologising discourse is to include critical language awareness (CLA) in all school curricula, so that from an early age learners can "become more conscious of the practice they are involved in as the producers and consumers of texts" (1992, p. 239). A project of such magnitude is of course also directed toward bringing about radical change, but one which Fairclough believes to be consciousness raising and thus potentially emancipatory. In the context of this study, I as a discourse analyst am aware that these findings may be used in various ways to promote different socio-political agendas. From the perspective of the NPs, undertaking basic CLA studies in order to raise their consciousness regarding the power of texts and how language and discourse shape their role would no doubt provide many useful insights.

Listening to the voices of community members – are they really being heard?

In the report by Haddad and Williams, a large number of excerpts from the interviews of community members and the NPs were included, and these were somewhat loosely clustered under eight and seven thematic headings respectively. Notably, all of the excerpts from the NPs were de-identified, which kept their comments anonymous whereas all those by community members were followed by identifiers in parentheses, such as '(Lokia Settlement community member, Raiwaqa)', '(Lomati husband and wife, Cicia)', and '(Laselevu grandmother)'. Perhaps this was done to reinforce the fact that a wide range of community members were consulted, and by clustering their comments under themes there were common issues raised across these different groups. All the community quotes were also placed in inverted commas, whereas those from the NPs were not, even though they also appeared to be quoted verbatim. The reason for these inconsistencies is unclear, but may reflect a comment by the authors that "Since communities speak more eloquently for themselves than can be summarized in a table, the **Voices of the Communities** section honours their contribution to this review." (bolding of the title was included by the authors). No such acknowledgement was accorded to the NPs for their input, but they were thanked for their 'warm hospitality'. These subtle clues within the text suggest that a very different relationship was established between the reviewers and community members, and the reviewers and the NPs, such that involvement of the NPs was assumed, lacked little if any negotiation, and appeared of almost secondary importance to the goal of engaging with as many community members as possible. In contrast, involvement of the community members was ostensibly voluntary and thus used different and possibly more subtle forms of coercion and was as a result valued differently by the reviewers. One hundred and eight interviews were conducted with community members served by the seven NPs interviewed, and this reflected the statement that these communities were the 'primary intended users' of the review (Haddad & Williams, 2000, p. 15). Notably, however, it was not stated how the findings could actually be operationalised by those communities. Also, in the 'suggested readers guide for stakeholders' table mentioned previously, by ticking a box the reviewers nominate which aspects of their review should be read by which groups. Communities were advised to read the least number of components,

namely the Executive Summary, Issues raised by the review, Actions for Consideration by the Ministry of Health and Appendix C, which was the 'stock take' of their health centre. This not only assumed a level of familiarity with this style of document, but also an ability to be able to read it and that it was made available to them. Given that many of those interviewed reportedly did not speak English (though it is not stated how many), and Fijian and Indian translators were required, it can be reasonably assumed that many may not have been able read English, and thus would not have been able to read the document without assistance. By contrast, the WHO and future NP program evaluators were advised to read all fourteen sections of their review. Importantly, ***none*** of the 'Actions for Consideration' were actually directed toward the communities or the NPs themselves, but to the Fiji Ministry of Health and the World Health Organization, which effectively removed the former groups and their 'voices' from any further direct participation in the change management process. Analysis at the level of discourse practice indicates that directing the review and its findings to the attention of the organizations which have the power and resources to bring about change appears appropriate and 'commonsensical'. At the level of sociocultural practice, however, this may serve to further disempower the NPs and the community members, and reinforce the hegemonic domination of the Ministry of Health and the WHO in controlling the decision making associated with health care delivery in remote communities.

The final section of the report contrasted markedly with the narrative style described above, as many pie charts and bar graphs to present aspects of their data were used, giving the impression of a level of statistical analysis and a style of data presentation more often seen in government documents or research reports that use quantitative analytical methods. The reviewers identified 15 themes and these were then synthesised into 5 'key issues', described as 'Actions for Consideration' by both the Fiji Ministry of Health and WHO Western Pacific Region. The report did not state how these key issues were identified or whether they represented reality as far as those interviewed were concerned, but they nevertheless were specifically directed at the Government and WHO for their consideration *and* action. Placed under the title 'Actions for Consideration' may be interpreted as being a somewhat 'softer' option than the heading 'Recommendations' normally included in a formal Mission Report. It is tentatively suggested that this served

to reinforce not only the lower status of the students as reviewers, but also that their report was less formal, carried less discursive 'weight' and therefore held reduced power and influence.

In the short preamble to the discussion of these themes, the reviewers appeared to go to some lengths to foreground the positive aspects of the NP role, thus backgrounding any of its negative elements. They described the program as 'sound in design and successful in implementation', and stated that their report 'validates the wisdom and careful planning that has been invested to date', and repeated that the program was both sound and successful and that their 'Actions for Consideration' were 'offered as ways to support and strengthen a visionary program…'. Deliberate use of these somewhat obsequious phrases served to position the reviewers as enthusiastic supporters of the program as well as those involved in its development, the principal consultant Elizabeth Downes and the NPs themselves. The report's objectivity must therefore be questioned, so too its contribution toward the maintenance of the status quo in terms of the social practices that shaped the NP role. It does not appear to challenge the power position of the Government and medical profession and thus may be seen as maintaining existing power relations (Phillips & Jorgensen, 2002).

Notably, the reviewers were also NPs and thus would have been cognisant of the educational preparation, scope of practice and resources required to perform the role, at least in the United States. As Downes stated in her associated Mission Report, "the findings [of Haddad and Williams] have provided data that can be used to improve the Fiji nurse practitioner programme." (2001, p. 2). The text is therefore clearly supportive of the practice of using NPs as replacements for doctors in remote health centres, whilst offering polite suggestions as to how the program might be improved.

Pedagogic concerns related to the NP Course

Haddad and Williams' report described above highlighted the positive impact that the seven NPs had in their communities, and the high level of acceptance of them by people in those communities. Similar to other reviews, it also reinforced the difficult circumstances under which the NPs practiced, particularly due to a lack of necessary human and material resources needed to do their job effectively, many of which continued to be a concern when I interviewed the NPs. Unfortunately, despite there being

a unanimous view among the NPs that the program needed to be extended, that it was too intensive, and that this significantly affected their learning, this did ***not*** translate across into an issue for action by the Ministry of Health. This finding was also highlighted during the interviews conducted for this current study, with respondents stating that the Course could have been longer, over at least 2-3 years to enable proper consolidation and integration of the theory and practice components. A number of the NPs interviewed expressed real concerns over the Course, as seen in the following excerpts:

> *'No! I think that there should have been, oh well….they could have made it more, a bit longer! Given us more time! And one of the things that we have talked about when we came out was that we didn't have a period of internship where we came to work under somebody, under supervision. That I didn't understand, because the medical students, who did it for six years had an internship year, where they were still supervised. Why didn't that happen to us? I mean, we were taken from where we are and thrown into the place and you had to do it on your own and make decisions and refer and everything.'*
>
> (Timoci, p. 6, 177-183)

> *'It's not, not long enough. It's really too, too compact. I think it has to be at least three, two to three years, mm, then you can really become ah well prepared, you, you can be well prepared to come out.'*
>
> (Simon, p. 5, 146-148)

> *'I think it's too short.*
> *DL Too short. Yeah. How long do you think it should be?*
> *At least for two years, yeah. Aaah, because like for the nursing thing in Fiji it's just like a* ***shocking*** [said with strong emphasis] *thing for us, yeah! Having to go from here registered with clinical assessment and yeah, so…ummm, I don't know about now with the nursing, the basic nursing program, eh? But, like from the time that we went into nursing school it's more diversified now but I think that ummm, the, the length of time we would appreciate it if it would be just at least about…two years.'*

(Talica, p. 7, 276-283)

This latter NP contrasted the dramatic (‘*shocking’)* difference from when she had undertaken her initial nurse training many years ago, to what was covered within the NP program. Other NPs described the Course as being ‘really intensive and tough’, and that there was a lot of pressure placed on them, reading and writing assignments. One also stated that it “didn’t prepare me for the administrative side, having to look after staff of 20 people” which for this graduate was at the hospital on the remote island of Rotuma, where she was placed in charge immediately following graduation. Some stated that the Course ‘brushed over’ some things, such as the management of emergency cases, and that mental health was not covered to any degree. It appeared, therefore, that the NPs felt they were inadequately prepared for a number of aspects of the NP role, and that the short time frame over which the course was conducted was largely responsible. The rigorous nature of the course was contributed to by the fact that the students had not studied for some time, certainly never at the level required in this Course. Added to this, most of them had spouses and several had school age children either at home or at boarding School. The negative impact on the family brought about by undertaking the program and becoming an NP role should not be underestimated and certainly not ignored; a number of those interviewed in this study referred to the high degree of personal and family stress associated with being an NP, as shown by the following excerpts from NPs working in both hospital and rural settings:

> *‘It has! Aahhh, partly because my, for me, my kids are small they are both ummm under fives, so ummm say this week has been one week that our number of patients has really come down, yeah, yeah with the influenza that was been going on it’s probably about for the last ….it’s almost a month! That we were having, aahh, mmm this place was really full, lots of ‘flu. Mm mm. So like for these last four weeks, I’ve been actually stressed out because I get tired from the hospital and I have to look after my…so personally, it has some stressed thing on me, yeah.’*
>
> (Talica, p. 12, 505-511)

> *'Ah yes it is! It's very stressful, ah it's okay now you haven't seen the crowd but on the weekends it can be very, very frustrating. Ah, a lot of times my husband says I think you are better off resigning and ah try and go overseas and work because of my children are just growing up they are still too young to be left behind. Ah, sometimes if there's only two of us, normally there would be three of us on a shift but if there's only two of us and ah people kept coming in with abusive, ah you know language and er sometimes you just have to ignore it because if you stand up and start arguing with them that's the end of it and one thing I don't like is if I am angry I don't want to work, you know, because it's really demanding here and I tried pushing and I think I've got thick skin for that I ignore them, they abuse I ignore I just continue with what I am doing but it's very stressful, um I used to be very ah big, ah very fat from the time two years I have spent here I've lost so much ah lots of times after duties I just go home and just go straight to bed.'*
>
> (Lati, p. 13, 393-405)

These two NPs highlighted the high levels of work related stress associated with their roles, which resulted from high workloads, frequent abuse from patients, inadequate staffing numbers and acute increases in admissions resulting from outbreaks of illnesses such as influenza. Factors such as this not only contributed to physical symptoms such as weight loss in at least one NP, but also to feelings of anger, frustration, tiredness and the potential for burn out. As the second NP stated, pressure from her spouse to look for work overseas was a result of the apparent stress that she endured working in the Accident and Emergency department at the CWM. This NP has since joined many of her nursing colleagues from the Western Pacific in going to the United Arab Emirates to work as a nurse. Like many developing countries, Fiji is unable to match the better salary and conditions available from wealthier nations, and in a sense is thus a victim of the globalisation of the health workforce. At the macro level these factors also constitute unequal relations of power, and places Fiji in a state of continued, increasing disadvantage which flows through to the way in which the health workforce develops and

is managed. In the context of this study, it has clearly contributed to the establishment and evolution of the NP role, and remains an ongoing challenge for the future.

In one of her Mission Reports (MR/98/0671), Downes made a number of references to significant teaching and learning difficulties that arose due to the one year schedule within which the course was placed. She noted, for example, that because the students progressed at different speeds a wide gap in student performance was created, but that the pace of the course could not be slowed to allow them to catch up because "The one-year schedule precluded this option." (p. 7). She also stated that "The time allotted for the paediatric component was insufficient…" and that "Time constraints affected the course content especially in the area of adolescent health…".

Despite what appeared to be significant pedagogical concerns, no recommendation was made by Downes in any of her reports to extend the length of course, adjust the curriculum to incorporate the large amount of content that was covered, or modify the approaches to teaching to cater for the different learning needs and speeds of the students. One can only assume, therefore, that she remained supportive of the Steering Committee's original proposal that the course comprise a 12-13 month, full time program of study focussing on basic primary care curative skills, a proposal regarded as 'entirely appropriate' by Dr Ruth Stark in her initial Mission Report. The NPs' voices do not appear to have been heard in terms of their belief that the course needed to be less intensive, and to allow more time to cover many of the content areas more comprehensively. For several graduates, these problems were exacerbated when they were deployed to the Fiji School of Nursing as tutors to implement the delivery of the Course. These NPs possessed little, if any teaching experience and had limited opportunity to consolidate their own knowledge and skills as NPs, which reportedly led to concerns by subsequent students over their credibility. Usher, in her review of the NP program (MR/2001/0864) suggested that these concerns were to be expected as more of the teaching was taken over by NP graduates, and recommended that "the education of the current nurse practitioner tutors at the Fiji School of Nursing should be urgently upgraded to increase their credibility within the workforce and the profession" (2001, p. 1). She also proposed that NPs be offered the opportunity to complete appropriate tertiary

level education at the Bachelor or Masters level, to provide a broader academic base to their strongly clinically oriented preparation.

In relation to the content of the curriculum, Stark proposed in her initial report (1997, p. 3) that skills in history taking and physical assessment, followed by 'studies of common health conditions' constitute the theoretical components, and that curative skills must be the focus of clinical training. She argued that the inclusion of non-clinical subjects in the curriculum would extend the course unnecessarily and cause the clinical training to 'suffer'. No information was provided, however, regarding what 'non-clinical' subjects might comprise or in what ways they would be detrimental to the program. Stark noted that "There are curricula available in the region which could easily be adapted for use in Fiji" (p. 3), and this appeared to have occurred, as Downes (1998, p. 4) reported that "Much of the course content was adapted from successful nurse practitioner programmes in the region, but refined for Fiji." Though not stated in her report, Downes coordinated and taught the Health Assessment subject, a topic with which she appeared very familiar as she currently teaches it at Emory University. It is not clear who coordinated the remaining five subjects: Advanced Clinical Decision Making, Advanced Community Health Nursing, First Responder, Maternal Child and Reproductive Health, and Seminar and Clinical Internship in Advanced Primary Health Care. However, many guest lectures were provided by doctors from the Fiji School of Medicine and Colonial War Memorial Hospital, as well as by 'laboratory personnel, the chief pharmacist, educators and staff of non-governmental organizations." (Downes, 1998, p. 4). Notably, following the first cohort of students, the 'Maternal, Child and Reproductive Health' subject was separated into two subjects: Paediatrics in Primary Care, and Reproductive Health, both of which have increased content areas. Downes (2000, p. 4) identified the areas of microbiology and pathophysiology as being 'in need of support'. Following a survey of past NP graduates, current NP students and School of Nursing tutors by the Lecturer at the Fiji School of Medicine's School of Allied Sciences, a two-week medical microbiology course was introduced into the curriculum. An epidemiology module was also developed in conjunction with the School of Public Health and a one-day suturing workshop conducted by a Senior Lecturer in Surgery from the Fiji School of Medicine. Other workshops of varying durations (8 hours to 4 days) included throughout the program

covered the topics of intra-uterine contraceptive devices, Pap smears, counselling skills, breastfeeding, mental health, trauma and sexually transmitted infections. Collectively, these additions to the curriculum further intensified the already substantial workload for students and tutors, increased the teaching, learning and assessment required within the available timeframe, and added to the overall costs of running the course. Usher (2001, p. 6) commented that "It may be necessary to review the content within the programme to decide just what is possible in a 12-month course." Given these significant curricular changes and substantial difficulties experienced by the students, one must question why the Course continued to be of 12-13 months duration and seek explanations regarding the ideological, political and social consequences of this decision. Viewed through a critical lens, it is suggested that the Ministry of Health clearly had an agenda which was primarily aimed at expediently filling health centre positions that had long been left vacant by doctors and MAs. This appeared to take precedence over the educational preparation of the NPs, creating a significant 'tension' at the interface between bureaucratic pragmatism and the needs of the NPs.

The series of Mission Reports described above reflect a certain style of text document commonly used by the WHO when compiling reports of this nature. They were distributed to Ministers and senior officials within the Fiji Government and Prime Minister's Office, the United Nations Development Programme Office in the South Pacific (Suva), and to a wide variety of staff at the Regional Office of the WHO. It appears as if the reports were only produced in English. The purpose and objectives of each Mission were stated, some background information provided, the activities and findings of the consultant described and a number of conclusions and recommendations listed. Depending on the intent of the mission, varying numbers of Annexes were included. All the Missions were stated as being funded by the WHO out of the 'regular budget' and were designated under the project title of 'Human resources for Health'. The time taken to conduct each Mission varied significantly, with the first taking 9 days, the second 13 months, the third 11 months, the fourth 8 months, the fifth 1 month and the last 2 weeks. Not surprisingly, a budget was not attached to indicate the cost of these missions, but it is reasonable to assume that the expenditure required to cover the time, travel, accommodation and incidental expenses of the consultants would have been

substantial. This not only reflects a heavy financial investment by the WHO in establishing this role in Fiji, but also the large number of key stakeholders in Fiji who contributed time and resources throughout the years that this process has been in train. It was not specified how the reports were to be utilised, but many of the recommendations were clearly used to guide decision making as the course and the role progressed. Other key recommendations were **not** addressed and arose repeatedly as needing action in subsequent Mission Reports over several years and, based on information gained from respondents in this study, many of these issues have continued to be a significant concern. From a critical perspective, one must question the slowness of change that occurred at the socio-cultural level. It is possible to dismiss this as a cultural artefact associated with the political process in countries such as Fiji, however it may also have been due to a lack of political will to make the structural changes required, or a reticence to inject the resources needed to address the concerns raised by the investigators. Whatever the cause, it is clear that the NPs remain disempowered, lack any collective professional identity and continue to harbour feelings of exploitation.

Implementation of the NP role heralded a dramatic shift in health care provision

Stark's initial report (1997) provided the framework for the creation of the NP role, specifically designed as it was to produce staff for health centres in rural areas where there were no doctors. Indeed, all those interviewed in this current study stated that the shortage of doctors provided the impetus for the implementation for the NP role. It is suggested that the practice of NPs 'substituting' for doctors is a fundamental and, in some circles at least, a very contentious issue concerning the implementation of this advanced nursing role. The word 'substitute', as both a noun and a verb, indicates the notion of an alternative, replacement or proxy style arrangement and this has been a key characteristic of the discourse surrounding the evolution of the NP role: that it represents a colonization of traditionally medical 'territory' by nurses. This contrasts to the concept of nurses working as doctor 'supplements', where they provide an extended, or complementary service to that offered by the doctor. The Practice Nurse role exemplifies this relationship, wherein Registered Nurses work for doctors in General Practice clinics and have their practice regulated and controlled by the GPs. As Halcomb, Patterson & Davidson (2006) note, this relationship has been a major impediment to the development

of the practice nurse role. Furthermore, these authors state that “as the primary employers of practice nurses, general practitioners have largely determined their scope of practice and have had significant influence on the amount and type of continuing education they are able to access” (p. 384).

Not surprisingly, the Medical profession strenuously supports this latter ‘supplementary’ model, given that it not only maintains their professional dominance over nursing, but also controls what tasks or skills ‘belong’ to medicine and which ‘belong’ to nursing. It is **this** issue more than any other that has ignited and fuelled the debate regarding the implementation of NP roles. From a business perspective, it means that they are able to offer a broader service, see more patients and thus increase their income.

The outcomes of a Cochrane Review published in 2004 entitled “Substitution of doctors by nurses in primary care”, stated that “In general, no appreciable differences were found between doctors and nurses in health outcomes for patients, process of care, resource utilization or cost.” (Laurant, Reeves, Hermens, Braspenning, Grol & Sibbald, 2004, p. 1). It is essential to note that the NPs described in this study had not completed a recognised, Master level NP program, not had they received formal authorization or accreditation as NPs. The point here, therefore, is that the practice of nurses who are accorded the title of Nurse Practitioner in an unregulated environment such as exists in the United Kingdom, should not have that practice compared to that of GPs for the purposes of cost comparison. Whilst NPs in the above review comprised one of several nursing groups providing primary care (along with practice nurses, clinical nurse specialists and advanced practice nurses), it was found that all nurses working in extended roles can provide both high quality and cost effective care, and may also reduce the workload of doctors. A randomized control trial conducted by Laurant, Hermens, Braspenning Grol & Sibbald (2004), examined the impact on general practitioners' workload of adding nurse practitioners to the general practice team. This study, conducted at 34 general practices in the southern region of the Netherlands, found that “adding nurse practitioners to general practice teams did not reduce the workload of general practitioners, at least in the short term.” (p. 1). Importantly, the authors suggested that this finding was due to nurses providing a supplementary rather than a substitutional role, further supporting the view that “Gains for the efficiency of services can be

achieved only if general practitioners give up providing the types of care they have delegated to nurses and instead invest their time in activities that only doctors can perform." Clearly, the NPs in the above study were working in a very different geographic area and health system to those in Fiji, who were initially expected to function in a substitutional rather than a supplementary role.

It is proposed that the introduction of NPs in Fiji has dramatically changed the model of primary care provision in rural and remote Fiji, such that NPs must no longer be seen as merely a substitute or alternative for doctors. Rather, they now comprise a legitimate and long term solution to the chronic problem of health care provision to people in these areas. It is also suggested that the implementation of a nurse led model of mid-level practitioner to replace the failed MA and PCP medically oriented models, marked a profound conceptual shift within a number of spheres, including:

- Requiring the Fiji Government and the nursing workforce to investigate the role and function of the NP as it is implemented and experienced in countries outside Fiji;
- Re-appraisal of the Government's approach to medically oriented models of primary care provision in remote areas;
- Willingness of the nursing profession to provide leadership by advocating that the role be introduced;
- Establishment and acceptance of an identity for, and role and function of, the NPs within the existing nursing workforce;
- Recognition of the different knowledge and skill mix that NPs would bring to remote areas of Fiji, in comparison to the MAs and PCPs;
- Perceptions regarding the provision of health care by NPs;
- The establishment of new clinical relationships between people in remote areas and NPs because of this altered perception;
- Changes that occurred to the traditional roles and relationships between nurses, doctors and allied health groups, and
- A new role for the Fiji School of Nursing to develop a suitable curriculum and teach the programme.

There is evidence that *some* of these changes have happened as the NP role has become established. Others with a more process orientation are more elusive and tangential and as a result I can only assume that they have occurred or will occur. Importantly, elements of these issues surfaced in the data examined in this study, and are referred to as the analysis progresses. Unfortunately, little if anything has been recorded as these changes have occurred, particularly by the nurses and NPs in Fiji which, as mentioned earlier in this thesis, may reflect a professional and social culture that is more oriented toward an oral rather than a written tradition of communication. This is very significant, for the NPs have made little if any formal contribution of their own to the discourse that surrounds their role and function, an issue that will be explored further when considering the factors that have mitigated against the development of their professional image, identity and 'voice'. Rather, the corpus of literature pertaining to these nurses has been developed by organizations and researchers from outside the country, including this author. Clearly, there exist many potential opportunities to engage in collaborative research in order to raise the profile of the NPs and assist in their empowerment as a professional group.

Rhetoric or reality? Government perceptions of nurses and NPs

As indicated previously, there appeared to be strong support for the NP role from within the Ministry of Health, though it is important to examine other discursive processes to obtain a broader picture of the social context within which the NPs are situated, and the depth of support for their role. To this end, analysis of a text using Fairclough's schema has been undertaken in an attempt to shed more light on this issue.

One of the documents produced by the Fiji Government that provided contextual information regarding the health system in Fiji, is entitled *Fiji Today*. Developed, printed and distributed annually by the Ministry of Information & Media Relations since at least 2003, this substantial document provides an overview of the country's key activity areas, including Government and external relations, the economy, tourism, health, social welfare and living standards, education, and so on. This was clearly an expensive document to produce and distribute and would cost the Government a significant amount annually; one could assume, therefore, that its distribution would primarily target high profile individuals and groups both within the country and overseas, but also be available to the general public in Fiji, or at least those groups that had access to libraries or

Government Departments. Interestingly, the document can be found on Fiji Embassy and High Commission web sites in countries such as Japan, the United States and New Zealand, as well as via the Fiji Government website <http://www.fiji.gov.fj/uploads/FijiToday2005-06.pdf>

It was notable that the actual *purpose* of the document was not stated anywhere within it, perhaps inferring that this was axiomatic. Nor was there any identification of who the authors were, what sources were accessed to compile and validate the information, how the information was obtained, and how and to whom the document was distributed. Furthermore, the information contained within the document was not referenced in any way, contained few links to any other documents or web sites, and appeared to only be published in English, and not in Fijian or Hindi. The absence of this information reflected a fairly high level of informality, and this was reinforced by the use of colour photographs on most pages, akin to a tourist brochure style of document. Notably, the information contained throughout included many facts and figures and generally promoted a positive 'spin' to all aspects of Fijian society, in an attempt to give the reader the sense that Fiji was developing and moving ahead as a nation. It appeared, therefore, that the document's purpose, or what Titscher, Meyer, Wodak & Vetter (2000) refer to as its intentionality, was directed (on the face of it, at least) toward it being used as a generic information resource for those within and outside the country. Following is the Fiji Government Press Release that preceded publication of the 2004 edition:

> Ministry releases *Fiji Today* 2004-05 edition
> Jul 30, 2004, 13:00
>
> The Ministry of Information, Communications and Media Relations has released its latest edition of Fiji Today. The 2004/2005 Fiji Today is a handbook produced annually by the Ministry and this edition contains 84 pages of comprehensive updates of Fiji on a wide range of issues.
>
> It features the latest information on the development of the various industries of Fiji's economy especially the agriculture, education, transport, health, communication and tourism sector. Furthermore, Fiji Today provides a wide range of information on the

> geographical, historical and cultural aspects of the nation. It is produced in full colour, has a glossy finish and bound in a handy pocket-style finish. There are currently 3000 copies of Fiji Today being distributed by the Ministry and this has proved to be popular with students, visitors, academics and professionals. The publication supplements the work of the ministry's other mediums of disseminating government's programmes and polices with the objective of creating a well-informed and united Fiji.
>
> Fiji Today is also available on the government website www.fiji.gov.fj
>
> (Fiji Government, 2004).

Interpretation of a Government Press release such as this recognises that it constitutes a particular 'genre' which indicates not only the *type* of text it contains, but also the *way* in which it is produced, distributed and consumed (Fairclough, 1992). It was accessed via the Fiji Government's online portal, though one could assume that different communication genres such as inter-departmental memos, letters and email were also used by the Government to advertise the publication of the handbook to its intended recipients and perhaps also the wider public. That it was produced by a specific Ministry area within the Government implies that it had been endorsed by the Minister responsible for that portfolio, giving the statement and the document referred to high status in terms of their validity and profile. Calling the Handbook Fiji *Today* suggests that the information it contains represents an overview of the country as it currently stands, at least from the perspective of the Government (The word 'Government' appears over 280 times in the document). It thus reflected a reality that is by comparison different than a metaphorical 'yesterday' or an unknown 'tomorrow'. Despite this, there appeared to be elements of the document that were forward looking and growth oriented, particularly in sectors related to the economic status of the country such as tourism, agriculture and exports. As the Press Release indicated, the Handbook had allegedly proven its popularity, with a wide range of groups reportedly using it for activities as diverse as School or higher education projects, research, business, and as a general visitor reference. This assumed that the document holds a certain intrinsic value and broad utility that further legitimised the Government's investment in producing and distributing the *Handbook*.

The last sentence of the Press Release is particularly interesting as it is quite different to the informality of the preceding sentences, reverting to the formal style used in the opening sentence. This served to foreground the underlying theme, namely the pre-eminent role that the Government believed it had in shaping Fiji as a 'well-informed' and 'united' country, via its various policies and programmes. At the textual level, use of these two adjectives to describe the Government's goal for Fiji is in itself noteworthy; alternative words such as 'contemporary', 'democratic' or 'progressive' may have been used, for example, but clearly those chosen were intended to represent the desired state being promoted. At the level of sociocultural practice it could be argued that this reflects an ideological position, or construction of reality which, as Fairclough (1992, p. 87) states, "contribute[s] to the production, reproduction or transformation of relations of domination." To this end, it may be seen as serving a hegemonic function, in that the Government via its institutional practices is exerting its power and domination over Fiji society through the construction of alliances which are coercive in nature. The aim here is to win the consent of the subordinate classes to contribute to the Government's objective for Fiji, namely that it become united and well-educated. In addition, the final sentence indicated that the document is part of what Fairclough (1992, p. 232) refers to as an 'intertextual chain' of mediums by which the Government disseminated information about its activities with the objective being to create a 'well-informed and united Fiji." This indicates several issues, firstly that this portfolio area is representative of a Government seeking to be perceived as providing leadership and is active, transparent, informative and reform-oriented in its processes; secondly, the Government believes that Fiji (as a country and a populace and thus also themselves) is currently ***not*** as well-informed and united as it could or should be; third, that information and knowledge generated by the Government has primacy in terms of their ability to move Fiji forward to a hitherto unattained condition, and lastly, as suggested above, by using the lever of civic nationalism the Government is seeking to reinforce its hegemonic power via the attainment of general consent for its programmes and policies, such that any opposition to them could be interpreted as working against the Government and its objective of creating a well-informed and united Fiji, namely promoting ignorance and disunity. By way of interdiscursivity, the Release appeared to draw on several orders of discourse, for

example political discourse through its reference to 'the Ministry' in the title of the Release and also several times within the text; use of the word 'government', linking the availability of the document via the Fiji Government's web site, and the fact that the Release was produced and distributed by the Fiji Government. Specifically stating that the handbook was 84 pages in length and that it provided 'comprehensive updates' suggests that it was thorough, informative, current and wide ranging in its coverage of topics. The sentence "It is produced in full colour, has a glossy finish and bound in a handy pocket-style finish", marks a sharp departure from the grammatical style of the opening sentences. Inclusion of these phrases draws on discourses associated with advertising and promotion, and use of the adjectives 'full', 'glossy' 'handy' and 'pocket-style' suggest that the document was expensive to produce, is 'user-friendly' and attractive to look at and read. This may be interpreted as not only serving a self-congratulatory function designed to convince the reader that the document was important and authoritative, but also attempted to emphasize the prestige of its producers. Articulating these two quite contrasting discourses within the Press Release reflects a relatively low level of interdiscursivity which, according to Fairclough's model, 'signals the reproduction of the established order', which is associated with maintenance of the status quo and low level change (Phillips & Jorgensen, 2002, p. 82-3).

Nurses, NPs and midwives 'invisible'

Further analysis of the above media release is outside the scope and intent of this study, however it has been important to explore these elements as they do provide valuable insights into the sociocultural and political milieu in which the nurse practitioners are situated. What is of particular salience is that the latest edition of *Fiji Today* (2006-2007) states that "Primary health care involves the provision of primary medical treatment, preventive medicine and health education. About 95 per cent of primary medical care is provided by doctors in government hospitals, health centres and nursing stations throughout the country."(Fiji Government, 2007, p. 53). Nurses are only mentioned in terms of how many there are (2, 472) and that using the 1996 population figure, the nurse: population ratio is about 1:312. There has been no census since 1996, but at the time of writing the Fiji Government announced that a new census would be completed by the end of 2007. Nurse practitioners did not rate a single mention *anywhere* in the

document, despite their crucial role as the providers of nursing, midwifery, preventative, primary and curative health care in many remote locations, and as a vital link between these centres and sub-divisional and divisional hospital services. Midwives were also not mentioned at all, although the document stated that "Good obstetrical services contribute to the lower infant death rate with about 95 per cent of births being attended to by trained medical personnel." (p. 51). Furthermore, the Fiji School of Nursing, which is the only Government funded nurse education provider in the country, was not described anywhere among the many educational organizations included in the document. As such, readers of the *Handbook* outside the country would have to assume that such an institution existed to educate nurses, midwives and NPs. In stark contrast, The Fiji School of Medicine (FSM) was well described and its function as a regional provider of medical and a number of allied health programs highlighted. It is worth noting here that the FSM has a well developed web site <http://www.fsm.ac.fj/>, however the School of Nursing has no such electronic portal which, I suggest, reinforces its invisibility to those outside Fiji and reflects its significantly lower status and power in relation to Medicine.

It is proposed that collectively these discursive elements have served to render the NPs, nurse and midwives invisible to those who read this document. Furthermore, it is suggested that failure to articulate the vital role played by nurses, midwives and NPs within the health system, reflects the Government's derisive and belittling attitude toward these groups, and a lack of genuine consideration for their education and professional development needs. By so doing it has shaped social practices relating to health care provision by promoting and thus reinforcing medicine's identity, status and primacy over the seemingly lower status, role and function of NPs, nurses and midwives.

Professional and occupational stratification within health care has a history as long as that of medicine and nursing, with medical dominance controlling core elements including the discourses associated with health and illness, health systems organisation and funding models (Freidson, 1988; Mackay, Soothill & Melia, 1998; Gordon, 2005). Viewed through a critical lens, these arenas comprise relations of power and domination, and bring into sharp focus the *dis*empowerment and feelings of exploitation experienced by nurses and, in the context of this study, the NPs in Fiji. A closely related issue is the health and well being of people in rural and remote communities, which globally has

always struggled to keep pace with that of those in urban and peri-urban areas, largely due to reduced services and a limited workforce (Humphreys, Hegney, Lipscombe, Gregory & Chater, 2002; Strasser, 2003; Smith, 2004). Given these realities, it is somewhat surprising that the *Fiji Today* document mentioned above also stated that "The Ministry of Health has formulated its new Strategic Plan for 2005-2008 and will focus on five main thematic areas.." (Fiji Government, 2005, p. 48), including the

- "provision of affordable, well planned, quality health services (preventative, diagnostic, clinical, pharmaceutical, rehabilitative) to everyone in Fiji.", and
- "development and retention of a valued, committed and skilled workforce to enhance the delivery of quality health services."

These thematic areas situate the goal of the Government to provide comprehensive healthcare to all Fijians irrespective of where they live, against the reality that there is currently neither a sufficient workforce or infrastructure available to achieve this goal, particularly in rural and isolated communities. This problem is not peculiar to Fiji, of course, with all countries across the region and indeed globally experiencing varying degrees of difficulty in this area.

Introduction of NPs a two-edged sword

From the evidence presented above, it is reasonable to conclude that at the political level the NP program was instituted to develop a cadre of multi-skilled nurses who could be produced relatively quickly and cheaply, and deployed to remote sites to fill health centres left vacant by doctors and MAs. From the nursing perspective, the NP role may be viewed as offering a new and advanced career path, yet from the Government's standpoint there is clearly an agenda centred on political expediency, control and economic rationality which ultimately reinforces unequal power relations and maintains the hegemonic domination of the Government. One might reasonably argue that Governments have a legitimate mandate to solve workforce problems such as this in an efficient and cost-effective manner, and this is not being questioned here. What *is* being proposed, however, is that the data gathered for this study support and extend that obtained by previous WHO consultants, which found that the NPs perceived themselves to be exploited, unsupported and inappropriately remunerated given the multiple roles that they undertake. Moreover, comments by the senior members of the Health

department clearly reflect the influence of globalisation discourse on health workforce planning in Fiji, and the commodification of the NPs as a cheaper and more controllable alternative to doctors.

Interestingly, one NP I interviewed also used the term "kill two birds" mentioned above, although she was referring to NPs having to also fulfil a vacant nursing role when the health centre did not have a nurse. She stated that:

> *'..because at the moment they* [the doctors] *are appreciating us as we, they offload a lot of their responsibilities to us, yeah, but like I am just thinking for how long will this go on until, yeah, something um comes up? Um, sometimes I feel that we are sort of being used, if I can call it, yeah, because er in most places where the nurse practitioners are going to, the nurses are always short and they have to be doing a lot more than just to clinically see patients they have to still fulfil the role of the nurses when aaah, a nurse should be there to do, it's a lot, it's too much for only one person to be doing it, because I know that one of the advantages of being a, a nurse practitioner is that eh? they kill two birds…*
>
> (Talica, p. 18, 540-548)

Like many other NPs interviewed, this NP voiced the belief that they were being 'used' by the Government to not only replace a doctor in a remote Centre, but *also* to fulfil a nursing role in the absence of clinic nurses in those sites. The NPs therefore not only serve the Government's need to provide a comprehensive primary care and nursing service in remote areas in a relatively cost effective manner, but the communities have access to a level of care that they did not have previously. Furthermore, doctors are able to further their largely urban based practices without being deployed to remote sites, which might otherwise have pushed them to look overseas to 'greener pastures'. It appears, therefore that the NPs felt they were being further exploited by being required to not only perform a wide variety of advanced roles but also provide a service normally afforded by Registered Nurses.

Social positioning and 'naming' of the NPs

The provision of health care by the Fiji Government to people in remote communities is now largely mediated by the NPs, in conjunction with Registered nurses who run the many Nursing Stations scattered throughout these areas. Numbers of remote villages may also have a *nasi ni koro*, or village nurse, who works in a voluntary capacity but may be the only person available with some health-related knowledge. Their practice may involve may involve the dressing of wounds, bandaging of fractured limbs, and prescription of herbal medicines for a variety of ailments (Bola, 2007). It is unknown how many such workers there are across Fiji, however as will be highlighted in the next chapter the interface between traditional and mainstream approaches to health care is currently a key issue in many countries around the world.

The professional role of the NPs has been normalised by the Government, the medical and nursing establishments and the NPs themselves, to the extent that there is now nothing unnatural or uncontestable about them being the senior health professionals in remote communities. Indeed, the vast majority of people in remote areas have also accepted, even welcomed these arrangements, largely because prior to this there was no equivalent level of health care available locally, which often meant expensive and time-consuming travel to the sub-divisional hospital by road, sea or air in order to receive treatment by a doctor.

By consenting to the power accorded to the NPs by virtue of their status, knowledge and expertise, people in remote areas have in a sense been coerced into accepting the status quo created by this arrangement. Althusser's (1970) concept of interpellation is of relevance here. Fairclough (2002, p. 15), drawing on Althusser's understanding of ideology and subject positioning, defines interpellation as " the process through which language constructs a social position for the individual and thereby makes him or her an ideological subject". Thus, texts such as the series of Mission Reports developed by World Health Organization consultants describing the implementation of the NP role in Fiji have served to construct the subject position now ascribed to the NPs and accepted by the Government, the medical and nursing professions and the wider community. By accepting these subject positions, the NPs have surrendered some of their power to their interpellators, and by doing so have allowed themselves to be dominated (Janks & Ivanic,

1992). As will be shown later in this chapter, however, there is evidence that the NPs are contesting elements associated with the way they have been positioned, particularly by the Government.

NPs as 'vuniwai'

As there is no Fijian term for 'Nurse Practitioner' the appellation 'vuniwai', the Fijian word for doctor, is widely used by the public, in particular. The distinction must be made here between colloquial use and understanding of this word, and that which is used to describe NPs and doctors in formal documentation and dialogue. This informal usage appears to represent nothing more than a gap in the Fijian language, and use of a term that most closely describes the role of the NP. Vuniwai is ***not*** used as a descriptor for NPs or their practice in any Government documents, media reports or other publications that I used within this study. Indeed, the NPs do not refer to themselves or each other using this term.

Notwithstanding this important distinction, use of this term places the appellators in a subject position as potential patient, thus reinforcing the appellation. It also places the NP in a certain subject position not only in terms of the social practice of ascribing language to the position but also in terms of the role and function, status and relationship that it represents. It is suggested, therefore, that relational, intrinsic and extrinsic power reside within the title 'vuniwai' normally ascribed to medical doctors and that Nurse Practitioners, in recognising and accepting this appellation and its associated social construction in terms of the role and status of doctors and their relationship to their 'patients', have reinforced this subject position at both a conscious and sub-conscious level. This is always open to contestation or resistance, however, particularly when it reinforces asymmetrical power relationships. Following is an excerpt from an interview with a doctor at a sub-divisional hospital:

> *…most of the times villagers from outside they do not go to the NP because (chuckle) er the, the community here has, has dev has not developed that er has somehow developed that er belief that er these nurse practitioners are not real doctors, you know, they, they have come to know that, so most of the times villagers closer to where she is serving, they call over here*
>
> *DL ……Rather than go to her.*

Rather than go to her.

DL Oh, ok.

When I inform them that "hey you guys there, there is a doctor just beside you, you cannot, you might die on the way but there is someone just beside you who could save your life."

DL Vuniwai, eh?

Right, you have to see that vuniwai, aye you have to see that vuniwai and then they come with all these excuses giving us that you know, "Oh she's not a qualified.." "who told you she's not qualified? If she's not qualified she wouldn't be there!"

(Jona, p. 3, 122-136)

I suggest that this excerpt demonstrates evidence of resistance by some members of a remote community, who did not view their local NP as having equal knowledge and status, and thus credibility, when compared to a doctor. As a result, they avoided going to see her and instead chose to go to the hospital which was much further away. The reasons for this are unclear, however the doctor responded to those people by calling the NP a doctor, and twice stating that they 'have to see that vuniwai' otherwise they might die 'when there is someone beside you who could save your life.' The doctor is asserting his position on the issue to these people in a somewhat off-hand way: "hey you guys"; he then challenges their 'excuses' and the credibility of their argument that the NP is 'not qualified' or not a 'real doctor' by endorsing the qualifications of the NP and her rightful position as someone who is credible and who can even save their lives.

Community support for the NP role

In contrast to the above example, people in many other remote communities clearly have embraced the role of NP, as evidenced by the many positive comments gathered by Haddad and Williams (2001) during their review of the NP role, including the following:

Before the nurse practitioner came, they [the villagers] *were really reluctant to seek care from the medical assistant. Now with her here, they feel relaxed*

enough and have no problems seeking care from the NP. When she came here she came as a real member of the community, and not as a stranger.

Although the NP is a woman, the community really looks up to her and like her for all that she has done for the communities in the area, all the way up to Udu. The NP is a workaholic, forgets to eat and moves around all the time. She is a very good vuniwai to all of them."

There wasn't a doctor here for five years when the NP came. It was a real relief because the quality of services provided has been improved. For the past four years only nurses were at the Health Centre.

The NP always visits the villages and settlements. She goes to the schools and looks after the children. She calls on the settlements and does blood glucose and blood pressure screenings. The NP is much better than a medical practitioner, because the NP comes to visit them often.

She is doing a great job. The relationship between her and the community is very good, how she greets us when we enter the Health Centre, a very great smile. Her relationship for her work and us is very near. Plenty sick people around, but the NP stays at the Health Centre at night too, she is available any time.

(Haddad & Williams, 2000, p. 16-19)

These quotes suggest that NPs appear to have had a more integrated, proactive approach to their health care activities than the medical assistants (MA), who utilised a more episodic, passive approach to consultation more akin to that which normally characterises the interaction between doctors and patients. Being accepted as part of the community is a key factor to gaining their trust and respect, even though there appear to be some gender related issues associated with this. The NP is again referred to as vuniwai, or doctor, and appeared to be a hard worker although being a 'workaholic', 'forgetting to

eat' and 'moving around all the time' suggest a high level of work related activity that one might interpret as being ingredients for potential burnout. As will be shown in this analysis, the NPs carry an enormous workload and those in remote areas are responsible for a large population spread over a wide geographical area. Access to such areas is limited by the infrequent availability of suitable transport, environmental factors such as flooding, and time constraints. It will be shown that these and other factors severely limit the capacity of the NPs to perform their role effectively, and reflect a wider social agenda that is disempowering for both the NPs and rural and remote communities.

People in other sectors also support the role of the NP, as evidenced by the following excerpt from my interview with another medical officer, who was a senior employee of the Ministry of Health in Suva:

> *'The strength basically is the provision of complementary, I would say complementary health services in the area of diagnosis and treatment in the community. To us that is I think one of the strengths and that's how it's displayed in the community, in fact when they go to the community they are called doctors.*
>
> *DL Vuniwai.*
>
> *Mm, by the people, that's how they are accepted.*
>
> *DL Vuniwai, yeah, yeah. So they are well accepted by the Indian and Fijians?*
>
> *Both. You have to remember that most of the rural stations are Fijian, that's where most of ah the stations are.'*
>
> (Tevita, p. 6, 268-276)

Here the interviewee again identified that NPs were called doctors in the community and accepted as such by the Fiji Indians and Indigenous Fijians. He further indicated that the NP had a 'complementary' role in the diagnosis and treatment of people, and that 'to us' it was one of their key strengths. The 'us' referred to here I assumed to mean the Ministry of Health. While not *personally* acknowledging their title as doctor, he recognised that their role involved 'diagnosis and treatment', terms traditionally associated with medical work and medical discourse.

Power relations evident in forming the NP role

From the analysis provided thus far, it is clear that various forms of political, institutional, professional and individual power were brought to bear in establishing and legitimizing the NP role. For example, via its Cabinet, the Fiji Government formally approved the establishment of a NP program and enshrined their scope of practice within the *Nurses, Midwives and Nurse Practitioners Act* (1999) and its associated *Regulations*. Adoption of the nomenclature 'Nurse Practitioner' situated the role among other similar advanced, mid-level roles throughout the Western Pacific region and, indeed, internationally. By so doing, it not only created a new and highly autonomous nursing role that had the potential to empower the nursing profession, but also recognised the expanded scope of practice already being undertaken by many nurses in remote communities. Establishment of the curriculum and formal course of study specific to the preparation of the NPs, entitled the 'Advanced Diploma in Clinical Primary Care', circumscribed the particular knowledge and competencies associated with the role, and positioned the School of Nursing as the educational provider responsible for the preparation and continuing education of the NPs.

Endorsement of the course by the Nurse Practitioner Steering Committee, chaired by a medical doctor who also held the position of Director of Primary and Preventative Health within the Fiji Government, further legitimized the role in the eyes of both the Government and the medical profession. Finally, NPs were posted by the Ministry of Health to remote areas, with a mandate to be the senior providers of health care in those locations. It is suggested that collectively these processes have significantly changed the orders of discourse associated with health care and the health workforce in Fiji, challenged unequal power relations between nurses, the medical profession and the Government, and brought about significant social change. The need for radical change such as this is not surprising, given the reported crisis in the health workforce at the national, regional and global levels (WHO, 2006).

Governance and management of the NPs

A core issue influencing the NP's autonomy is their interprofessional relationships, particularly with Medical Officers. MOs at sub-divisional or divisional hospitals provide a consultative role in relation to the medically oriented aspects of the NP's role. In

practice, this means that if the NP is unsure about the medical diagnosis of and/or treatment regimen for a particular patient, then they must consult with a MO, and this is clearly stated within the Nurses, Midwives and Nurse Practitioners Act (1999). Importantly, this places the decision to initiate medical consultation firmly with the NP, and reflects the high degree of autonomy they possess. The rates of, circumstances under which and methods used for formal or informal consultation between the NPs and physicians is largely unknown, and will be discussed in more detail later in this thesis. The wider issue of clinical information needs and information seeking practices by these NPs will also be discussed.

For NPs working in remote locations, there is no requirement or practical possibility of direct or indirect medical supervision; indeed, having such a proviso would clearly defeat the purpose of placing them there in the first place. This appears to be a trend in other countries also, and Mundinger, Kane, Lenz, Totten, Tsai, Cleary, Friedewald, Siu, & Shelanski (2000) have noted, for example, that in many U.S. states NPs now also practice without any requirement for medical supervision or collaboration.

NPs working in peri-urban Health Centres or hospital environments in Fiji have much more direct contact with MOs than those working in remote locations, though the former are filling a vacant MO position as opposed to being specifically for them as NPs. One NP in a divisional hospital had been allocated to work in General Outpatients, and then was assigned by the Medical Director to look after the people diagnosed with sexually transmitted infections (STI) and HIV in that community, a post previously managed by a doctor. This constituted a significant challenge for the NP, who had had little contact with such cases prior to the appointment. As she stated, “It’s really a challenge for me because I have never had, encountered to work with HIV cases except, and also for STI only during our clinical attachment and a few cases that er I, so…yeah.” Allocating NPs to such roles without adequate preparation, simply to fill a vacancy normally filled by a MO appears questionable, and one wonders what support and collaboration was available to the NP once in the role. The issue of appropriate workforce planning, including development, deployment, support and retention is at the heart of such arrangements, and will be addressed as the major focus of the discussion chapter later in this thesis.

While NPs have a consultative and referral relationship with MOs for *medically* oriented matters, the equally important nursing, midwifery, public and allied health dimensions of the NP's clinical role are seemingly managed independent of medical involvement. The extent to which the NPs require and seek support for these elements of their role is unknown, but is also clearly a workforce planning and development issue.

Senior nursing staff at the sub-divisional level appear to oversee the administrative components of the NPs role, which has created substantial frustration and role confusion for the NPs, and divided their accountabilities between medicine and nursing. One NP I interviewed expressed their frustration as follows:

> *'That is the conflicting part of it, mm. Because we are doing patient care and it's more the doctor's side of it but we are still under the, the nursing and most of the work we are doing they are not well versed of, our supervisors especially. Because we, we can't, it's, it's just like talking a different wavelength because they don't understand certain things that we are doing especially when we talk about patient care. Conditions that we talk of they er can't understand.'*
>
> (Simon, p. 13, 378-383)

This is a reflection of the broader issue of the role and function of the NPs being perceived as a replacement, or substitute for a Medical Officer and thus the medical elements of their practice needing to come under the control of medical services. Despite this, they maintain a nursing, midwifery and public health role and thus are administratively managed under nursing services and paid under the nursing award. Downes (2000, p. 6) identified this as a concern when it came to conducting performance reviews of the NPs. She noted that there was an apparent lack of transparency regarding the process for deploying the NPs, and that while they administratively came under the nursing umbrella, substantial elements of their clinical practice fell within the medical domain. Thus, she noted, "there is no clear process for their ongoing performance evaluations.". Although the need for NPs to collaborate closely with doctors appears to be unequivocal, the relationship will realistically be indirect and spasmodic for NPs in remote areas. NPs interviewed as part of this study reported that they actually received

the majority of their medical support via telephone or two-way radio, and this was usually related to seeking approval to prescribe a medication, or in the diagnosis of a particular patient presentation.

Many difficulties associated with the NP role identified

Despite the key role that NPs have been found to play, many problems were identified by Downes and Usher in their WHO project reports, including:

- Difficulties in recruiting suitable students into the Course;
- Frequent deployment of NPs by their medical supervisors to work in sub-divisional and even divisional hospitals;
- Insufficient resources to perform their role effectively;
- Failure of clinical protocols to accurately reflect their role, and
- An urgent need to review their remuneration, career structure and professional development.

As I spoke with the NPs these problems clearly remained unresolved, and were sources of strong feelings of disempowerment and exploitation. Practical issues such as inadequate transport were also often cited by the NPs as a significant impediment to providing an effective outreach service to the remote communities. They reported having to make use of whatever was available, including boat, horseback, walking, bus, lifts from community members or taxis. When conducting clinics out in these areas, the NPs reported being away from their base for days, even weeks, at a time. These clinics provided a vital primary care, public health, screening and educational function across a broad range of health topics and inclusive of all age groups. Without these visits, Indian and Fijian community members would rely heavily on traditional medicines and healers accessed locally to treat a variety of conditions, and only make the journey to the nursing station or health centre if these failed. Unfortunately, a number of NPs reported that patients regularly presented in a worse condition following the use of such treatments, and considerable education was required by the NPs to encourage Indigenous Fijians, in particular, to present earlier for assessment and treatment. Despite this, many positive stories were also shared of occasions on which the leaves, bark and roots of certain trees and plants had apparently been effective in the treatment of fever, systemic and topical infections, wounds, boils, muscle sprains and strains, burns and cuts. Clearly, the practice

of using traditional medicines and healers remains an important element of Fijian society, particularly in remote villages where access to western medicine remains problematic. The interface between these traditional methods and the predominantly western, scientifically based approach to health care taught in the NP Course, raised a number of interesting issues that I explored in my interviews with the NPs, and these will be discussed later in this thesis.

Career structure and remuneration

Appropriate salary and a suitable career structure are two key elements linked to job satisfaction, recruitment and retention. The WHO in the Western Pacific has previously highlighted the importance of these and other factors in relation to the migration of health workforce personnel into, out of and within the region (WHO, 2004). Furthermore, their review of mid-level and nurse practitioner models and issues in the Pacific (2001, p. 21) recommended to Ministers of Health that:

> "Performance evaluation systems should be implemented, where required, along with the institution of clinical career ladders, supporting career advancement for experience and expertise in clinical practice. Salary structures commensurate with the competencies, responsibilities, education and experience of mid-level practitioners are required, in order to recruit and retain mid-level practitioners."

In line with the findings of these reports, all the WHO NP Mission Reports cited previously recommended that a career structure for the NPs be established based on job performance and years of experience, and that their remuneration be commensurate with their increased level of education, advanced role, high level of responsibility, and remote location. Downes' Report (1998) noted that the NP position was initially designated at NU 0-3, which is at a mid-level point in the range of NU 0-6, being for new graduates, up to NU 0-1 which is for senior matrons. She reported that this was subsequently 'revised down to a NU 0-4 posting', though no indication of who made this decision was stated, or a rationale provided. It reportedly had a negative effect on the morale of students who were already enrolled in the NP course, however, and resulted in one student withdrawing from the programme (Downes, 1998, p. 7). An NP's starting salary is thus approximately FJ$17,800 per annum, increasing incrementally up to a maximum of

FJ$19,500, representing a very narrow pay increase from a beginning to a senior NP. In contrast MAs, who come under the same award and pay structure as doctors but have less training than the NPs, earn more as a starting salary and are able to obtain increasingly higher salaries than NPs, even though the NPs are providing a much more comprehensive level of health care. MAs commence at FJ$18,000 but progress up to FJ$28,000, representing a much larger pay increase. NPs in remote sites are effectively on call 24 hours a day, 7 days a week, which effectively means they are *always* 'at work', which in itself places a significant burden on the NPs and their families, and highlights their commitment to but lack of control over this dimension of the role. Furthermore, like their nursing colleagues they receive no night shift allowance and less on-call allowance than doctors who do similar work. This was a very common issue among many of those I interviewed and clearly was also a concern raised by the WHO consultants in their Mission Reports. Following are just some of the many comments from my interviewees regarding salary:

> *Oh, the major concern is that we are doing a lot of work and then we're not being paid for. We're doing all the things that the doctors do* [said with exclamation and a raised voice] *whereas them, they do both and are paid highly.'*
>
> (Naomi, p.6, 180-182)

> *'I think the salary is very inadequate. Comparing to the work that we are doing um it's the work we are doing is, a lot is expected of us and the salary well it's always a problem the salaries ah but ah we try not to look at the salaries if we do look at it we will be frustrated whole day so we just enjoy the day to see whoever comes to see you and er when they talk about salary then okay my salary is, I should be on that level but we are paid on this level and that's okay, mm.'*
>
> (Lati, p. 11, 540-545

'..because they are now replacing doctors in a lot of our rural areas and even in our busy urban health centres ah they believe that they do the same work as the doctors but they are paid the nurse's salary.'

(Mereani, p. 3, 64-66)

'well that's again, like I'm saying you know the nurse practitioners rightly said that the Ministry is now using them as cheap labour. There is a full-time er at the children's outpatient ah here in Suva. There is um I think, well, R is in Valelevu and is taking in as much er patients as the other doctors they get rostered and they sit in and er acting as a doctor um but paid a nurse's salary and Wainibokasi is another place where they have the nurse practitioner. I believe there is one in Naisori, but like I said they are now being put there to replace the vacancies that have been left by the doctors. And however they are being paid the nurse's salary. They do exactly the same job!!.'

(Mereana, p. 10, 281-288)

Many NPs interviewed stated that they felt exploited because they were not entitled to the same allowances or equivalent salary as their medical counterparts, even though they considered that they were doing most of the work of a doctor. Furthermore, as civil servants, they shared the burden the whole public service had to carry when pay cuts were imposed by the Interim Government in order to save money during the coups d'etat. One NP responded to my question of whether there would be a change of Government at the next election, as follows:

I don't know. I don't know right now. I'm sure that will change, but we don't know how that will help and as civil servants we are at the mercy of the Government of the day. You know that in 19, these coups that happened we were the ones that took the brunt of err the economic status of the country, we are the ones that had the pay cut, so that the government could keep going [brief chuckle] *but we are very optimistic that this will go out somewhere because of the discussions that we are having right now and because there*

has been a change in headquarters I feel that the current CEO, the new one that's just come in, is very receptive to ideas.'.

(Timoci, p. 24, 727-734)

Feelings of exploitation

One of the concerns raised by the NPs and also the WHO consultants was the practice of deploying the NPs to work in the sub-divisional and divisional hospitals, often at short notice. This practice appeared to be coordinated by sub-divisional medical officers, who deployed the NPs to relieve medical officers or fill in where there was a vacancy. Downes noted in her 2001 Report that:

> "Frequently the nurse practitioner is called the day before and told to be at another location. This common occurrence leads to frustration for the community and the nurse practitioner, jeopardizing health care and community relations. Additionally……it places the nurse practitioner in a precarious legal position, as protocols for inpatient management still do not exist. These frustrations are negatively affecting nurse practitioner motivation." (p. 5).

Downes highlighted that this was outside the NPs scope of practice, was not legally sanctioned and created substantial frustration for both the NPs and their communities. Furthermore, it established a pattern of deployment that can rapidly move from occasional practice to convention, whereby NPs are increasingly used by their medical supervisors to 'plug gaps' when medical vacancies occur across a particular region. Haddad & Williams (2000) in their interviews with community members and NPs similarly found that NPs were increasingly being called away from their remote communities to work at sub-divisional hospitals. Clearly, health care provision to the remote communities was being seen as a lower priority compared to that provided at the hospitals. Moreover, the primary intention that NPs were established to staff remote health centres was being disregarded, and the NPs and the communities were being significantly disadvantaged. Usher (2001) also identified this practice occurring, and stated that it 'borders on exploitation and must be reviewed' (p. 5). Despite these calls for

such practices to cease, I found that it was still occurring some years later. Two NPs I interviewed stated:

> *'…yeah, I was thrown out into the island, yes! Ah, you know after finishing the course what happened I was thrown out into the island where there was a hospital, a sub-divisional hospital, and then automatically the medical officer that was there, SDMO went on leave, and I was there to man the hospital. Imagine, just been out of er school and then ah there…'*
>
> (Ema, p. 7, 180-183)

> *"Um, like, um you know especially me having a family, eh? Four children and then er like in Rotuma I, you have to be on call 24 hours…and then er I stay in the quarters I have to go home to see to the family and then when you are having a break, you having a day off and you home and then the hospital call you because there's an emergency there then you have to run up again, and you find that you have to be ready all the time, eh? Because if it's an emergency you just have to run! So er I think it's very stressful."*
>
> (Sera, p. 12, 559-564

The expectation that the NPs can be used to cover for medical officers in hospitals appears to have become an entrenched practice in some rural areas and now also is becoming normalised in divisional hospitals. One NP recounted that 'bullying' by medical officers to take on some of the doctor's work occurred, as evidenced in this interview excerpt:

> *'I am not sure about today but because they told me that they really, they really busy on ahh call they like er…they bully the nurse practitioners, mm mm. And I used to go and relieve at Nausori, to relieve the medical officers and err what's this command from the nurse practitioners, they said 'oh, you know medical officers used to bully us. They give us a lot of work to do, and they "okay, you do this", and after the next second they'll be out of the door*

and go to town.' There is another problem, medical officers bully the nurse practitioners, if they are working together.'

(Faranisese, p. 18, 525-532)

Despite this report, evidence of bullying of NPs by doctors was not a common finding in my interviews, and I found that generally the NPs reported a high degree of support from medical officers. This was usually by phone, of course, and involved the giving of clinical advice or negotiating for the referral or transfer of a patient from a remote area to either a sub-divisional of divisional hospital. Perhaps this inter-professional relationship changed when the NPs were actually working alongside doctors in a hospital or peri-urban setting, which appeared to be a growing trend. For example, I interviewed two NPs who worked in the outpatient/accident and emergency department at the Colonial War Memorial Hospital. One was a 'special' paediatric position created at the request of a Paediatric Medical Consultant, the other a general position. Both positions were essentially substituting for medical officers and while both NPs enjoyed the work, it clearly was not what they were initially educated for, in terms of filling vacancies in remote health centres. Another NP I interviewed worked at the St Giles Psychiatric Hospital in Suva, and worked as a member of a team providing community oriented mental health services as well as assisting the medical officers in procedures such as electro-convulsive therapy at the hospital. Lastly, an NP was overseeing the clinical area of sexually transmitted infections, including HIV/AIDS, based out of the divisional hospital in Labasa, on the northern island of Vanua Levu. Importantly, most of these NPs had at some stage worked in remote health centres either as senior nurses or as NPs, and had successfully requested to return to the larger centres where they were now being deployed into a variety of roles. The concerns raised by the WHO consultants remain, however, particularly those associated with being deployed to work in hospitals at short notice and leaving the health centres vacant, the NP's educational preparation, scope of practice, legal coverage and unsuitability of their clinical protocols for practice in hospital settings.

Conclusion

This chapter has explored the theme that the professional world of the NP in Fiji is characterised by unequal relations of power and exploitation. Using Fairclough's schema a variety of texts were analysed and it is evident that unequal power relations exist in many aspects of the NP's role. On the one hand it appears that they are highly valued by the Government, yet as nurses and civil servants it appears that this support did not flow through to the discourses that surround their role. Strong feelings of being used and exploited by the Government and Medical Officers, particularly in relation to what was perceived as inadequate remuneration for their highly advanced and autonomous role, lack of a viable career structure, inadequate educational preparation, and frequent deployment away from the remote health centre were just some of their main concerns. As indicated earlier in this chapter, many of these issues were previously described by Usher (2001), and they were also identified by the WHO as common problems facing all Pacific Island countries with mid-level practitioners (WHO, 2001). The new data collected in this current study provides further evidence that these concerns have still not been addressed, even though it is now nearly a decade since the NP role was first introduced. The status quo has largely been maintained, therefore, and this has effectively served to maintain the unequal power relations between potential NPs and the Government. From a critical perspective, one must question the political capacity and will to address these important concerns, and what impediments exist that prevent them being resolved.

CHAPTER 5: NURSE PRACTITIONERS: PRACTICE CONTEXTS AND INTERSECTION WITH TRADITIONAL HEALTH PRACTICES

Introduction

In the previous chapter an explanation of what I interpreted as evidence of asymmetrical power relationships within the role and function of NPs in Fiji was provided. Fairclough's three dimensional model of critical discourse analysis was applied to selected data sets, to describe a number of the linguistic features of these texts, the discursive practices involved in their production, consumption and distribution, and how they impacted on broader social practices, in relation to the topic being analysed.

This chapter explores the theme that NPs in Fiji have a complex and multifaceted role that is founded on advanced nursing and midwifery practice, overlain with primary clinical care functions akin to that of medical doctors. Elements of public and allied health are also included in their role, together with the primary health care ingredients of promotion, rehabilitation, education and community development. This broad and eclectic mix is outlined within their job description and legal scope of practice, and applied within a range of professional contexts. Emergence of the NP role has heralded an ethical and power-oriented shift in the relationship between these advanced practice nurses and 'their patients', and this chapter will link aspects of this relationship to the concept of 'service' as described by a number of the NPs. This discussion will be contextualised within wider socio-cultural norms, professional expectations and religious duty.

Backgrounding these domains and their associated discourses are those associated with traditional healers, birth attendants and traditional medicine (TM), which are not mentioned in any of the documents associated with the role of the NPs. Possible explanations for the absence of these important contextual elements will be offered, and I will explore what I see as the tension that exists at this nexus and how TM intersects with so-called mainstream or allopathic services provided by NPs to remote communities. I believe that western medical discourses have powerfully shaped the role and function of NPs in Fiji, and marginalised those associated with traditional Fijian and Indian medicine. Furthermore, I suggest that the subordination of traditional medicine and its

associated discourse by orthodox approaches is an instantiation of post-colonialism and post-colonial discourse. I have focussed my analysis of traditional medicine on one of a rapidly growing number of publications by the WHO on this topic, together with responses from the NPs that I interviewed.

Traditional, complementary and alternative medicine and the WHO

Since its initial conference on TM in 1978, in which it formally acknowledged the credibility and effectiveness of these practices, the WHO has maintained a significant interest and involvement in indigenous healing approaches around the world. Many and varied documents have been produced as a result, and in 2002 WHO published its first *global* TM strategy 2002-2005, which established its policy platform and provided a framework for action. In this document, TM referred to "…systems such as traditional Chinese medicine, Indian ayurveda and Arabic unani medicine, and to various forms of indigenous medicine. TM therapies include medication therapies if they involve use of herbal medicines, animal parts and/or minerals — and non-medication therapies — if they are carried out primarily without the use of medication, as in the case of acupuncture, manual therapies and spiritual therapies. In countries where the dominant health care system is based on allopathic medicine, or where TM has not been incorporated into the national health care system, TM is often termed "complementary", "alternative" or "non-conventional" medicine." (WHO, 2002, p. 1). There appears to have been a strong push by the WHO over the past decade to harmonise traditional and so-called 'modern' medicine, not only in the Western Pacific region but from a global perspective. This is reflected in the sharp increase in publications, training workshops, conferences, funding, technical support, research and evaluation, curricula, policy development and engagement with both government and non-government agencies by the WHO (WHO, 2000; 2002; 2003; 2005; 2007). The establishment of collaborating centres for traditional medicine throughout the WHO's four global regions is further evidence of its overt commitment to, and significant investment in, traditional medicine. Publication in 2002 of a 'Traditional Medicine Strategy for 2002-2005' by the WHO (in English, Russian, Chinese and Arabic) provided a framework for action, and defined TM as "including diverse health practices, approaches, knowledge and beliefs incorporating plant, animal, and/or mineral based medicines, spiritual therapies, manual techniques and

exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness." (WHO, 2002, p. 7). TM practitioners are noted as including traditional healers, traditional birth attendants, herbalists and bone setters (WHO, 2000). The distinction has been made between TM and complementary, or alternative medicine (CAM), the latter being defined as "a broad set of health care practices that are not part of a country's own tradition, or not integrated into its dominant health care system." (p. 7). Therefore, what constitutes TM in one country may be CAM in another, with the reverse also being true, under this definition at least. Furthermore, TM/CAM practices appear to be qualified on the basis of historical derivation as well as the extent to which they are integrated into the dominant mode of health care in a given country. In western countries, allopathic medicine and its associated discourse is generally recognised as the dominant system of health care, with its scientific, evidence based approach achieving pre-eminent status. Thus, practices outside this system are seen as being complementary, or alternative.

Despite the establishment of so-called 'mainstream', or 'modern' allopathic medical models across the Western Pacific Region, traditional medicine knowledge and practices in Fiji and many other countries are clearly far from being relegated to a position of mere cultural artefact. On the contrary, as I have indicated above, the WHO is actively engaging with countries "to ensure that traditional medicine in the Western Pacific Region is developed and used appropriately, contributes to building healthy populations and communities, and combats ill health." (WHO, 2002, p. 2). It aims to do this by 'bring[ing] traditional medicine into the mainstream of the health service system, where appropriate.' (WHO, 2002). In 2005, WHO published a national, entitled 'Global Survey on the Regulation of Traditional Medicine(TM) and Complementary/Alternative Medicine(CAM) and the Regulation of Herbal Medicines'. Clearly, the WHO has been increasingly active over the past decade as people in developed and developing countries continue to use and increasingly [re]turn to traditional or complementary health practices. Greater 'top down' regulation and control over TM/CAM practices has thus been in evidence by Governments and non-Government organizations, inevitably resulting in the formulation, *inter alia*, of legislation governing the production, supply, preparation, marketing, sale and distribution of herbal medicines, for example. Indeed, in 2001 the

WHO published a comprehensive report describing the legal status of TM/CAM around the world, the findings of which reportedly took over ten years to compile (WHO, 2001). Such regulatory processes also serve a legitimising function for those who have long propounded the efficacy of TM/CAM, and theoretically, at least, also ensures that accurate information and greater quality control mechanisms are in place for consumers. While it is outside the scope of this study to analyse in detail these significant developments or the discourses represented within all the WHO publications on TM/CAM, they nevertheless provide important contextual aspects to the professional practice of NPs.

The high levels of affordability and accessibility of traditional medicines are key factors contributing to the use of these approaches, particularly by people in remote areas where 'mainstream' options are less likely to be available. There is a considerable literature describing the ethics, economics and equity associated with access to mainstream health services by people in rural and remote areas, particularly within countries such as Australia, the Americas, Canada, China, Africa and India. For example, the degree and impact of disadvantage created by this so-called 'tyranny of distance' has been researched in relation to aged care in rural America (Zhang, Tao and Anderson, 2003), maternity care in rural Guatemala (Glei & Goldman, 2000) and mental health care in rural Australia (Morley, Pirkis, Naccarella, Kohn, Blashki & Burgess, 2007). Clearly, these are global concerns that touch on all dimensions of health care, and thus constitute a significant challenge for governments and communities in developed and developing countries alike. Of particular salience to this study is the response to these issues by the Government and people of Fiji, and the role of NPs within this dynamic relationship.

The philosophical and culturally embedded beliefs associated with traditional medicines and a growing public interest in alternative, or complementary approaches to western medicine in developed countries, has led to resurgence in the use of these practices across the Western Pacific region and beyond. Fiji has a long and strong history of TM use and yet, like many other countries, its impact on health is largely unknown other than anecdotally. A number of ethnographic and descriptive studies of rural Fiji have included descriptions of traditional healing practices (see, for example the early work by Spencer, (1941), and more recently that by Parsons (1985), and Weiner, (1999)). Katz's

anthropological text (1993) recounts his lived experiences with a traditional healer on a remote Fijian Island over a two-year period. The focus of his book is on the *dauvagunu (dow van goo noo),* or spiritual healers, who are one of several traditional healers in Fiji; others include the seers, or *daurairai (dow ray ray),* who Katz notes are reportedly expert at 'seeing' spiritually; the massage specialists, or dauveibo *(dow ve imbo)* and the herbalists, or dausoliwai *(dow soli why).* Collectively, these healers are called *vuniwai vakaviti,* or doctors of Fiji. Katz reports that Indigenous Fijians denote two broad categories of sickness depending on their cause, namely 'natural' sickness caused by physical factors, and 'spiritual' sickness, or that caused by the work of the devil. Both forms invariably have physical symptoms and thus people go to the *dauvagunu* for treatment, as they are seen as the most powerful healers. While it is beyond the scope of this study to explore further these complex roles and relationships, or other texts that describe different elements of them, Katz's book provides many previously unrecorded insights into the work and life of traditional spiritual healers in rural Fiji.

Increasingly interwoven within this rich tradition of healing are the threads of contemporary modern medicine, for the two are neither distinct or incongruent entities; rather, I suggest that a dynamic relationship is rapidly evolving, in which each is increasingly impacting on the other in a dialectical and interdiscursive manner, and as a result transforming orders of discourse and shifting power relations between and within these social practices.

Reproductive health in Fiji: traditional epistemes and praxes confronted by Western approaches

In the early days of British administration Indigenous Fijians were trained in many aspects of western medicine to become Native Medical Practitioners, which expanded through the 1900s to include the training of Fijian women as Native Obstetric Nurses (NONs) (Lukere, 2002). This latter group were introduced to replace the traditional midwives, though as Lukere identifies they were poorly received by many women because of their limited skills, youth, childlessness and perceived association with their colonial rulers (2002, p. 110). During this era, extremely high rates of infant mortality threatened to make the Fijian race extinct and were it not for the concurrently high fertility rate such an outcome was a distinct possibility. As Lukere (2002) notes, the

introduction of new pathogens such as measles and tuberculosis by their European administrators contributed significantly to this population crisis. Fortunately, interventions such as widespread vaccination programs, improved hygiene practices and the development of natural resistance served to significantly reduce the high mortality associated with these diseases.

Feelings of embitterment and disaffection characterised the agonistic relationship between the NONs introduced by the colonial government and Fijian midwives at this time. Throughout the post WW11 era a more subtle, integrative approach was adopted, yet the entirely male cadre of Native Medical Practitioners and doctors were largely unable to gain access to the female dominated domain of maternal and child health; Fijian women would simply not to go to see a male doctor about such issues. Despite this, many NONs resigned or were dismissed and had children of their own only to later return as older, wiser nurses who had experienced motherhood first hand and thus were more accepted. The polarization that typified the early relationship between NONs and traditional midwives eased over the ensuing decades such that coexistence and interpenetration became the norm (Lukere, 2002).

Western medicine continued to increase in profile and prestige such that since the 1970s childbirth has, in urban and regional areas at least, occurred within hospitals and under the supervision of medical officers. Curative approaches to the care of infants through new drugs and vaccinations produced a sharp decline in the infant mortality through the 1950s and 1960s. The management of gynaecological conditions by traditional means has also now been totally supplanted by the expansion and acceptance of western medicine (Lukere, 2002). Despite these transformations, support for the preservation of a core of traditional knowledge and practice in the area of midwifery parallels that of medicine discussed earlier. It is against this complex socio-historical backdrop that new dialogues and understandings about how traditional practices intersect with modern approaches has emerged. This study also draws attention to the contemporary role of the Fijian NP as midwife, and how this core domain of their practice is viewed by medical officers and their nursing colleagues alike. For those NPs who serve in remote interior or small island communities, they clearly have a vital role in providing maternal and child health care to people in those communities who otherwise would not be able to obtain local access to

such support, necessitating lengthy travel by land and/or sea to a regional hospital, which may endanger both mother and unborn child.

The following Venn diagram illustrates the overlap between the NP role, western medicine, traditional medicine and traditional birth attendants.

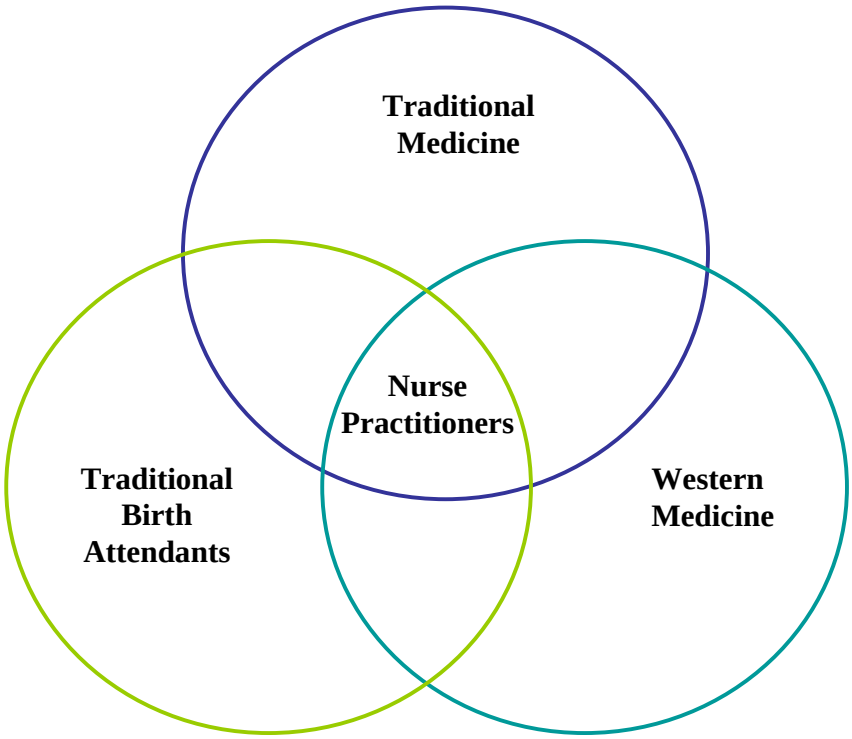

Figure 3 Western medicine and associated reproductive health practices, Nurse Practitioners, Traditional Birth Attendants and Traditional Medicine: a theoretical model demonstrating the overlap between these domains

The importance of the knowledge and skills possessed by the NPs in the area of reproductive health was typified by the response of a medical officer when interviewed:

> *'we have a pregnant lady who still haven't delivered and is in a clinic now; she was booked for Suva because she wanted to have er a tubal ligation after that so she was trapped in the village and was calling us then I just had to inform the NP and please go and see that case it's closer to you and then she*

went there and brought her over to the clinic she's closer to her now and if anything happens now the NP is there I mean the good thing the good thing about it is they are midwives… so, you feel good. I mean most of us, to be frank, most of the medical officers don't get that much obstetrics and gynaecology experience compared to the midwives, we don't get that – ah it's what, a 10 weeks attachment? To obstetrics and gynaecology and a 3 month attachment after that during internship, and that's it.

DL That's it.

Right! Yeah, when the midwives have so much experience so having that er quality in the nurse practitioner is just an asset, yeah, and we feel good when they say that the patient is stable you know it is stable that is coming from a midwives mouth who is an NP, eh? It's just so heart warming (laughs) yeah.'

(Jona, p. 4, 144-158)

Note: the patient referred to in the above quote was 'trapped in the village' because the road was impassable via vehicle due to floods.

Nurse Practitioners and traditional health care

Perhaps more than any other health professional in Fiji, NPs are closest to the interface between allopathic, traditional medicines and traditional birth attendants. As mentioned, this is largely because of the remote contexts in which they practice, the associated lack of local access by remote communities to comprehensive health services, and the NPs education and scope of practice, which emphasises a western approach to care. As Indigenous Fijians, the NPs have grown up being exposed to and personally using a variety of these traditional medicines, yet there currently appears to be little capacity for incorporating these practices into their role. This creates a very challenging dynamic for NPs in Fiji, who not only use TM themselves but in their professional role daily interact with many Fijian and Indian community members of all ages in rural and remote areas who use TM as a primary resource for maintaining health and treating a variety of conditions. This situation is not unique to Fiji and reports describing the use of both western health care and traditional therapies in Hawaii (Broad & Allison, 2002) and the

United States (Cattell, 1999) by NPs highlight the active role they should have in incorporating such practices in a manner that does not challenge their legal accountability and liability.

The NPs that I interviewed reported that herbal remedies were used by both Indians and Fijians as first line treatments for many conditions because the plants, herbs and trees were readily available in the villages and the fruit, leaves, roots or bark of these flora were cheap to use and reportedly efficacious for conditions such as axillary boils, coughs, cuts, muscle sprains, bruising, fever, lowering blood glucose levels in diabetes, easing gastrointestinal upset and treating skin conditions such as tinea. The use of massage was also reportedly used to relieve muscular pain, assist in relaxation and as an adjunct to herbal remedies. As one NP I interviewed stated:

> *'When I went to do nursing it* [TM] *wasn't even taught in nursing, but I know that it's part of us Fijians that we use traditional medicine.*
>
> *DL So why do you think that it's not integrated?*
>
> *Because when it* [the NP program] *started in Fiji we went into western medicine, but before western medicine came we had our own, traditional, but a lot of us Fijians and Indians……well, Fijians I can tell you will go to herbal medicine first and when it doesn't work then they'll come here. Mm.'*
>
> (Timoci, p. 15, 453-454; 458-461)

> *' I think so. I wouldn't know what your views of it may be, but in our culture we were brought up by our parents and their parents to use traditional medicines and I know that in the stations where I worked before one of the most interior places in Namoamoa they'll go to traditional medicines, they even have traditional birth attendants, and it's amazing that they don't use any Western things and sometimes like just take a delivery and a episiotomy sometimes it get infected , but those that deliver in the village and have a cut, second-degree or third degree and it doesn't even sink in they use herbal medicines and they heal, so there must be some merit in this and we use that. Now whether it's psychological I don't know, (chuckle) but it's been proven to work. So what's happening right now is that the Ministry of health has*

> *brought in traditional healers and people who have traditional medicine knowledge, it's compiled a book and they are allowed to use it. But not in the health centres.*
>
> (Timoci, p. 16, 474-485)

Speaking from first hand experience, this NP recounted a variety of situations in which various forms of traditional healing and medicine had been used, including the treatment of burns, the setting of bone fractures, and the healing of infected episiotomy incisions following childbirth. Another NP noted that when they ran out of essential medicines in the remote health centre (which apparently was often), they resorted to advising patients to use traditional approaches, and used them themselves if there was nothing else available. While TM was not included within the formal education or clinical protocols utilised by the NPs, they regularly treated patients who had used these approaches and continued to do so after they had consulted with the NP (or doctor). Another NP stated she advised patients to use herbs topically, but did not support the ingestion of herbal medicines. Concurrent use of herbal and so called 'essential', or manufactured medicines was a concern to the NPs, many of whom advised their patients not to ingest or apply herbal medicines while taking a prescribed essential drug, as the interactions were unknown and could be harmful. Fear of litigation was also mentioned, should a NP recommend a particular herbal remedy which then caused a patient's condition to worsen. As mentioned, NPs reported personally using traditional medicines outside their professional roles and were firm believers in their efficacy despite stating that such practices lacked scientific evidence. This appeared to be the dogma espoused within the NP Course, and a common response offered by the NPs when questioned as to why they did not use TM in their professional practice. It is reasonable to conclude that the non-inclusion of traditional medicine in the NP course curriculum is a reflection of the dominant allopathic, or western approach to medicine that is also taught in the undergraduate nursing and medical curricula in Fiji. These discursive practices have clearly shaped the views of the NPs regarding the role and use of TM, as evidenced by their responses during the interviews. As one NP stated when asked if she used TM in her practice:

'Oh no. No. I don't. And I don't advise. Although some of them ask me whether they can take, ah, traditional and ahh and the medicine that I give them, I said "I've only, I only know the work of the medicine that I am giving you. But the, there is some drugs, like there is interaction of drugs, eh? So I don't know whether your medicine and my medicine can work together, or they…" So I used to explain it like that. So if you ask me about the herbal I won't say anything but I'll tell you what my medicines are for, and why they important and this and that.'

(Sera, p. 8, 350-356)

Another NP stated that:

'I used to tell them, um, when we are talking to the mothers, err, who bring in their children with cough, then we used to tell them when you go home, aahh, you give this antibiotic, ah, and then, ah, advise them on using soft, soothing remedy, which we didn't give, but that is, ah, with us, ah, Fiji situation we know that the soothing remedy as some, ah, mild umm herbs that just grown around the house that are dropped, or a teaspoon can be used just to soothe, er, the child's complaints, mmm.'

(Marafu, p. 9, 281-287

It appears, therefore, that varying degrees of advice to patients regarding the use of TM was provided by the NPs. Concerns regarding the scientific basis of these remedies, together with potential drug interactions and the possibility of litigation were most commonly cited by the NPs as reasons for not formally incorporating TM into their practice. How might such interactions be interpreted and explained? I suggest that at the level of discursive practice, the communicative events that constitute the interactions with NPs and their patients about the use of TM are shaped by the dominant discourses that comprise the NP role, namely those of nursing, midwifery, primary curative and preventative health care. These discourses all emphasise an evidence-based approach to health care entrenched within the western biomedical model, and by so doing marginalise those that do not have this scientific basis, including those associated with TM. By

maintaining this separation, the dominant orders of discourse remains largely unchallenged and thus unchanged. At the level of social practice, however, there are tensions between these competing orders of discourse.

Role of the WHO in shaping discourse

As has been highlighted above, the WHO is actively seeking to set the global agenda for incorporating TM/CAM into so-called mainstream medical approaches, and regulate the practice and processes associated with their use. The following quote from the WHO's recently published 'Regional Strategy for Traditional Medicine in the Western Pacific' (2002, p. 32) reflects this agenda and its intention regarding these practices:

> WHO will continue to work closely with member States of the Western Pacific Region to promote the proper use of traditional medicine. The development of evidence-based policy and management of information are essential to achieving this goal. This regional strategy is designed to be used by governments to promote the appropriate use of traditional medicine and to integrate it into mainstream medicine.

This statement may be interpreted that the WHO, in conjunction with governments will decide what is the 'proper' and 'appropriate' use of traditional medicine, though what is meant by these terms is not defined anywhere within the document. Perhaps more importantly, the Regional Strategy's purpose in assisting governments to 'integrate' TM into so-called mainstream medicine indicates that it currently doesn't enjoy such status or acceptance, and that TM practices must be aligned with the dominant health care model in a given country. Indeed, the Strategy states that modern medical schools generally don't include TM within their curricula, and that many doctors trained in these settings reject such practices because of their lack of a scientific basis.

The document was available for downloading from the Internet at the following URL: http://www.wpro.who.int/health_topics/traditional_medicine/publications.htm, where it was included with the WHO's many other publications on different aspects of TM, which may also be downloaded. Access to these documents by individuals or groups who do not have a hard copy relies on them being able to log on to a computer, and have internet access, a printer, paper, and the necessary software to download the files from the Web. Needless to say, for people in remote villages in Fiji that do not yet have electricity or

telephone lines, this is profoundly problematic! Downloading these documents was thus a simple task for me, yet not possible for the very people who are likely to be most [dis]affected by these publications, namely the practitioners and users of TM in remote areas. It is reasonable to assume that NPs working in these areas would also not have access to these documents, and be equally uninformed about the WHO's agenda regarding TM. This provides a sobering example of assumptions that are made regarding the production, distribution and consumption of such texts, and how people who are already marginalised and disadvantaged geographically, economically and socially are further disempowered by effectively being excluded from access to documents that directly affect their lives.

The Strategy document commences with a Foreward by Dr Shigeru Omi, Regional Director for the WHO in the Western Pacific, who is himself a medical doctor trained under the western model of health care. Being Japanese, Dr Omi would no doubt be familiar with the traditional medicine history and practices used within that country and its near neighbours, and also have been directly involved in the delivery of western medicine within that context. The document is forty pages in length, and includes a combination of text and graphs throughout the body of the text, all of which are printed in English. A number of citations are included throughout, and their references included on the page on which they are used. These references are from a range of different sources, including unpublished WHO and governmental survey and working party reports, World Health Assembly resolutions, articles from medical journals such as the *Lancet* and the British Medical Journal, a Chinese *Heath Newspaper* and a Japanese document *Information on Oriental Medicine*.

Linguistic elements and discursive processes

Drawing on this eclectic mix of text types, or genres, and the various discourse types they represent in the development of a text comprising a different style or register, namely a 'strategy' document, reflects its manifest intertextuality and links the text to its context. As mentioned, many references are unpublished survey, committee, working party or status reports, the authors and contents of which may well be largely unknown to readers of the document. As links in an intertextual chain, therefore, I would tentatively suggest

that several of those drawn on within this strategy appear somewhat tenuous, and lack the necessary high level of supporting evidence expected in such a pivotal document.

The document's conclusion reinforces the intent of the strategy and lists seven major strategic objectives for the period 2001-2010. A series of tables presenting a variety of data sets completes the final section. Clearly, the intent, information included, format and text type indicates that the document has not been developed for use by the lay public; rather, it forms one of a series of texts produced by the WHO Western Pacific Region that serve a more 'macro' function, assisting governments, non-government organizations (NGOs) and the WHO itself to integrate TM into mainstream health services. This series of fourteen texts are listed by date as a Table in the appendices, covering topics such as 'Medicinal Plants in China' (1989), 'Standard Acupuncture Nomenclature (Parts 1 and 2) (1991) and 'Guidelines for the Appropriate Use of Herbal Medicines' (1998). Thus, the Strategy document is linked intertextually to these and other historical publications, most of which serve to reinforce the objectives of the WHO in mainstreaming, regulating and thus powerfully shaping TM practices. At the level of discursive practice, there is little information provided regarding the production, distribution and consumption of the document, other than stating that it is to be used to guide by 'national Governments, WHO and other partners in the efforts to ensure proper use of traditional medicine and its contribution for maintaining health and fighting disease in the Region." (WHO 2002, Foreward). The draft strategy was formally endorsed by the WHO Regional Committee at the 52nd Session in September 2001, and one would assume it was then distributed to the Governments of WHO Member States in the Western Pacific Region. All States were 'urged' to apply the strategy framework within their particular country, and the WHO Regional Director requested to provide support and assistance in order to ensure its facilitation. Processes for reporting on the progress of these activities were also stated, and it is clear that the WHO intends to keep TM firmly on its global agenda for the foreseeable future. This was evidenced by the inclusion in the 'Follow up Reports" section of the 58th Session of the WHO Regional Committee which was held in Korea in September, 2007. At this Session, the Committee stated the following in relation to the TM Strategy:

> To implement the strategic objectives outlined in the Strategy, the Regional Office for the Western Pacific has undertaken a number of activities in the areas of policy, education, research, regulation and standards, including terminology, acupuncture point locations and clinical practice. These activities led to two important publications: *Guidelines for Quality Assurance of Traditional Medicine Education in the Western Pacific Region* and *WHO International Standard Terminologies on Traditional Medicine in the Western Pacific Region.* Two additional publications, *WHO Standard of Acupuncture Point Locations* and the *Revised Guidelines for Clinical Research on Acupuncture*, are expected to be available later this year.

As mentioned, the Regional Strategy document focuses on the process of integration of traditional medicine into mainstream health services. Associated with conceptions of integration are bureaucratic practices such as increased regulation, legislation, policy formulation, the setting of standards, licensure of providers, scientific evaluation, standardization, economic assessments regarding the commodification and marketization of TM and the use of evidence-based research to legitimise their use within mainstream health systems. Production of these publications that serve as guidelines, standards and benchmarks for quality assurance further emphasise the WHO's stance in seeking to regulate and control the TM agenda across the region. These documents become part of the network of discursive practices that make up the order of discourse within the wider realm of social practice in which TM is situated. While it is outside the scope of this study to explore the non-discursive elements that constitute what Fairclough (1992, p. 237) terms the 'social matrix of discourse', I suggest that the discursive practices associated with these documents are transforming the order of discourse, and thus contributing to social change. This change is being carefully and deliberately scripted by the WHO via its bureaucratic systems, processes and discursive practices. For example, in the Strategy's Conclusion, WHO recommends that, 'where appropriate', the document be used by all Member States "as a framework for the development of national traditional medicine programmes" (WHO, 2002 p. 32), an element of which is the establishment of a national policy on TM. Five 'needs' are also identified as issues to be addressed, but

there is no indication as to how they were identified, by whom, or whether they were prioritised in any way. The interdiscursive mix that characterises the document is evident within these five needs statements. For example, manufacturing discourse is drawn on when the need for good manufacturing practices (GMP) that ensure quality standards are met, is identified. Traditional medicines are called 'products', and their active components must be 'isolated, characterized or quantified.' (p. 14). Users of TM are referred to as 'consumers', unless they are in a professional relationship with a TM practitioner, where the appellation 'patient' is used, as seen within mainstream medical discourse.

Unfortunately, little if any linkage is made between the five chapters of the document and each chapter consists of many paragraphs of varying lengths that also frequently do not link well. Thus, the overwhelming sense I had after a number of readings of the text was that it comprised a somewhat haphazard collection of disparate and often unsupported statements that culminated in a strategy that in itself lacks a degree of coherence and cohesion. Many assumptions are made throughout the document, such as the sweeping statement that "Medical schools often consider the culture of indigenous communities to be based on mythology and folklore." (p. 4). Furthermore, WHO assumes that there exists a desire by and capacity within governments to integrate traditional and western medicine; that there is a common and agreed understanding of what 'integration' actually means; that this is a culturally appropriate and acceptable undertaking, and that such philosophically different approaches can be harmonized, particularly when there is clearly an unequal power relationship strongly favouring western medicine. Throughout the Strategy document, issues such as the lack of regulation and scientific basis for TM practices are constructed as being problematic, and presented as 'challenges' **for traditional medicine** rather than for the WHO, Governments, mainstream medicine, patients, or communities. The following quote from the document highlights this construction:

> Developing standards and regulations for training in and practice of traditional medicine, broadening research so that it encompasses its holistic nature, maximizing the economic potential of traditional medicine, and developing

> policies and programmes that ensure that traditional medicine benefits the people who need it most are formidable challenges facing traditional medicine.
>
> (WHO, 2002, p. 1)

Balancing this somewhat is the declaration that the document is to be used as a guide, rather than as a prescriptive set of activities that each country must adhere to and incorporate. Despite this, the seven strategic objectives are clearly action oriented, have a timeframe associated with them (2001-2010), and include a reporting mechanism requiring all Member States to submit a review of their progress to WHO by 2006.

Political and bureaucratic discourses are also strongly evident throughout the document, and evidenced in the statements that identify the need for governments to form review committees, develop action plans, policies, legislation, regulations and standards, and put in place processes for the registration of practitioners and licensure of traders. Elements of what Fairclough (1992, p. 128) refers to as 'techno-scientific medical discourse' are manifest within the calls for 'methodologically sound research', 'evidence based practice', and support from the 'scientific community' to integrate TM into mainstream health services. These contrast with the discourses associated with traditional and alternative approaches, which by distinction do not boast these characteristics and are thus perceived as being potentially unsafe, possessing unknown and irregular efficacy which at worst may be harmful, are not well documented, and lack standardization. I believe this promotes a professional stigma associated with the use of TM by health professionals such as NPs who have been educated within the western model, further marginalising it and therefore those that use it. The fact that the majority of people who use TM also experience disadvantage in other aspects of their lives because of their remote location, reinforces the need to approach the notion of integration from the perspective of those who for whom this is most germane. Importantly, the conduct of research involves obtaining prior informed consent where ancestral lands, customs, traditions, practices and mores of a community are involved, which at least gives tacit acknowledgement of cultural discourses. Ethical and legal discourses are reflected in the discussion regarding intellectual property rights of TM practitioners, the need to protect them from exploitation and misappropriation, patenting of products by private companies

and the development of national legislation to protect indigenous knowledge and the holders of such knowledge. Lastly, economic and marketing discourses are drawn on, as seen in the use of phrases such as 'tax incentives' to encourage practitioner involvement in accreditation and regulation, 'an industry that generated A$1 billion in turnover' (referring to CAM in Australia), and calls for the economic potential of TM to be identified and assessed, and investment funding sought from industries and agencies to enable viable markets to be established. Articulating these diverse discourse types within this document suggests a high level of interdiscursivity which, according to Fairclough's model, is associated with change at the wider societal level. The role of the WHO in driving this agenda for change *vis a vis* TM is assumed to be unequivocal given its global influence, resources, high level relationships with governments and NGOs and weight of history behind it. Clearly, therefore, this strategy document presents readers with a framework for intended change. As mentioned, it requests that all Member States develop a national TM programme and policy based on the Strategy, and "submit a review of progress to WHO before the fifty-seventh session of the WHO Regional Committee for the Western Pacific in 2006." (WHO 2002, p. 32). Thus, WHO has constructed a relationship of accountability wherein countries in the region are coerced into adopting the strategy, implementing its objectives and reporting back to WHO on their progress. It is assumed, therefore, that consumers of the document will read it predominantly from what Janks (1997) calls an engaged, rather than an estranged position. In other words, the text has been constructed such that the reader is positioned to read *with* the text, rather than *against* it. The latter is what Fairclough (1992) refers to as resistant reading and interpretation, suggesting that it forms "one mode of hegemonic struggle over the articulation of intertextual elements." (p. 136). By contrast, readers and interpreters of a text may do so in a compliant manner and in so doing succumb to the power of the text, accepting the lines of reasoning, argumentation, assumptions and conclusion stated within it. Construction, distribution and consumption of the text is overtly directed *toward* governments, reinforcing the WHO's operations as being situated *outside* any particular country, while at the same time working closely with its 193 Member States around the world. This represents an enormously powerful relationship in favour of the WHO, and reinforces its domination over public health discourse on a global level.

Links to social practices

Within the Strategy document modern, western health care is espoused as the dominant model, despite the inclusion of statistics demonstrating a burgeoning acceptance of, and market for traditional and CAM approaches. Many key statements within the text are unsubstantiated or unsupported by references, particularly when it comes to the core sections of the strategy, namely the chapters entitled 'Issues' and 'Strategic Objectives'. Furthermore, there appears to be some confusion in the use of nomenclature within the document. For example, TM is defined as "an ancient medical practice which existed in human societies before the application of modern science to health." (Foreward) and, citing a separate WHO document (2000), is "based on indigenous theories, beliefs and experiences that are handed down from generation to generation.". CAM is stated as being the 'umbrella term' under which both traditional and 'more recent forms of non-standard medicine' are included. However, in other WHO documents (see, for example WHO, 2003) traditional, alternative and complementary medicines are placed under the umbrella term of traditional medicine, though it notes that "In some countries where traditional medicine has not been incorporated into the national health care system, it is often termed "complementary", "alternative" or "non-conventional" medicine." This inconsistency is not helpful and suggests that the WHO is unclear about the definitions and relationships it is endeavouring to describe. In Fiji, where TM sits firmly outside the national health care system, it is not referred to as complementary or alternative medicine, even by the WHO (2001).

The language used within the text strongly indicates that the integration of traditional medicine *into* (rather than *with*) orthodox western approaches (certainly not the other way around) is highly desirable, rational, inevitable and of benefit to all involved. One could interpret this need by the WHO to integrate these two approaches as recognition of the inherent limitations and benefits of each, and promotion of the positive synergies that harmonization could theoretically produce. From a critical standpoint, conceptions of mainstream medicine and mainstream health services are perceived as being heavily ideologically laden, and efforts by the WHO to form alliances between traditional and mainstream systems may be explained in Gramscian terms as endeavouring to secure hegemonic power through consent via the provision of leadership in this area. Control

over the sphere of health care is linked to many other socio-political elements including the health workforce, economics, productivity, legislation, education and training, and technology. Each of these elements has its own discourse and set of discursive (and non-discursive) practices, as well as inherent power relationships. Within the social practice dimension, therefore, I suggest that this document contributes to a rearticulation of the orders of discourse associated with traditional and mainstream medicine by the WHO, with the latter order strengthening its dominance through integration of the former. While hegemonic power may be achieved within the macro-political sphere, contestation via hegemonic struggle will occur at the operational level, for example when NPs interact with their clients and communities and the two approaches to health care intersect with each other. To achieve hegemony, notes Crossley (2005, p. 114), "contending groups must seek to build bridges with already existing organic cultural configurations. Otherwise these will prove to be a very stubborn obstacle. In reality, TM practices remain the cheapest, most convenient and culturally acceptable form of health care for the majority of rural Fijians, and thus will continue to be used despite the presence of the western model of health care made available by the NPs. From a cultural perspective, the use of TM is inextricably linked to their ***identity*** as Fijians; part of what it means to ***be*** Fijian is to use traditional medicine, as it reportedly strengthens their links with the land and each other (Katz, 1993). Juxtaposition of these philosophically and culturally disparate approaches within developing countries like Fiji is changing the health care milieu, and within it the relationship between consumers of health care and health professionals such as NPs.

In the section above, it was proposed that the essentially western model of health care reflected within the role of the NP in Fiji has colonised and to a degree supplanted historical and culturally embedded traditional knowledge and its associated techniques. It was explained that at the level of social practice this process has in part been driven by the WHO as it sets the global agenda for change in favour of 'integration' and 'harmonization' of the two philosophically distinct approaches. Notably, the goal is to subsume traditional medicine knowledge and practices *into* western, mainstream models of health care. Formal health services in Fiji are constructed around these latter approaches, particularly in urban and regional centres; by contrast, people in rural areas

who have reduced access to such services tend to use traditional medicines and practices as their primary mode of health care for many ailments. As a result there was evidence, I believe, of a tension reported by the NPs within the clinical exchanges with their 'patients' as they endeavoured to apply their evidence-based, mainstream approach within a traditional health care milieu.

It has been previously stated that the professional identity of the NPs in Fiji has been discursively constructed within the many WHO Mission Reports, their job description, the legislation that governs their practice, the Course curriculum, and the media. Fairclough (1992, p. 168) notes that language serves a potent identity function, "…because the ways in which societies categorise and build identities for their members is a fundamental aspect of how they work, how power relations are imposed and exercised, how societies are reproduced and changed." Within their diverse practice, the NPs use a variety of semiotic elements including verbal and body language, visual images, and written texts as they engage with community members. For example, running an ante-natal session for expectant mothers, conducting a public health survey within a village, holding a general outpatient clinic or organising a health education session on sexually transmitted infections all constitute different social activities within their professional practice as NPs. The varied contexts in which NPs are being utilised are shaping their work practices and requiring them to not only draw on an increasing number of discourses, but apply them differently according to the practice environment. One result of this is the development of different interprofessional relationships with other members of the health care team. The following sections describe these relationships, linking them to different clinical environments in which NPs were working. In particular, the discourses and dynamics within each will be highlighted, linking them to wider sociocultural practice.

Work practices and interprofessional relationships

Educational preparation of the NPs has adopted a biomedical approach to health and health care, and as the foundation for the construction of their new professional identity this para-medical role has been grafted onto their pre-existing practice as experienced nurses and midwives. This combination of medical, nursing, midwifery and public health roles distinguishes these NPs from other mid-level practitioners, such as Medical or

Physician Assistants (MAs, PAs). In contrast to the NPs, these latter groups are educated within Medical Schools, have much closer professional links with doctors, and work under different awards, legislation and scopes of practice. A vast literature now exists describing virtually every aspect of these roles either individually, in combination with each other or in relation to doctors, patients, organizations, governments and education providers, to name just a few. In an unpublished discussion paper, for example, O'Connor (2001) provided an extensive overview of the roles of NPs and PAs and proposed that, akin to the experience in the United States, the latter group could be introduced into the Australian health workforce as a part solution to the acute shortage of medical officers currently being experienced in that country. Hooker and others have published a variety of papers (see, for example Freeborn & Hooker, 1995; Hooker & McCaig, 1996; Hooker, Potts & Ray, 1997; Hooker & Cawley, 1997; Hooker & McCaig, 2001) exploring the PA role and comparing it with that of NPs, principally within the United States. As stated earlier, Fiji previously implemented the MA role but has since abandoned it in favour of the NP, who is perceived as being a more flexible and cheaper alternative, yet is highly skilled and capable of providing efficient and effective care in a variety of medically underserved areas. Elements of a variety of professional discourses are drawn on in this diverse role, including medicine, pharmacy, psychiatry, radiology and dentistry, and these are articulated within the many new inter and intra-professional relationships that have needed to be formed as the NPs have established their practice within rural, peri-urban and urban settings and across a range of clinical environments. These advanced nurses have established new interprofessional relationships as they have become a vital component of the health workforce in that country. When asked about the health professionals they interact with, the NPs named the following (not in any order of priority or frequency):

- Pharmacists and pharmacy assistants
- Radiologists
- Physiotherapists
- Dieticians
- Dentists and dental therapists

- Doctors at sub-divisional and divisional hospitals and at St Giles, the Psychiatric Hospital
- Environmental health officers
- Public Health nurses
- Laboratory technicians
- Tutors at the School of Nursing
- Sisters, staff nurses, sub-divisional health sisters and Matrons.

What makes the NPs unique and distinct from these groups is that elements of **all** of them are contained within the role and function of the NPs, particularly in rural areas. As one NP stated,

> *'If there is no dietician, then the nurse practitioner can become a dietician. Okay? If there isn't a dental officer the nurse practitioner can become a dental officer. So, because of the, our scope of practice, as I told you we are trained to look after the people in the community so we can become a dietician, I can become a dental officer, I can also become a technician. I, I am really thankful that they bring this program up to pull the nurses up, the nursing career up.'*
>
> (Faranisese, p. 17, 492-497)

It appeared that the availability of and access to the many health professionals in the above list directly shaped the extent to which the NPs took on aspects of these other roles. Thus, one of the great strengths of the NPs, I believe, was that they possessed a great degree of flexibility and adaptability to be able to modify their practice according to the availability of other health professionals.

Contrasting Nurse Practitioner roles

NPs have been deployed by their administrators to a variety of clinical contexts, and as such have had to adapt their practice accordingly. As mentioned previously, those I interviewed were working in situations such as remote or peri-urban health centres, outpatient departments at sub-divisional or divisional hospitals, and in community mental health. This is not dissimilar to how the NP role has evolved in the United States, having

emerged in 1965 in response to shortages of primary care providers in both rural and urban areas (Carnegie Commission, 1968 cited by Pulcini & Wagner, 2002). These authors chronicled the development of the NP role in the U.S.A. and described how within five years of its inception specialization began to proliferate as the NPs aligned themselves with the many spheres of medical practice. Thus emerged NPs in the areas of paediatrics, family health, neonatology, mental health and many other clinical specialties. Fiji has yet to formally implement NP specialties via the establishment of preparatory curricula and the development of appropriate protocols, but given the diverse clinical areas to which they are now being deployed and the need for a suitable career structure, it may be a direction that the Government takes in future.

Paediatric outpatients

The NP who worked in paediatric outpatients at the Colonial War Memorial stated that this position was specifically created by a Paediatric Consultant, and as such the NP's role was sanctioned and supported by him. This may be explained as an example of the control exerted over the NPs by the medical profession, who oversee the clinical practice of the NPs and are able to also place them in positions otherwise held by a doctor. Professional power was thus conferred on the NP by the Paediatric Consultant as a major component of the construction of her role, so that at the operational level the NP was presented to the public and as an authentic and approved health professional in that area of practice. At the institutional level, such arrangements were sanctioned by the Ministry of Health, Hospital Administrators and the nursing, medical and allied health fraternities, to the extent that her position was accepted as being the conduit through which many paediatric cases were admitted to hospital, treated and either sent home or referred elsewhere.

Her role included conducting full patient assessments, taking a health history, classifying the patient according to the Integrated Management of Childhood Illness (IMCI) guidelines, diagnosing their complaints, developing a plan of care, treating the patient, prescribing medications and advising the child and parents regarding drug administration, consulting with the medical officers as necessary, admitting the patient if required, ordering x-rays and other diagnostic tests, taking blood and listening for the presence of heart murmurs that may indicate rheumatic heart disease. She also received referrals from

other hospitals, which again required taking a full history and then either admitting the child or treating them and sending them home with the parents. Her role thus drew heavily on medical discourse and associated practices, combined with those associated with nursing and child health. Applying Fairclough's conceptualisation of CDA (2001, in Wodak & Meyer, 2005), one can see that articulation of these different genres, discourses and 'voices' (where 'voice' refers, in this context, to the type of language used by NPs and is closely linked to their identity (Chouliaraki & Fairclough, 1999)) within the role created new dialectical relationships between the semiotic aspects of the role and other social practices. Exploration of these relationships would require the use of different social scientific research methods, for example ethnography, to produce a fuller understanding of what Chouliaraki & Fairclough (1999, p. 62) describe as the knowledge associated with 'different moments of a social practice: its material aspects (for example locational arrangements in space), its social relationships and processes, as well as the beliefs, values and desires of its participants." However, for the purposes of this analysis CDA has been used to describe, interpret and explain, at this juncture, the different professional contexts in which NPs are located. The linguistic and semiotic significance of this is important here, for being a NP in paediatric outpatients requires that language (written, verbal and body) is used in certain ways. For example, interviewing a parent(s) with a sick child, talking with that child, documenting one's observations in the patient's file and consulting with the Paediatrician requires that the NP use specific language that represents the articulation of appropriate genres, discourses and voices in a way that can be understood by the child, the parents, other nurses, those that read the case notes and the doctor. Chouliaraki & Fairclough (1999) argue that discursive interactions such as this contain internalised power relations represented by 'relations of domination' (p. 62), wherein the NP, as the health professional, exerts power through the material activities associated with assessment and treatment as well as discursively through her dialogue and documentation.

This NP had access to the full range of diagnostic and treatment facilities available at the major hospital, a stark contrast to her counterparts in remote areas whose resources would, by comparison, be described as rudimentary. It is unknown how the NPs in remote areas perceived those working in urban or peri-urban centres, but there appeared

to be a degree of empathy displayed for those in isolated areas, mainly because those in urban areas had at one time completed what was referred to as their 'rural stint', and thus had an appreciation of the hardships associated with practice in these areas.

The NP noted that taking in-depth histories of her patients and being able to do much more for them was the major strength of her role, stating that "You, you tend to know patients more better, yeah, rather than just nursing them." Having graduated to a much more comprehensive and autonomous role, *just* providing nursing care appeared to have been relegated to a somewhat lesser position. The NPs were not specifically asked about their perceptions of nursing now that they worked in an expanded, advanced role though like others I interviewed this NP indicated that the next logical step for her would be to become a 'fully fledged' medical officer. She stated that she was in a post that was supposed to be filled by a medical officer, but that she and the other Sisters that worked with her were now fulfilling that role, and that the medical officers stayed on the wards. Like all the NPs, her major grievance was the lack of adequate remuneration commensurate with the role that she was performing. As she stated, "Oh the major concern is that we are doing a lot of work and then we're not being paid for. We're doing all the things that the doctors do [said with exclamation and increased force] whereas them they do both and they are paid highly." When questioned about whether anything was being done about this, she replied:

> *'I just do not know because most of the people, ah, they just come well even my administrators up there they come and say "E sa, you are doing a lot of work and no, nobody is helping you". I just do not know what they are doing whether they are doing something about me or about all of us I don't know! Or just saying those pretty words and walk away!'*
>
> (Naomi, p. 7, 190-194)

This response appears to reflect a degree of despair, cynicism and disengagement also verbalised by other NPs I interviewed. Their empowerment as advanced, autonomous practitioners was strongly counterbalanced by feelings of isolation, role ambiguity and a lack of information regarding the evolution of their role. Furthermore, despite being able to complete all the new tasks described above, the NP felt that the protocols within which she worked did not adequately enable her to complete all the aspects of her clinical role.

These protocols were originally developed for NPs working in medically underserved, remote areas and had a primary care orientation. They certainly did not specifically address the scope of practice of NPs working in urban centres in specialty fields such as Paediatrics, Mental Health or Accident and Emergency. The extent to which the protocols have become incongruent with the role of NPs in these areas is unknown, though as an aspect of discursive practice it may be interpreted that the absence of protocols that cover their practice suggests that the original homogeneous, or 'one size fits all' approach has since failed to include guidelines required for clinical specialization. Deploying NPs to these areas thus places them in a situation where the need for support and medical supervision is potentially much greater. When asked whether she was getting good support, this NP replied with exclamation: *'Yes! Yes! They really praise what I am doing.'* (Naomi, p. 7, 199).

The 'they' referred to were several of her senior nursing colleagues, who appeared to show considerable respect for her busy role and offered verbal encouragement and physical 'pats on the back'. The notion of professional support was thus understood to be that which was informally received from colleagues, rather than being a formal process aligned with professional development, continuing education or the provision of adequate resources that would enable her to carry out her job effectively. Formal assessment of their functioning as NPs was via the merit based, performance management system (PMS) that had been introduced across the entire civil service at that time (2004) as one component of sweeping public sector reforms. However, within a year of its introduction it was suspended, along with many of the other reforms, based on the recommendation of the World Bank and a ruling of the permanent arbitrator. The annual confidential report (ACR) was reintroduced and remained in place at the time of writing, though a 'new' PMS is expected to be introduced from 1st January, 2008 (Fiji Government, 2006). As the supervisors of the NPs, doctors complete these reports and, as the name implies, their contents are confidential though feedback is provided via interview and written communiqué. The closer, more direct relationship between NPs and doctors in urban and peri-urban settings suggests that these doctors would be better positioned to accurately evaluate the performance of the NPs; in contrast, those in remote areas where the supervision would at best be described as sporadic, would require the use of different

criteria, one would imagine. While this issue was not pursued to any great extent within this study, it was clear that the merit based PMS that replaced the ACR was found to be problematic, and many welcomed its suspension. Despite this, several NPs felt that introduction of the PMS was a positive move, as it offered more transparency to the evaluation process and being outcome oriented it forced them to be more organised. As one NP replied when asked about the PMS:

> *'uh, well it's, it's new*
> *DL: hmm*
> *and just by looking at, reading the handouts and trying to do it er, I'm I'm a bit er, a bit nervous about it but er, I I think it's good*
> *DL: hm*
> *so that we can develop ourselves, you know what Fijians are like…*
> *DL: you tell me.*
> *you know, like er, we are always complacent, we are always satisfied with whatever that was going on then we carry it on. Reading through that I think this should pull ah I mean make us Fijians reinforce us to work much harder, set our goals, set objectives, set our mission and our vision, eh? I, I I like it, I think I'm going to like it, yeah.'*
>
> (Ema, p. 13-14, 372-388)

These responses indicate that there exists a general cultural complacency associated with being Fijian which carried across into the workplace and that one of the purposes of the PMS was to increase the productivity of civil servants and overall efficiency of the public service. Clearly there had been information provided about this new system via 'handouts', and the NP was probably using the bureaucratic language they contained by using the phrase *'set our goals, set objectives, set our mission and our vision..'*

The extent to which the PMS and ACR processes effectively evaluate the role and function of the NPs is unknown, but as a relatively small group of unique and advanced practitioners working in diverse geographic and clinical environments, it would be

difficult to benchmark their performance, particularly when those in remote areas often lacked the necessary equipment, drugs, transport and communication facilities needed to effectively carry out their roles. For the NP in the Paediatric Outpatient Department at CWM, these issues are clearly less likely to affect her than one of her counterparts working in a remote Health Centre, for example.

Community Mental Health

Like many countries worldwide, Fiji is developing a greater understanding of mental health and the stigmatizing effects of mental illness within the community (Aghanwa, 2004). Akin to the NP role described above, the one in Community Mental Health was a new post, though it is not known by whom it was specifically created. The Ministry of Health deployed an NP to St Giles Psychiatric Hospital in the capital city, Suva, primarily as a member of the community team, though it appeared that she worked closely with the doctors. As she stated:

> *I work with the community team, and my role in here, I help the doctors. I help the doctors, clinically in hospital and in the community as well. In the community I have visited my clients outside for … oral meds and IMI. If the difficult cases, the default cases so I visit them, I assess them outside even when relatives call I go out and assess my clients outside and after assessing from here I informed the on-call doctors that this so and so patient is not feeling well, not mentally stable so the on-call doctors will then for this order, so I act on that order but or else I have you know the due to my job description I issue drugs to be countersigned by the medical officers but some cases that are chronic cases I just have to order drugs and distribute it to the community. But in the clinical area I help in outpatient department if they are short of doctors, doctors on sick leave, doctors have family problems so I help the doctors at outpatient department and also inside during ECT I help the doctors with ECT and I find it very interesting part of my practice as a nurse practitioner, so I help with the ECT, I helped the anesthetist to mix all our drugs and giving of our IV injections, Thiopentone, Sux or so that's part of it and the most interesting is like a few months ago just in March only myself*

> *and our doctor who has been running this outpatient because we are short of doctors, so I help with outpatient, I help with the ECT.'*
>
> (Faranisese, p. 4-5, 115-131)

Prescription and issuing of drugs appeared to be a key aspect of her role in consultation with the medical officers, as was helping the doctors with electro-convulsive therapy (ECT) and running public awareness programs on substance abuse and suicide prevention in Schools around Suva. During the interview, the NP came across as a zealous advocate for mental health care, passionately stating that mental health care was a 'unique' and 'specialized field', that she was working at a 'special hospital' which had 'all the special drugs'. She stated with real passion and in a semi-whisper that '*…So, even in nurse practitioner, nursing practitioner it's still not enough, not enough because I know, I came to work in St Giles, David, I now know that psychiatric is very important, very important in life, very important for you to be good, healthy, mentally, in order for you to carry out your nursing practice!*' (Faranisese, p. 10, 278-281).

Thus she appeared to stress the personal importance for her to be mentally healthy in order to perform effectively as a NP. She then made a substantial extrapolation by stating:

> "*mental health, when I compare mental health after twenty years of nursing med* [medical] *and surg* [surgical], *ahh, obs* [obstetrics] and *gynae* [gynaecology], *paediatric…I put mental health first. I put mental health as unique, you know the brain, because the brain controls and makes decisions. That's good, if you have good mental health, all this there will be no HIV, there will be no STI* [sexually transmitted infections], *there will be no rape, there will be no…other things, if you have good mental health. That is why I have found mental health, I must confess, mental health is the unique field that I* ***ever*** *come across, yeah."*
>
> (Faranisese, p. 10, 285-292)

At the textual level, one feature of this statement is the high degree of modality evident within it, where modality refers to what Fairclough (1992), drawing on Hodge & Kress

(1988) calls the degree of affinity that a person making a statement has with that statement. For example, by using the modal verb 'will' ('there *will* be no HIV, there *will* be no STI, there *will* be no rape), the NP has fully committed herself to these propositions (knowledge claims). As Fairclough (1992) notes, modality may be either subjective or objective, where "In the case of subjective modality, it is clear that the speaker's own degree of affinity with a proposition is being expressed, whereas in the case of objective modality, it may not be clear whose perspective is being represented – whether, for example, the speaker is projecting her [sic] own perspective as a universal one, or acting as a vehicle for the perspective of some other individual or group." (p. 159). In the above example, it appears that the NP is using objective modality as she did not use modal adverbs such as 'probably', or 'possibly' when describing the link between good mental health and situations such as rape. It is unclear whether she was stating (projecting) her own perspective regarding the links between good mental health and things such as rape, or whether it represented that of her employing organization (St Giles Psychiatric Hospital), the Ministry of Health, NPs or nurses in general, women's groups or even the Church. At the level of discursive practice, this perspective may have been interpreted (accurately or otherwise) by the NP from texts produced and distributed by one or more of these groups, and she has internalised and projected it, and the power it contains, in a manner that constructs those that commit acts such as rape, or who have HIV, as being mentally unhealthy or unstable. The NP's statement could also be interpreted that having 'good mental health' was the panacea for a range of primarily sexually derived conditions. What was actually meant by 'good mental health' was not explored, though one could reasonably assume from her statement that if you had it you would not commit rape nor possess any sexually transmitted infections, particularly HIV/AIDS (though the fact that HIV may be acquired through blood transfusion was not acknowledged by the NP). However, if you did *not* have good mental health the converse was, in her mind, also true.

Fairclough (1992, p. 159) suggests that the use of objective modality 'implies some form of power', and that high affinity with a proposition such that it can be claimed as knowledge and 'truth' reinforces the power of the statement and the discursive construction of associated social relations and meaning systems (Phillips and Jorgensen

2002, p. 84). Stating it in this way to me during the interview I believe reinforced her affinity with these statements and suggests that she may similarly assert her position and authority when making such claims in other settings, such as when educating the public about mental or sexual health. As Phillips & Jorgensen (2002) describe, a speaker's affinity to a statement, or proposition, is linked to another aspect of modality, that of truth. The knowledge-claim that 'if you have good mental health there will be no HIV' is presented in such a way that it represents categorical truth and is thus incontestable, whereas if she had stated that 'if you have good mental health there *may* not be HIV', the force of the statement is lessened, it carries less authority and is left open to different perspectives. The NP also constructed the sentence so that it was conditional: *if* you have good mental health, *then*…. By syntactically linking the antecedent clause (which in linguistics is the subordinate clause: if you have good mental health) to the consequent clause (then there will be no HIV) in this way infers that one logically follows the other, the NP has further reinforced her truth claim.

There are also features within the NP's statement that link to the grammatical element of transivity, which has been described as 'the ideational dimension of the grammar of the clause and is concerned with the types of processes and elements that are coded in clauses.' (Locke, 2004 pp. 48-9). Fairclough (1992) explicitly draws on his Hallidayan systemic linguistic roots when describing this grammatical element particularly, as Phillips & Jorgensen (2002, p. 83) state, 'how events and processes are connected (or not connected) with subjects and objects." Fairclough (1992) suggests that when analysing transivity one is attempting to identify how social, cultural, political, ideological or theoretical factors 'determine how a process is signified in a particular type of discourse…or in a particular text." (p. 180). In the NP's sentence "*if you have good mental health, all this, there will be no HIV, there will be no STI, there will be no rape"*, agency is absent by the use of the word 'you'; I assumed she was not referring to me personally, but used 'you' to refer to a desired state (good mental health) within society in general. The type of process being described in this sentence is what Fairclough (1992, p. 178) refers to as 'relational', where the effect (HIV, STI, rape) is emphasised but the responsible agent is absent and the actions and processes that actually cause these conditions are disregarded. In doing so, the *people* who are HIV positive, have a sexually

transmitted infection, or commit rape have been moved to the background in favour of the need for good mental health. The identity of agents - those with or without good mental health, is partly constructed in the sentence by linking it to the presence or absence of these sexually oriented conditions. Furthermore, linking good mental health to three highly stigmatised and socially, culturally and politically 'sensitive' issues: HIV, STI and rape, may be significant when endeavouring to explain the broader social context in which this statement is embedded. While discourse analysis on its own cannot fully explain the social practices reflected within these relationships it can, at this juncture, begin to illuminate the discursive processes and their social context, and any related ideological or hegemonic effects (Fairclough, 1992). The NP's statement may represent, and thus reinforce, the normatively held view within the mental health service in Fiji (or, indeed, wider Fijian society) that possessing 'good' mental health would result in the eradication of what she perceives as being socially and morally unacceptable, sexually oriented behaviours and conditions. The interdiscursive blend of mental health and sexual health, mixed together with the criminal act of rape within her statement offers insight into the way she de-constructed and rationalised these social conditions.

One other aspect of textual analysis is the grammatical element of ethos which, as Fairclough (1992) notes is an issue for intertextuality and relates to the construction of social identities through language and bodily expression. As an example, he states that "It is not just the way in which doctors talk that signals ethos; it is the way they sit, their facial expression, their movements, their ways of responding physically to what is said, their proxemic behaviour (whether they get close to, or even touch, their patients, or keep their distance).)" (p. 167). This NP talked about the verbal and non-verbal ways in which she communicated with her patients, as seen in the following excerpts from the interview:

> *'Even though we, I, we talk…the way we touch patient, it's holistic, compared…you know in comparison, patients have been coming in they said 'oh yeah, you know', because my husband has been telling me "why don't you go and do MBBS now it's your second year at St Giles?" I said "no I don't want to become a doctor. I want to remain as a nurse practitioner, because it is my field, I am a nurse and I have special touch, I have special feeling for my patients."*

> *I know where to, yeah…because I, I would love to be called a nurse because as I've told you earlier on because of special gift given to us, yes, we have the feeling, the touch, we treat the patient holistically.*
>
> (Faranisese, p. 11, 301-306; p. 16, 451-453)

Here the NP emphasised the 'special' touch and feeling she had for her patients and that this was a special gift given to them. She linked the emotional aspects (*the feeling*) to the physical (*the touch*), and related these to the notion of treating the patient holistically, which she appeared to infer was unique to nursing. By using the inclusive word 'us', she indicated that all other NPs (and possibly all other nurses) had also been given this gift, which was enacted through the holistic way they interacted with their patients. Elsewhere, she appeared to be contrasting this to the way in which the doctors treated their patients which she felt at times lacked empathy. However, she rationalised this to some degree by suggesting that the doctors were tired and needed to relax. As she stated:

> *'Maybe they are tired, too? Maybe if they are overstressed at work so they give away the duty to the nurse practitioners, because they know we are nurses, we cannot refuse things as I've mentioned, we have the heart for our patients. Ah, we can not just turn our patient out like some of the medical officers. Yes, they do that! They can just turn the patient out, but nurse practitioners you hardly see them to turn their patients out, they minus their lunchtime, they minus their times we are supposed to go off duty, they are sick and complete their work.'*
>
> (Faranisese, p. 19, 552-558)

The NP appeared to be contrasting the social identity that she has with that of the doctors, wherein her verbal and non-verbal interactions with patients reflected an ethos of caring that was unique to nursing. Fairclough (1992, p.167), in relating the notion of ethos to doctor : patient interactions, describes it to include the ways people respond physically to what is said: their facial expression and 'proxemic behaviour (whether they get close to, or even touch, their patients, or keep their distance).' A number of cues evident in this statement reflect what Fairclough (1992, p. 166) refers to as "a wider process of

‘modelling’, wherein the place and time of an interaction and its set of participants, as well as participant ethos, are constituted by the projection of linkages in certain intertextual directions rather than others.” The NP specified a number of different scenarios where she interacted with the public; these included working in the Hospital, assisting in Outpatients, conducting home visits and talking to preschool children and their parents about growth and development. These diverse settings and interactions contribute to the construction of the social and professional identity of the NPs, which they in turn ‘signal’ via what Fairclough calls their ‘verbal and non-verbal comportment.’ (Fairclough, 1992, p. 166). Thus, it is reasonable to assume that the NP would conduct herself differently and deploy a mixture of communication styles and genres as she engaged with the different participants in these diverse locales.

There seemed to be a strong element of altruism being alluded to by this NP in her response, in stating that the NPs missed lunch, worked beyond their shift times and when sick rather than ‘turn their patients out’, which I understood to indicate that, for example, a clinic time had expired yet patients would not be turned away. She contrasted this with some medical officers who, in her view, had a less caring and empathic approach and who would place their needs above the needs of the patients. The repeated affirmation, increased force and sense of incredulity with which she stated, ‘*Yes, they do that!’* indicated that to this NP, at least, the practice of ‘turning patients out’ by some medical officers was professionally unacceptable and commonly seen, relative to NPs who ‘you hardly see’ doing it.

At the level of social practice, this may reflect contrasting orders of discourse between nursing (and NPs, particularly) and medicine, in terms of their approach and attitude toward patients. The notion that the doctors could, if overstressed ‘give away their duty to the nurse practitioners’, infers a more superficial relationship which may, in reality, be a coping mechanism employed by the doctors in a workplace characterised by a high degree of stress, low doctor-patient ratios, high staff turnover, increased waiting lists for admission and increasing pressure on hospital beds. In contrast, nurses and NPs in particular, were constructed as being hard working, self-sacrificing, prepared to work above and beyond the call of duty and possessing a heart for ‘our patients’. Use of the epithet ‘having a heart for our patients’, inferred a deeper relationship that involved

compassion and empathy, and reinforced the notion of service that emerged fairly consistently during my dialogue with the NPs. In some cases, this appeared to be tied to their Christian beliefs and duty to serve God and others through their work as NPs. For others, it was linked to their employment as civil servants, or as a condition of their being accepted into the NP program. The following excerpts from interviews with the NPs and the Director of Nursing Services emphasise these perspectives:

> *'Maybe it is not safe for them, given the nurses school the basic training for three years training for nurses most of the Indo- Fijians refuse, totally refuse to go out into the islands, so only the Fijian people are willingly they are hired because we know this is our own kind, own people, you have to go out and serve them.'*
>
> (Faranisese, p. 3, 61-68)
>
> *'It's very important, that's why, I am just said I praise the Lord that he pays me. At first, David, I must confess, at first I refused to come here. Inside me, but I don't know, the Lord called me here, for me to come and serve this community, to serve the community psych…'*
>
> (Faranisese, p. 10, 282-285)
>
> *'I just wanted to, I feel that my services with the people is needed more, so all this time I prayed that one day I would do such, you know come in contact with patients and interviewing patients so I at last when they gave me the opportunity to go through the NP program I was just too happy to accept it.'*
>
> (Lati, p. 1, 16-20)
>
> *'…and they also, sorry, also part of the criteria they express their wish to you know one of the criteria then is they must be willing to serve in the rural, rural. At least they have that ah that ah concept that realisation that they'll have to serve they have to go, they are taken in they have to serve in the, yeah.'*
>
> (Mere, p. 3, 7-13)

There are elements of social, professional and religious duty to one's people, one's community and to God evidenced within these quotes. The concept of 'service' and 'serving' which historically, at least, has been a characteristic of the nursing ethos, may

be interpreted here as having become normalised under the rubric of religious duty, cultural expectation and/or personal and professional responsibility, such that it appeared embedded within the knowledge, belief and value systems of a number of those interviewed. Evidence indicates that the traditionally highly patriarchal nature of Indigenous Fijian and Indo-Fijian cultures (Katz, 1993), the Christian church and Hinduism (Adinkrah, 1999a; 1999b; 2001), as well as the influences of post-colonialism that are still evident within contemporary Fijian society (Tanner, 2007), not only shape the structures within that society but also the orders of discourse which promote and restrict interaction (Chouliaraki & Fairclough, 1999). To apply this, interactions between NPs and their patients constitute part of the practice of nursing, aspects of which are constructed around the concept of serving, or service. The order of discourse of nursing, as well as those associated with Indigenous Fijian and Indo-Fijian cultures, the Christian and Hindu faiths, post-colonialism and the civil service bureaucracy which, from a structural perspective, represent a network of discourses that are interdiscursively drawn on by the NPs when describing the concept of service. Chouliaraki & Fairclough (1999, p. 63) indicate that when 'specifying relations between the social and discourse moments of the social practice', one is inevitably drawn to questions of power. Power inherent within relationships involving service, as described above, also give rise to ideological and hegemonic effects, 'which contribute to the production, re-production or transformation of relations of domination (Fairclough, 1992, p. 87). When the NPs articulated the notion of service, therefore, it may be explained as a 'desired and required' activity, or relationship that is initiated by them with their patients or community. Several of the clauses in the statements indicate what Fairclough (2003, p. 173) refers to as deontic, or obligational modality. This is evident in the first excerpt, where the NP states "*..we know this is our own kind, own people, you have to go out and serve them."* Fairclough suggests that this is linked to evaluation (2003, p. 173), wherein the NP is inferring that, as a NP, serving the people is a *good* thing to do; indeed it is something that you *have to go out and do.*

In the last excerpt, the interviewee repeatedly indicated that the NPs must serve in rural areas, and that this was a prerequisite to them being accepted to undertake the NP program. Again, there is evidence of an imperative here, although this was from the

perspective of an administrator who was involved in the selection of NPs students and the initial deployment of graduates. There are two perspectives of service evident here, therefore. The former is a verb and linked to a cultural obligation – *'our own kind, own people'* to the role of NP in serving them. The latter is also a verb, but is strongly bureaucratic, indicating service in remote areas to be an administrative requirement of the civil service and Ministry of Health, rather than referring to any professional relationship between the NPs and their communities.

I suggest that by describing and validating this relationship in terms of service, the NPs were transforming the order of discourse which tended to marginalise and disempower people in remote areas. By so doing, the NPs were challenging the status quo, shifting the balance of power and creating possibilities for social change. In contrast, the administrator reinforced the status quo, which was characterised by unequal and unchallenged power relations and domination. By so doing, the order of discourse was reproduced and any possibility for social change in this instance was limited, even lost.

NPs as rural community capacity builders

The other major functional component of the NP's role, apart from their clinical and administrative responsibilities, is as a promoter of health through community education and development. In their job description, these are described as comprising "the provision of Primary Health Care and Public Health activities to improve and maintain the state of well-being of the community" (WHO, 1998, Annex 2). This broad statement is articulated somewhat more succinctly within the Nurses, Midwives and Nurse Practitioner Act, 1999, which states that NPs may, in the context of government service, "counsel and educate patients, and other individuals, families and communities about health promotion, the prevention of illness, disease or injury, the management and treatment of disability and of impaired functions, and palliative care" and "provide health assessments of individuals, families and communities". (p. 276). As highlighted previously, NPs in remote health centres are on call 24 hours a day, 7 days a week and provide a primary care, nursing, midwifery and public health service, at times to as many as 10 villages comprising up to 15,000 people spread across a large and at times difficult to negotiate geographic area. Ready access to these villages and settlements is made more challenging by the frequent unavailability of suitable transport, such as a four wheel drive

or boat. Despite these difficulties, NPs in remote areas reported being able to fulfil a health promotion role, as exemplified by this response from one NP based in a rural area on the main island of Viti Levu:

> *'Okay, we have a program here, like Monday is outpatient day, okay, and then Tuesday I see ante-natal mothers, okay, the whole day plus some outpatients, and on Wednesday is MCH day, Maternal Child Health and outpatients, well the nurses do that, maternal child health and I help along, they refer cases to me, some cases of maybe mild or moderate malnutrition and then I help along with them, do health education to the mothers. Thursday is always my busy day, that's the day when I see my outpatient cases, special outpatient cases like diabetes and hypertension and some other cardiac, yeah, the whole day and Friday (clears throat) is bookwork for me, for me and the nurses, but I fit in, like this week on Monday we went out on a outreach clinic, we took, we went out to one village and did screening, did health education and er did er um clinic just general outpatient in one village. Like, in a month I must make sure I go three times or four times to, out to the village to do outreach clinic and then on Saturday, Sunday in the night I just wait for emergencies.*
>
> (Ema, p.11, 299-309)

NPs working on the outer islands reported a similar approach to their work, though much of their travel was obviously via boat when available. Conducting village inspections to check on sanitation, calling in on schools, carrying out domiciliary visits and organising health promotion projects were all included with the various clinics that were run throughout the week. There did not appear to be a systematic or strategic approach to these health promotion (HP) activities, though one NP mentioned using the Ministry of Health's Health Promotion Calendar of events as a guide to the topics and timing of HP activities throughout the year. As one NP on an outer island stated:

> *' For example, we have to do a lot of health education. We have to go right down to the village and do health education, do outpost clinics, we have to do visits, in every quarter we have to make plans on the routine visits, and it's not quite easy, not quite easy.*

> *With um with me out in Qamea we, I've I draw up ah quarterly programs and that is submitted to the subdivisional hospital so they are well aware of ah my whereabouts. So in a month I draw up ah plans to visit around there and so these programs would be like er if er I'm not in the clinic there are two nurses in the clinic. I will be around the island doing out post clinics, visiting the domiciliary cases, doing health educations together with that would be MCH [*maternal and child health]*, ANC* [ante-natal clinic] *I'll do all of that when I go around the island.'*
>
> (Simon, p. 2, 33-35; p. 8, 208-213)

All NPs I interviewed described their involvement in health education and promotion as activities undertaken in conjunction with the running of various clinics, such as those stated in the quote above. It was unclear how much time was committed to health promotion or whether it was considered to be a less important element of their role. Given the extremely busy curative, primary care role that the NPs appeared to have, it is reasonable to assume that health promotion was a lesser component of their practice.

There is a growing body of literature describing community development and/or health promotion by nurses in rural and remote areas (see, for example Farmer, Lauder, Richards & Sharkey, 2003; Fuller, Edwards, Martinez, Edwards & Reid, 2003; Kelly, Howard & Smith, 2007), but to a much lesser extent that provided by nurse practitioners (Worster, Sarco, Thrasher, Fernandez & Chemeris, 2005; Bailey, Jones & Way, 2006). Several papers have been published by Laverack *et al* describing community capacity building within a health promotion context in rural Fiji (Laverack & Labonte, 2000; Gibbon, Labonte & Laverack, 2002; Laverack, 2003; Laverack, 2006), though none of these publications relate to nurses or NPs specifically. Roberts (1997) has described the three-year Kadavu Rural Health Project, which focussed on health promotion and community development on the island of Kadavu, the fourth largest island in Fiji. This project was formally evaluated via a partnership between AusAID and the Government of Fiji (2000).

Of salience to this study are the dominant discourses which shape health promotion, and what Laverack & Labonte (2000, p. 255) identify as a 'major tension' in contemporary

health promotion, namely that "many health promoters continue to exert power through 'top down' programmes whilst at the same time using the emancipatory discourse of the Ottawa Charter." Moreover, these authors suggest that two main health promotion discourses have developed; the first is what they term 'conventional discourse [which] emphasizes disease prevention through lifestyle management or, in the case of infectious disease, vector control.' (p. 256). The second they state as being 'radical', in the sense that it 'emphasizes social justice through community empowerment and advocacy.' (p. 256). There is a tendency, they argue, for 'top down' programming of health promotion to adopt the conventional, specific problem oriented approach, and for health promoters to therefore be constrained by the guidelines, funding, time frame and goals of the sponsor organization, which often is a section of Government. In contrast, community empowerment approaches tend to target more complex, systemic issues that are defined *by* the community and they are thus positioned as possessing the locus of control over the problem solving process. Though coming from philosophically different directions, the authors argue that they are *not* necessarily mutually exclusive, either in theory or practice, and that both approaches in fact need to inform and be sensitive to each other throughout each stage of the life of a particular programme.

The Fiji Government has been active in establishing structures to support health protection, health promotion, education and community capacity building strategies and processes. For example, establishment of the Fiji Institute of Environmental Health, National Health Promotion Council, and the National Centre for Health Promotion, the latter two of which are both situated within the organisational structure of the Fiji Ministry of Health, link local programmes to regional health promotion initiatives facilitated by the World Health Organisation and other key stakeholders. Galea, Powis & Tamplin (2000) have chronicled a number of key developments in health promotion throughout the Western Pacific region, many of which relate to the Yanuca Island Declaration (WHO, 1995) and resulting Healthy Islands concept, which "is a broad-based participatory approach and an overarching framework for health protection and health promotion in the Pacific, with the core elements of community action, environmental management and policy and infrastructure development." (WHO, 1995). These former authors note the challenge Fiji faces to bring together groups such as nurses, health

promotion workers and environmental health officers in an integrated and strategic way to maximise the knowledge and skills of these professionals and provide a more collaborative and effective approach to improving community health.

The Community Health Nurses (CHN) in Fiji work closely with nurse practitioners, nurses and volunteer community health workers in rural areas of Fiji. These CHN now have a set of Competency Standards and a Handbook for Community Health Nurses, which were both published in 2007 as part of a three-year, bilateral health project between the governments of Fiji and Japan. Called the "In-service Training of Community Health Nurses" project (IST Project), it aims to "improve the management skills of the community health nurses through In-Service Training at the sub-divisional level. The expected result of this In-service training is to see that the community health nurses are able to improve the quality of health care giving to the community."(JICA, 2005, p. 1). A press release by the Ministry of Information, Fiji Government (August 28, 2007) related to the release of these two documents stated that "They were developed with the aim of expanding the capacity of work for Community Health Nurses in Fiji so that they can do their work better." As highlighted in the earlier discussion about service, the press release also repeatedly referred this notion, for example stating that "The handbooks now mean thousands of Community Health Nurses (CHNs) in Fiji have an option to develop their career objectives and serve the community better." (Government of Fiji: Ministry of Information, 2007, p. 1).

It is clear that there will be overlap between the NPs and Community Nurses in the areas of community health education and health promotion. No publications were able to be located which described this relationship, the resultant activities or outcomes, which means they effectively remain invisible to those not directly involved. As Laverack & Labonte (2000) note, there may be evaluation processes which report on specific risk factors, such as a quantifiable reduction in people who smoke tobacco, though such processes tend to be linked to top-down approaches, outcomes, and the reaching of 'targets'. This is not to say that these are not important or necessary, though as these authors argue, they must be balanced with bottom up approaches which employ a variety of evaluation methods that capture the changes deemed to be important to the community, rather than just the outside agency.

From this discussion, it is clear that the NPs are one of a number of groups whose remit includes a health promotion and education role. The network of discourses associated with sectors such as environmental and community health, health promotion, Government policy, nursing and primary health care will doubtless shape, and be shaped by, the NPs in Fiji as they maintain this involvement in the core dimensions of health education and promotion. The interdiscursive blending of these different discourse types has shaped the production of texts such as the Healthy Islands policy framework, and the aforementioned Competencies for Community Health Nurses and Nurses, Midwives and Nurse Practitioners Rules (1999). Moreover, as the texts are distributed they enter into intertextual chains from which they are transformed into different text types (Fairclough, 1992). For example, aspects of the Healthy Islands document have been integrated into a Fiji Government Press Release (Fiji Government Online, 2007), and formed the basis of an article written by the Deputy Director-General of the Secretariat of the Pacific Community (SPC), which was published in both French and English in the bi-lingual 'Inform'ACTION' newsletter of The Public Health Surveillance and Communicable Disease Control (PHS&CDC) Section of SPC (SPC, 2001). These two texts have quite different audiences and serve different purposes, given that the first is a general press release and the second an opinion piece in a newsletter. Both were published on the internet, although hard copy of the article could also be gained if one purchased a subscription to the SPC Newsletter. Readership is thus limited to those who either purposefully search the internet or receive hard copy of the documents, neither of whom are likely to be the NPs. At the level of social practice, one is mindful of the ideological influences embedded within these discursive practices, and the ways in which they might 'contribute to the production, reproduction or transformation of relations of domination.' (Fairclough, 1992, p. 87). The two texts indicate that there is multi-sectoral interest in health promotion, not only in Fiji but across all Pacific countries. In the wider social context, competing interests *vis a vis* health promotion reflect the ideological positions of these social institutions, identities and relations, and the orders of discourse that are interdiscursively represented in their various practices. While Fairclough (1992, p. 88) maintains that 'ideology invests in language in various ways at various levels', and that texts provide clues to ideological processes and structures, he recognises that one cannot

directly identify ideologies from texts. Nor does he appear to accept the Althusserian view that ideology is an inseparable element of society; rather, he suggests that discursive practices are potentially open to ideological investment 'in so far as they incorporate significations which contribute to sustaining or restructuring power relations." (Fairclough, 1992, p. 91). Using Fairclough's conception of hegemony, therefore, in which leadership and domination are exerted across the major domains of a society, one is able to identify hegemonic struggle within the orders of discourse associated with health promotion. Such struggle purports to be change oriented so that, for example, the health of Fijians is improved, the burden of chronic disease lifted and the economic capacity of the country increased. As the press release stated, "Apart from doctoring and nursing the country the Ministry of Health is also tasked with the mammoth task of promoting healthy living amongst a people of laisser-faire [sic] culture." The CEO for Health was quoted as saying that 'the era of neglect is over, it is now time to cure lifestyle diseases by changing the mindset of our people.' Perhaps not surprisingly, this statement was linked to the announcement of a modest increase in government funding for the National Health Promotion Council (mentioned above), which the release stated was the coordinating body for the Healthy Islands initiative in Fiji. The release also noted that the Council created awareness and promoted healthy living as well as conducting research 'to gather data to better implement its programmes.' These phrases appear to reflect a somewhat simplistic view of the links between health promotion, lifestyle change and entrenched cultural practices associated with diet, exercise and smoking, for example. Moreover, it was worded such that change was going to be generated (and funded) by the government, and the NHPC would be responsible for bringing about this new 'mindset' in the Fijian people that would lead to improved health. There was no indication as to *how* the Ministry of Health planned to achieve this 'mammoth task', though clearly it believed it was responsible for doing so, along with 'doctoring and nursing the country'. I suggest that contrary to the goal of achieving change, such a view merely reproduces the bureaucratic order of discourse and thus contributes to maintaining the status quo (Phillips & Jorgensen, 2002). As stated in the aforementioned press release, "The Ministry of Health's Corporate Plan recommends that health promotion, protection and prevention be given the highest priority." (Fiji Government, 2007). This

statement intertextually links the press release to the Government's policy framework for health and the role and function of the Ministry of Health. It is thus made subject to the institutional and economic conditions which prevail within the Government which, at the time of writing, was still in the hands of the Fiji Military following the coup of December 2006.

There is no evidence that the NPs were consulted or included in decision making regarding health promotion activities or policy development, despite their close working relationship with remote communities. Indeed, when specifically asked during interview whether they believed they exerted any influence on, or contributed to decision making for the wider health care sector, the NPs all responded in the negative. While they believed they should be included, they stated that all such decision making took place at the sub-divisional level and within the Ministry of Health. This appeared to reinforce their feelings of powerlessness, isolation and disadvantage, and demonstrated that the health promotion component of their role lacked 'bottom up' connection with other individuals and groups. It is unknown how this perceived lack of influence regarding decisions made at levels above them affected their implementation by the NPs, though it is reasonable to assume that they may not have a sense of ownership of those decisions. Thus, the processes of change in relation to health promotion being promoted by the Government, the WHO and organisations such as the NHPC and SPC, to date display a lack of real engagement with the NPs as a vital group providing health education and promotion to those in rural and remote areas. I suggest that this maintains unequal power relations in favour of health professionals in urban, peri-urban and regional areas, who have far greater access to health information and maintain the locus of control over decision making.

As part of his doctoral research, Laverack (2003) evaluated the capacity of two rural communities in Fiji, where such capacity is defined as 'a process that increases the assets and attributes that a community is able to draw on in order to improve their lives.' (Laverack 2006, p. 267). These may relate to health concerns or indeed any other problem identified by that community. He links the concept of community capacity building to community development and suggests that practitioners involved in programme planning and evaluation can benefit by including specific objectives that

address factors that positively influence community capacity. In particular, he describes the use of a visual representation tool, which is a modified 'spider web configuration' described by Rifkin, Muller & Bichmann (1988). Nine 'domains' of community capacity, previously identified by Laverack (2001) were used to evaluate these two rural communities; these domains included, for example, stakeholder participation, leadership, organizational structures, problem assessment and resource mobilization (p. 100). While NPs were not specifically mentioned by Laverack as practitioners involved in community development, their role and function as health professionals in rural settings clearly situates them as key stakeholders in programmes that focus on capacity building in health. Indeed, I suggest that given the high priority purportedly being accorded to health promotion by the Fiji Government, greater acknowledgement of and support for the work done by NPs in this area would not only decrease their sense of disempowerment, but enhance their capacity to work inter-sectorally to improve the health of people in remote communities. This remains a significant challenge, I believe, given the relatively small numbers of NPs and the diverse clinical settings to which they are now being deployed.

Conclusion

This chapter has focussed on a number of factors that have shaped the role and function of the NPs. Highlighted was the tension that exists between traditional medicine and the mainstream, allopathic approach which now dominates formal health care services in Fiji. I suggested that there is evidence of a significant shift occurring to integrate these two approaches, and that this is ostensibly being driven by the World Health Organization as a global campaign. Given that people in rural areas have the least access to mainstream health services and thus largely rely on traditional medicines to treat many conditions, this was perceived as a major issue for NPs as they endeavoured to work at the interface between these two approaches.

The diverse settings to which NPs are deployed, and the inter-professional relationships which they developed were also described, using as a focus the NPs that worked in paediatric outpatients and community mental health. The concept of service was also explored in terms of its social construction and application by the NPs in the conduct of their role. Lastly, health promotion as a core component of the NP's role was discussed, and linked to a wider regional strategy again driven by a range of stakeholders including the WHO, governments and organizations such as the Secretariat of the Pacific Community. Throughout these discussions, I have endeavoured to identify ways in which various discourses have functioned as forms of social practice and served to reinforce asymmetric power relations within the professional world of the NPs. By 'unpacking' these relationships, new insights have been gained regarding the production, distribution and consumption/interpretation of selected texts (their intertextuality, interdiscursivity and coherence) and the wider social processes and power relations that may exert ideological and hegemonic effects on discursive practices, and also be shaped and changed by them. The ways in which the NPs have been positioned and their identities influenced by these processes have been explained and possibilities for change proposed.

The following chapter discusses the influence the NPs have had on the development of nursing and midwifery practice in Fiji.

CHAPTER 6: NURSE PRACTITIONERS: SHAPING HEALTH CARE DELIVERY, THE HEALTH WORKFORCE AND NURSING IN FIJI

Introduction

Throughout the previous two chapters, and true to Fairclough's model (1992), incidents of language use that pertain to the NPs have been described as elements of a number of discourses, and these discursive practices have been contextualised within orders of discourse in the wider social sphere, for example those of politics, health care, traditional and mainstream medicine. A number of insights into the struggle for more symmetrical relations of power, and what Phillips & Jorgensen (2002, p. 88) describe as the promotion of 'more egalitarian and liberal discourses', have emerged through analysis of the various contexts in which NPs are deployed.

This chapter discusses the theme that the NP role, with its core elements of nursing, midwifery, primary care, public health and health promotion, functions in a reflexive relationship with those elements and thus shapes and is shaped by them. Furthermore, in the conduct of their expanded role NPs draw on and articulate in new ways the knowledge, networks of practices and orders of discourse associated with these domains. By so doing, it is proposed that they not only apply knowledge in new and different ways, but construct unique inter and intra-professional, client and community relationships. The concepts of 'field', 'habitus' and 'voice', as articulated by Chouliaraki & Fairclough (1999), will be employed to explore these discursive practices of the NPs.

It is also proposed that the NP role has dramatically shifted the discipline related boundaries and divisions of labour associated with the major health professional groups, challenged traditional stereotypes associated with medicine, nursing and midwifery and altered the image of these latter two groups, in particular, within Fiji. It is thus a contention of this study that the unique nature of the NP role has required these nurses to think, practice and (inter)act in new ways as they have made the transition to 'being' a NP. Critical questions arise as a result of these developments, for example to what degree have the practices and discourses of other health professions been colonised by the NPs? Conversely, how have nursing/midwifery discourses and practices been colonised by these other professions? At the level of social practice, does this strengthen nursing and

midwifery or weaken them? Does this strengthen these other groups or weaken them? What other social 'practices', be they of an economic, political, cultural and/or religious nature, are the NPs shaping outside their professional sphere? These questions will drive the key aspects of the discussion throughout this chapter, together with the analysis of several selected texts.

Shifting disciplinary boundaries

As the NP role has emerged and evolved across the globe, an issue that has generated considerable controversy has been their expanded scope of practice, particularly as these nurses have incorporated knowledge and skills that traditionally, at least, have been perceived as being within the medical domain (Mason, Vaccaro & Fessler, 2000). In Western countries such as Australia, opinion and debate regarding the scope of practice issue has at times become polarised within the media, with segments of the medical establishment vigorously defending their 'turf' and stridently opining that by introducing NPs patient care has been put at risk, medical care has been 'dumbed down', and that if nurses wanted to be doctors they should get a medical degree (Light, 2004; Pollard, 2005). While it is beyond the scope of this study to extensively analyse the discursive processes associated with this social phenomenon, viewed through a critical lens the emerging discourse can be said to have been characterised by issues of power and largely contested in the political, interprofessional and media arenas. Fairclough (1992 p. 87) suggests that such struggles are ideologically embedded and 'contribute to the production, reproduction or transformation of relations of domination'. It has earlier been shown that the professional world of the NPs in Fiji contains evidence of disempowerment and relations of domination, and that they have been subjected to exploitation by both the Government and the medical profession. Despite this, the role has slowly continued to evolve as numbers of experienced nurses and midwives have successfully completed the intensive preparatory course and embarked on a new 'journey' within their nursing careers. Somewhat ironically, this could not happen without considerable support from the Government and the other professional groups, particularly medicine and pharmacy. Importantly, such support appears to have largely negated any overt antagonism or scope of practices issues from the medical and pharmacy fraternities. It has also served to legitimate the role and function of the NPs *vis*

a vis those of other professional groups, and laid the foundation for the establishment of interprofessional collaboration and clinical support in the delivery of the role. The NP working in the Accident and Emergency Department at the Colonial War Memorial Hospital described an example of such collaboration:

> *'For example if cardiac cases come in we have to call the medical officer that is, ah, for them to um direct you, ah, although you know what is to be given you have to ring, consult them first you are not going to give the first treatment and if they tell you okay they'll come and sometimes they'll come and see the case but sometimes they said "okay you can give this to the patient" and then we, so but there are cases that they come in and we handle them straight away but it's mostly the cardiac cases that, ah we don't handle them straight away we have to consult but if there are cases they are known cases then we go ahead with the treatment.'*
>
> (Lati, p. 5, 226-233)

Here the NP indicated that telephone consultation took place with a medical officer (MO) when a person presented with a condition that required medical treatment, in this case a drug order for a client with a cardiac condition, which was outside the scope of their clinical protocols to prescribe. In this scenario it is evident that the NP had conducted an assessment of the person, identified their major health problem(s) and the appropriate treatment, documented her findings and was seeking direction from a MO to either go ahead and administer medication, or wait until they had been re-assessed by a doctor. This may seem repetitive, place the patient under unnecessary stress and potentially delay the implementation of treatment, however it does provide protection to all parties and reinforces the importance of interprofessional collaboration under circumstances where the limit of the NP's scope of practice was reached.

Talking the talk, walking the walk

Consultation between the NP and the MO constitutes an important form of discursive practice, or genre, that the NPs frequently engage in as they perform their role. The language used during such conversations would no doubt have certain characteristics, tenor and style and be structured in ways which conform to accepted norms and

conventions (Fairclough, 1992). Importantly, NPs holds substantially more professional power than other nurses, for example, and by virtue of their position have been granted 'permission' to use medical language and engage with doctors at a level that other nurses could never achieve. It is suggested, therefore, that by engaging in consultations with doctors and using language in new ways, represents an instance where the interprofessional boundaries have shifted to incorporate the practice of the NP. The NPs are in a far less subordinate position to doctors than other nurses, and their increased autonomy, assertiveness, and accountability has dramatically changed the relational dynamics between these two groups. An NP working in a rural Health Centre stated that she worked very well with the doctors at the sub-divisional and divisional hospital, and had no problems working along with them, even though at times they didn't speak the same 'language'. She referred to the greater level of medical, diagnostic and procedural knowledge that the doctors possessed, but which she drew upon in order to communicate information about clinical cases. The notion of using specific types, or styles of language was also reportedly important when interacting with pharmacists, particularly when needing to order supplies of medications. The NP stated that she at times had to justify her request for more medications, but that *'if we speak the same language he gives it, yeah.'* (Ema, p. 24, 677). She also described instances where laboratory technicians had called her in response to requests she had sent off for blood tests, stating that the test was not really required. X-ray technicians had also requested her to *'..cut down on your chest x-ray, please just treat your patient if you think it's really necessary.'* (Ema, p. 23, 653-654).

The dietician at the sub-divisional hospital also requested that *'.. please you have a new patient with high cholesterol; give advice, if after you repeat it's still high you send them down to me for a dietary advice then medicines are too good."* (Ema, p. 24, 664-666).

These brief examples reflect the communication that took place as this NPs became more adept at ordering diagnostic tests and supplies of medications. Such communication contributed to the establishment of new interprofessional relationships, helped shape the NP's identity, and affirmed their practice and status in relation to other members of the health care team.

Like others, this NP was regularly asked to 'do calls' at the hospital, which meant being on call and acting in the place of a medical officer. The sub-divisional medical officer (SDMO) said to this NP:

> *'".. come and do the call tonight", I said "No, I'm not coming because there, there's medical interns, the finalists, they'll be there." The SDMO replied "No, you work much faster and your work is more reliable than theirs."'*
>
> (Ema, p. 22, 617-619)

Here the NP is again negotiating an aspect of her work practice, in this instance with her medical supervisor. She appeared assertive in refusing to work on-call at the sub-divisional hospital (on this occasion, at least), even though the SDMO flattered her by stating that her work was of a better standard and more efficient than the interns. It is interesting to note this view by the medical officer, and one wonders whether it was a genuine assessment of this particular NP's practice, or a compliment simply aimed at getting the NP to work at the hospital. The frequency of such requests is unknown, however Downes (2000; 2001) and Usher (2001) have both reported on the practice of pulling NPs out from the Health Centre for varying lengths of time to fill a vacant Medical Officer position at a sub-divisional hospital. This issue has been highlighted previously in this thesis as having a significantly negative impact on the NPs, their families and the community, and was beyond their educational preparation.

Collectively, the examples cited above may be understood by employing several concepts from both Bourdieu (Bourdieu & Wacquant, 1992) and Bernstein (1996), some of which have been taken up by Chouliaraki & Fairclough (1999) in their exploration of the relationship between orders of discourse and their social contexts.

Field, Habitus and Voice

Fairclough's application within CDA of the concept of orders of discourse has been linked to Bourdieu's concept of 'field', which has been described as "a network of positions defined by a particular distribution of capital……which endows that field with its own specific practical logic" (Chouliaraki & Fairclough, 1999 p. 101). This concept may be used to "capture the differentiation of society into distinct sectors, or 'worlds': for example the world of the mass media, the economy, the church, the scientific world and

so on." (Crossley, 2005 p. 80). According to Bourdieu, such fields are by their very nature dynamic and comprise both physical and social 'spaces' inhabited by agents, or actors, whose interactions are shaped by the structure of the field (Phillips & Jorgensen, 2002). Thus, for Bourdieu, society consists of an array of fields governed by a 'field of power', or 'meta-field' in which "agents with power in the various specific fields contest the relative exchange values of the different capitals accumulated in different fields." (Chouliaraki & Fairclough, 1999, p. 101). For Bourdieu, capital is not merely economic, but may also be social, political or cultural, the distribution of which defines the position of the field within society. Health care would thus constitute a field, and within it the practice of nursing, midwifery, and that of the NPs would comprise sub-fields. Accordingly, NPs are agents positioned within the health care field by virtue of their "access to power and resources within that field." (Crossley, 2005, p. 81). Linguistic capital, notes Chouliaraki & Fairclough (1999), is the "power conferred on a particular linguistic form, style or dialect associated with the legitimacy and prestige of particular social positions" (p. 101), for example the medical language used by doctors and, in the context of this study, increasingly by the NPs. Due to the fusion of many roles within that of the NP they are able, via the capital and power within their role, to exert influence as they engage in a wide range of interprofessional interactions. It is suggested here that the NPs are challenging the boundaries placed on their practice by the *structures* in which they operate. For example, one NP in a rural Health Centre stated that she did not have access to intravenous (IV) antibiotics, and that this required some patients to travel to the sub-divisional hospital for treatment, which incurred a cost and placed the person and their family under added stress.

As she stated:

> *'I don't have any IV antibiotics here with me. You know most of the cases I see I can, I can treat them here rather than sending them down to the hospital but I don't have IV antibiotics. A boy came in with a skin infection or a child which needs IV Cloxacillin I can, I can treat the child here…But I don't have the drugs, I'm not entitled for IV antibiotics, if they you know if only they could give me some IV antibiotics I call the, I pick up, I call the phone "I'm*

treating a child here." Fine with me and fine with the patient because some of these people are poor, they cannot afford to go down, pay for…'

(Ema, p. 30-31, 865-875)

The NP stated that she was subsequently able to negotiate with her SDMO to have some IV antibiotics held at the Health Centre. This represents a significant change in practice, as the administration of antibiotics intravenously rather than orally not only had implications in terms of the added economic cost, but also carried increased clinical risks in terms of the possibility of anaphylactic reaction and the subsequent management of this potentially life threatening complication.

Other NPs were less enthusiastic about extending the borders of their practice to incorporate the prescription of IV antibiotics. As an NP from a remote island stated:

'There are certain areas that we are legally covered in, but, ah, for my counterparts that are working in er, um, big hospitals I think they are on a very risky side because there are other things, there are things that especially in ordering certain ah drugs, er I think some of them are doing it. They, they are just, er, that er has to go on er IV antibiotics and certain IV antibiotics we are not allowed to give. Mm, and I think they are on a very shaky part of it, mm.'

(Simon, p. 5, 122-127)

It is unknown whether the clinical protocols of the NPs have now changed to incorporate the administration of IV antibiotics under advice from a MO, but clearly it is a contentious issue and an instance where a shift in the distribution of capital is occurring, with a resultant change in the field occupied by the NPs.

All forms of capital may be converted into 'symbolic capital', note Chouliaraki & Fairclough (1999), which reflects the relative positions and power of the agents within a particular field. Doctors, dentists and pharmacists, for example, possess significant *symbolic* capital because of their elevated position within the health care field by virtue of their economic, social and linguistic capital. It is contended here that a key result of the shifting professional boundaries that has occurred to create 'space' for the NPs, has

concomitantly endowed them with substantially increased capital and in this regard separated them from their nursing and midwifery counterparts. By virtue of this repositioning, the NPs have increased their position of power *vis a vis* doctors, nurses and other professional groups and dramatically changed the structure of the field of health care, particularly in remote areas.

It can be seen, therefore, that fields are not static structures, but as "spaces of struggle in the course of which they can be restructured, and the boundaries which separate them from other fields redefined, strengthened or weakened (Chouliaraki & Fairclough, 1999 p. 101). As has been discussed earlier in this thesis, despite the expanded and advanced role that the NPs possess, there are many countervailing forces which have had an exploitative and disempowering function, and brought into sharp relief the relations of domination experienced by the NPs.

Another concept described by Bourdieu is that of 'habitus', though as Crossley (2005) notes it has a far longer history and has been used within the work of many scholars from a variety of spheres, such as philosophy, sociology and education. The Latin term habitus refers to an agent's embodied 'disposition' to act in certain ways under certain circumstances. To do so effectively, the agent must have what Bourdieu refers to as a 'feel for the game' (Crossley, 2005, p. 107), which involves the acquisition of a set of practical competencies combined with theoretical knowledge and an understanding of the many schemas that constitute a particular field. For example, to 'be' an NP the individual must have acquired the 'language' of nursing, midwifery, primary medical care, health promotion, and so on. They must also have obtained a level of practical competence in a broad range of skills and gained an understanding of their role in relation to that of others in the field of health care. Thus, the habitus of being an NP is formed by internalising the 'structures' associated with the role and reproducing those structures through 'skilful and inventive' action (Crossley, 2005). The NPs 'invest' their capital (and associated power) in the day to day conduct of their role, as they bring to bear a set of dispositions to act in certain ways under certain circumstances within their social field. An NP working in the Outpatient Department at the CWM Hospital recounted one situation where she gained practical competence in an area associated with her role:

'I take the bloods, I send them up, I call for my results. X-ray technicians and I had one time, I was told by one radiologist, um 'You are sending unnecessary cases', but not through direct to me but through another party, so I thought well, I'd better go and see this person, because I am not trained to ahh read x-rays, or…I had only two weeks session with x-ray in the School. That's all I had, no exposure to x-ray department. I had to go and see this consultant. So I went and saw her, in fact she was quite happy that I came, I said "I am not a trained radiologist, and I'm not trained to write the x-ray forms. I am learning now, almost all of the things I am learning and I'd appreciate if I did not fill out the form correctly please call me and tell me "V, this is what you should do", I'll appreciate that because we are colleagues, we are supposed to be working hand in hand, and if I don't like what you did I will come and tell you I will not and, er any x-ray that I send if it's not, er if the form is not filled properly let me know I can only improve if you people tell me.'

(Lati, p. 8-9, 388-400)

In this situation the NP has taken the initiative to address a concern that came to light in the discursive process associated with the ordering of x-rays. Her comments suggest that this process had been a sphere of struggle, involving a variety of communicative acts aimed at establishing the NP's legitimate, yet novice status and her desire to integrate the practice of ordering x-rays more seamlessly into her practice. Using Bourdieu's conception of habitus, she was 'getting a feel for the game', as she acquired an understanding of how to order x-rays appropriately. From this NP's perspective, the radiologist was perceived as being a 'colleague', and the desired relationship was one of close partnership, as evidenced by use of the metaphor 'we are supposed to be working hand in hand'. Here the NP is endeavouring to cultivate a new interprofessional relationship, and seeking to utilise the capital (and associated power) inherent within the practice of ordering x-rays which hitherto had been the domain of the doctor, dentist or medical assistant. The NP is incorporating the 'structures' associated with the identification of fractures via x-ray into her role as agent and, as Crossley (2005, p. 112)

states, “having incorporated structures we reproduce those structures through our action.” This shapes her embodied disposition (habitus) and combines it with a linguistic disposition to communicate in certain ways in the conduct of her role. Habitus thus acts as a ‘hinge’ between her agentive position and the structures within the fields in which she is located (Crossley, 2005, p. 112). It has been proposed that this latter role of the habitus benefits from adding the concept of ‘voice’ developed by the educationalist Basil Bernstein (1990), to “allow the theoretical relations of Bourdieu’s theory to work within CDA.” (Chouliaraki & Fairclough, 1999, p. 117). According to Bernstein, agents possess dispositions to use language in specific ways which are appropriate for a particular context, situation or conjuncture. In relation to CDA, ‘voice’ can be described “in terms of particular configurations of discourses and genres available for each subject [agent], in particular relations to each other.” (Chouliaraki & Fairclough, 1999, p. 117). NPs, therefore, may be seen to (inter)act and communicate based on their understanding and use of discursive practices within appropriate contexts, as well as the ‘voices’ that are brought together in the conduct of their role. In relation to the above example of the NP ordering x-rays, it may be said that on the basis of voice (akin to the notion of an order of discourse) that she is learning how to appropriately manage the range of clinical situations that require the taking of an x-ray. Similarly, other elements of the NP’s role bring together different voices, the articulation of which may be explored in terms of the power and control inherent within them and their relations with the discursive practices that exist within a particular conjuncture (Chouliaraki & Fairclough, 1999).

Returning to the above example, it seems apparent that this NP’s educational preparation regarding the ordering of x-rays had not been addressed within the NP course, probably because the curriculum was oriented to remote areas that have no radiology facilities. This emphasises the tension that exists between the habitus of the NPs and the field in which they operate, as a result of deploying NPs to clinical areas for which they were not educationally prepared. It has earlier been shown that they have become increasingly conscious of this tension and sought ways to vocalise and act on it, though this has largely been channelled through the industrial body that represents all nurses in Fiji, the Fiji Nurses Association (FNA). As the General Secretary of the FNA stated when interviewed:

> *'Well my role here is, the Nurse Practitioners are members of the Association. I take up their concerns, ah in terms of the salaries that they get, their working conditions, um, ah, postings if they, they are being posted to a place where they are not happy about I try to intervene and, er in, in my role as trying to create a good industrial relations with, between our members, the members of the Association and the Government as the employer, Ministry of Health, mmm.'*
>
> (Mereana, p. 2, 51-55)

Efforts by the Association to utilise its industrial relations capital and power to mediate between the NPs and the Government were aimed at bringing about positive change in the sub-field of practice in which the NPs are situated. It is outside the scope of this study to explore the success or otherwise of these activities, however based on the evidence presented in this study and elsewhere (Usher & Lindsay, 2003/4), it is clear that in a number of important ways the NPs remain a significantly disempowered group. By unpacking the circular relationship that exists wherein the NP role has been 'created' within and by Fijian society, and the NPs then recreate it through their relationship to the social world (Crossley, 2005), it is hoped that previously hidden processes and practices will contribute to a better understanding of their professional world.

Nurse Practitioners – playing a new 'game'?

Bourdieu's notion of 'acquiring a feel for the game' as one obtains competence is central to his concept of habitus, and there are echoes here of the doctor-nurse game. Neale (1999) has noted that the emergence of the NP role has further changed the doctor-nurse 'game' first described by Stein in 1967, which originally related to communication between doctors and nurses, the nature of which both reflected and reinforced the subordinate role of the nurse, and the authority of the physician. New interdisciplinary, collaborative relationships have paralleled the evolution of the NP role, and this has been found to contribute to increased job satisfaction, a more empowered workplace, less stress and better outcomes for patients (Almost & Laschinger, 2002). From a critical perspective, these new interactions reflect a shift in the professional power of medicine

vis a vis that of the NPs under circumstances when consultation was required. Examples of this are evident within the following quotes from interviews with two of the NPs:

> *'I only, when I come across a, a case that I think I've done all that I, you know..? But there's still no improvement or I need to refer a case, and that's it. When I need to consult with them concerning the treatment if I need help, you know? So I call them. When I refer cases I call them to tell them that this case is coming and I refer them because of this.'*
>
> (Sera, p. 10, ,475-479)

> *'But if there is a new drugs, like new patient is supposed to go on say for example on a depot, that's ah Modecate depot injection, I need to consult a medical officer. I consult a medical officer, if they say it's okay or you give the medical, the IMI then I prescribe then, and the medical officers to countersign with my, with my new ordered medications. And er even in their file I have to write that er okay this patient was ah discussed with medical officer so and so then….'*
>
> (Faranisese, p. 6, 170-175)

At times, however, it appeared that the MO would give permission over the phone for the NP to go ahead and administer medication without the patient being assessed by that MO. From the NP's comments it is unclear under what circumstances the MO did not come to assess the patient, but by not doing so they demonstrated confidence in the accuracy of the NP's assessment and were willing to transfer responsibility to them to prescribe appropriately. This is not dissimilar to the procedure for managing cardiac cases by NPs in remote areas, who rely solely on telephone advice from doctors at sub-divisional or divisional hospitals when dealing with a situation outside their scope of practice. One NP described his experiences with telephone consultation while working in a remote centre:

> *'Yeah, um, I didn't have any problem with the doctors because they came to appreciate er, um, our roles in the community and, er, they, the doctors actually regard us as one of their own cadre, as the doctors…And sometimes the expectation is so high that they would think that er whatever they do is whatever I can do. And, er, sometimes, like if I have to call and say "Oh, I've*

got this case and I want to, ah, to consult er you about what I want to give this" and sometimes they have said "you know that it's for that patient why you have to call me?" So I always tell them, "You know it's my protocol required me to consult", they say "Oh, never mind you just go ahead you know, you, you er you're doing well and er you are competent enough to, to decide on what should be given." But I always, er, I don't have any reservations for, I just call and whoever I want to speak with or discuss cases with, I just call them and talk with them. And er I think they have come to appreciate our roles ah in the field and because we have been… most of the cases that we are referring have been cases that needs to be referred for secondary opinion. '

(Petero, p. 16, 462-474)

This quote is interesting in that it appears to reinforce the doctors' confidence in the clinical judgement of the NPs and high regard for their ability, to the extent that they perceived them to be 'one of their own cadre'. This doctor also seemed to brush aside the NP's requirement to adhere to their clinical protocol regarding medical consultation prior to administering certain medications. Such an approach potentially creates tension for the NPs who on the one hand must work within the legal limitations imposed by their clinical protocols, and on the other find them at times to be restrictive and an obstacle to their practice and, perhaps more pointedly, that of the doctors. One can readily imagine, however, that if the NP were to work outside the protocols and misadventure occurred, such practice would immediately be censured and the consultative relationship with doctors altered overnight.

As has been mentioned, NPs not only consult with doctors but interact with a variety of health professional groups, and these relationships have also had to be cultivated by the NPs in the conduct of their role. The practice of NPs referring patients on to doctors further reflects the shift in professional boundaries that has occurred. The following quotes from NPs and doctors indicate that establishing referral relationships has generally been a smooth process. As one doctor at a sub-divisional hospital stated:

'Yeah, it works out well. This involves the referral of cases er when she has er cases that are too serious to be just looked after over there, she refers it to me, uh, sometimes when I and when I know that it is too serious to be there I get over and get them here sometimes we get to refer them to Suva.'

(Jona, p. 3, 114-117)

This doctor described the referral practices of the NP in his region as being effective, and cited an example of when the NP consulted with him about a patient who then needed referral on to the divisional hospital in Suva:

'Well, this was a case of er, of er, of, of er abdominal pain that presented to her clinic, it was a 19 year old Fijian lady from a village close by er she tried to monitor the abdominal pain but it was just so classical of acute appendicitis cause it started in the umbilical area and the morning after, when after, when I asked her and then she said "well it's gone down to the right iliac fossa" and er "any tenderness, or any guarding, or any rigidity?" And there was positive for tenderness, positive for guarding and positive rebound tenderness and that was just highly suggestive of acute appendicitis so all I had to do was just er I had to go up there and get the case down so we can get them to Suva..

DL ok.

..and that was just good because er I mean clinically you know she's er.. she's competent enough to be referring those acute abdomens from er that er that was one of the cases I had…

DL Right. So how did the patient get to Suva?

The patient got to Suva from our 4 wheel drive, we went up 4 wheel drive, got the case over, ride down to Suva and she had acute appendicectomy just a few hours later.'

(Jona, p. 4-5, 182-189)

NPs working in the Outpatient areas at the main CWM Hospital stated that they received referrals from other hospitals, and also referred patients on to doctors or specialists within

their hospital. *Intra*-hospital referral processes at times appeared more problematic, with NPs reporting that some doctors would not receive referrals from them. This appeared to have been resolved, however, once the doctor understood that patient referral was a legitimate component of the NP's practice. As the NP working in the OPD at CWM stated:

> *'I have no problems with them but I had problems with referring cases ah at one, not only at one time, two times I referred a case and I was told ah you are not a qualified doctor and I want to talk to the qualified doctor. So I handed over the case to my superior and he said ah from now on whatever case you refer if they don't accept it refer to the consultant. So um they when they tell me they want the medical doctor to come and refer your case I said 'no' I handle my case I'll refer my case I am as capable as them. Just like that. And if you don't accept my case I'm calling your consultant. Um, they accepted my case.'*
>
> (Lati, p. 8, 363-373)

In this instance, the NP resolved the problem of referral by 'going to her superior', who would have been a senior medical officer, and obtaining their permission to go over the heads of doctors that would not accept referrals from her. Once this was obtained, she appeared much more confident in her approach and claimed her legitimate right as a NP to 'handle' and refer cases. There is an important power struggle occurring here, which has a different dynamic depending on the context in which it occurs. NPs in remote and peri-urban Health Centres have had to establish referral relationships with doctors at the sub-divisional and divisional hospitals, and those working in hospital environments have had to take referrals from other areas, as well as refer patients on to doctors within the hospital. Nurses in remote nursing stations also refer patients on to the NP at the health centre. Instituting this complex set of relationships has been a vital component of the NP's role, and clearly is an essential element of the management of acutely unwell patients.

Clinical Protocols: shaping the practice of NPs

I have made mention on a number of occasions thus far the role that clinical protocols, or guidelines, play in helping to delineate the scope of practice of the NPs. It has been shown that these protocols do not accurately reflect the variety of clinical contexts in which NPs are placed, and their validity in terms of guiding practice must thus be questioned. Indeed, from a critical perspective, the protocols themselves may be perceived as contributing to the hegemonic control over the practice of the NPs by the Fiji Government and, more particularly, the medical officers that design the protocols. Acceptance of the 'naturalness' and need for protocols reinforces their acceptance and thus strengthens the hegemonic, controlling influence that they exert. This view is strongly supported by Carryer, Gardner, Gardner & Dunn (2007), who cogently argue that protocol driven practice for NPs, as highly experienced nurses, may not only reduce their autonomy but also their capacity to problem solve in a non-linear fashion. By their very nature, therefore, protocols thus constitute a form of domination over the practice of the NPs by the medical fraternity, and serve to reinforce the power imbalances between the two professions.

The NP's clinical protocols were produced by the Fiji Ministry of Health, with technical assistance from the WHO and substantial input from the Fiji School of Medicine. As such, they provide essential guidelines regarding the practice of the NPs (Usher, Rabuka, Nadakuitavuki, Tollefson & Luck, 2003), and also identify the myriad conditions and circumstances under which the NPs must consult with a medical officer. According to Fairclough's model, the NPs are thus situated as 'consumers' of this text and must interpret, or 'decode' it accurately and apply the information appropriately in their clinical decision making. It is outside the scope of this study to examine the utilization of the clinical protocols by the NPs, however these guidelines clearly provide a vital framework within which they perform their role. Importantly, the protocols were developed for use by NPs in remote health centres, rather than in urban and peri-urban hospital environments. As such, the NPs reported that under certain circumstances the protocols were not congruent with the context within which they were being used. When asked about this incongruity, one NP who was working in a sub-divisional hospital provided the following scenario:

> *'Police cases, ok. Ah, in the health centre, because you are the only medical person there, you you see that it's okay. Whereas here, I have medical officers, yeah, so I am not covered with um if I have to see them here, because there are are …more qualified people who are with me who are supposed to see so I have to have an understanding with these people that I won't handle ummm police cases. Yeah.*
>
> *D L So, what, what's a police case, what do you mean by that?*
>
> *NP people coming in um assaulted and having to be charged and…..yeah. So like for those sort of cases, the um the medical officers ah see them, yeah, take those.'*
>
> (Talica, p. 12, 352-359)

From this statement it can be seen that working in a hospital environment where there were doctors readily available changed the scope of practice of the NP, in relation to cases such as that cited above where violent assault and the Police were involved. As will be shown later in this chapter, substitution of medical tasks by NPs has been a major factor in delineating their scope of practice, however it has been contingent on them working in remote, medically underserved areas. The protocols, curriculum and Nurses, Midwives and Nurse Practitioners Act (1999) were not modified to cater for NPs being deployed to clinical areas such as Accident and Emergency/Outpatients in sub-divisional or divisional hospitals, St Giles Psychiatric Hospital, or peri-urban Health Centres. This potentially places these NPs in a somewhat invidious position in terms of having to modify the protocols for use in these different clinical environments. From a critical perspective, there appears to be a degree of dissonance, or incongruity created by these arrangements that challenges the wider social practice of deploying NPs across different points of the urban : remote continuum of health care. This can contribute to role stress for the NPs as they endeavour to establish appropriate interprofessional and client/patient relationships based on relevant clinical guidelines. The NP, above, also cited instances where she was called on to manage a trauma case on her own, particularly if the MO was busy and not immediately available to initiate treatment. For less urgent cases involving minor surgical procedures, an NP who worked in Accident and Emergency at the major

tertiary hospital in Suva indicated that she worked collaboratively with the doctors in order to learn new techniques. As she stated:

> *'…Trauma cases, and if they come in and if I am the first one to be called then I am the one to handle the case I'll handle the case and I will call the medical officer to come but sometimes as soon as the trauma case comes in they go together with me so some of the things that ah sometimes they ask me to for example a knee aspiration they say can you do the knee aspiration I said no you will have to come and do it I understand by their distress sometimes they can't but can you do it for me I said no you have to come and see the case have to come and handle your case I've done all my investigation you have to come and do it but when they are late or do some things I give it to the medical officer and they direct me on what to do and I sit with them and do the case, which I enjoy because if I am to go to the rural I am the only one there to do and I will have to do it.'*
>
> (Lati, p. 5-6, 245-255)

In this quote it is notable that the NP was being quite forthright and direct in relation to her communication with the medical officer. She sounded resolute regarding working within her scope of practice, yet demonstrated a willingness to learn new skills in order to be better prepared for the possibility of rural deployment. This may be interpreted as an instance of interprofessional negotiation *across* a professional boundary that resulted in the shifting of that boundary as the NP learnt the procedure and incorporated it into her repertoire. She thus internalised the psychomotor elements of the procedure, linked this with the relevant anatomy and physiology, identified the appropriate equipment required for the procedure, and also employed appropriate language when discussing the procedure with the patient and educating them about follow up care.

The MO appeared more than willing to allow the NP to perform the aspiration, even asking the NP if they would do the procedure for them. As such, this NP, at least, was perceived by the MO as being capable and able to be trusted to safely carry out a task normally completed by doctors. Fairclough understands that a communicative event such as this 'functions as a form of social practice in reproducing or challenging the order of

discourse' (Phillips & Jorgensen, 2002 p. 70), in this case the order of discourse of health care. It is suggested that the order of discourse has been transformed by this discursive practice, and that social change has occurred as a result. The position of the NP has been strengthened as she controlled the interaction with the MO; she stated the limitations of her practice yet was willing to negotiate a compromise wherein she undertook the procedure under the guidance of the doctor.

This example contrasts sharply with the 'tyranny of distance' experienced by NPs in isolated locations, and the impact that it has on relationships involving clinical supervision, consultation and scope of practice issues.

For those NPs working in remote areas, doctors are not available to come and assess the patient, which makes the telephone consultation that much more important. If the person requiring knee aspiration was in a remote area and the NP was unable or would not do it, then a potentially long and painful journey to a sub-divisional hospital would be required. In relation to the need to consult a MO before administering a medication, this presented a significant problem for NPs in remote locations. As one NP stated:

> *Sometimes, we, we I might be in a place that it's not accessible to communication through phone, there's no phone that in my protocols it says you have to consult the doctor before you give this drug. But I would do it, give it, ah without consulting. I mean what difference would it make anyway, I was going to give it anyway whether they say yes or no because I am the person who is there and looking at the patient and I know that this is best for this patient. I always think somebody who is far away not seeing the patient relying on the information that I give would decide for me. I'm not for that.*
>
> (Petero, p. 13, 374-384)

This NP went on to say that when working on their own in a remote area they may be seeing many patients in a day and if they strictly adhered to their protocols they would be potentially ringing a doctor many times throughout the day in order to obtain permission to give a drug or implement some other type of treatment. It was felt that this was a waste of time and resources and so on many occasions the NP simply did not call, but went ahead without consultation. The extent to which this was a common practice among all

NPs in remote locations is unknown, however given the communication difficulties experienced in these locations it may be reasonable to assume that it occurs with some regularity. From a critical perspective, this may represent resistance by this NP to cross a professional boundary and engage in what was perceived to be an over-regulated and unnecessary process. Even if they did call, regardless of what the MO said this NP would go ahead and give the drug because they were there with the patient and 'knew what was best for them'. This may be interpreted as being somewhat over-confident, even arrogant, and also sets a potentially dangerous precedent or trend that may one day result in the wrong medication being prescribed, with harm to the patient being the outcome. One can imagine that if such an incident were to occur, it may result in the limitation of prescribing rights for this NP, and perhaps have a domino effect across all NPs. Given the high incidence of medication errors known to occur across the health sector, the increasing rate of litigation and the ethical responsibility NPs have toward their patients, it is difficult to justify this NPs actions despite the rationales offered.

As the following quote from a senior educator at the Fiji School of Nursing showed, being a NP in a remote area with poor communication facilities and having to make decisions regarding the administration of drugs can have dire consequences for patients:

> *'That's right, that's right. I I believe they have their protocols but sometimes they work beyond than what is dictated in their protocol, but that's why if a doctor is there then that's okay, if a doctor is not there then they you know it's quite frustrating for the nurse practitioner.*
>
> *D. L. So what do they do, if a doctor is not there?*
>
> *Ahh why they have to no the like I believe in one case, they they had to they could not carry on, because they know they are not legally covered!*
>
> *D. L. what was that case?*
>
> *Ah it was, I think it was from Vatulele she was calling, she knew that it was a severe cardiac condition that she was attending and she knew that she had to give a certain type of medication but she could not give it because er the doctor was not there to give her the okay, so she just you know travelled with the case to the hospital without giving the medication and ahh her hands were tied, so I I believe she lost the patient, because it was travelling by sea and*

then finding the bus to get to Sigatoka and then arriving in Sigatoka the doctor was there not there, because communication was not….the radio telephone was not working for her to be able to warn the hospital what was happening, so a lot of factors contributed to that, and the patient died I think, mm.

D. L. So what could be done do you think to…?

yeah I I suppose we have to now that we want to look at extending the roles to now get them to be working in hospitals, but we just need to review the act and see or look at the syllabus. A whole lot of things have got to be done, look at the training component, look at the Act, look at ah the reality of practice, the area of practice.

(Mona, p. 16-17, 494-521)

This disastrous incident appears to have resulted from a multiplicity of factors, which began on the remote island of Vatulele where the NP and patient were located. Vatulele is a small island approximately 30 kilometres off the southern coast of Viti Levu, with a population of about 1,000 (Jones & Pinheiro, 2000). Having to travel by sea with a sick patient and then catch a bus to the nearest hospital on the mainland only to find that a doctor was not available because forward communication could not be established, unfortunately contributed to the tragic death of this patient. One wonders what impact this series of events had on the NP, and whether she was able to be debriefed or offered any counselling. The incidence of burnout and its effects on NPs continuing in the role in Fiji is unknown, however given the role's highly stressful nature it is clearly an issue that requires significant resilience and a strong commitment by these nurses to serve their communities under difficult circumstances and conditions.

Clearly, this NP took a different approach to medical consultation regarding the administration of medications that that of the NP quoted earlier. Perhaps if she had simply gone ahead and administered the medication the patient may have survived and not required lengthy transport by boat and bus in order to receive further medical treatment in hospital on the mainland. As the interviewee stated, the NP '*knew that she had to give a certain type of medication'* but without medical permission '*her hands were*

tied'. Given the life threatening nature of the person's condition, the NP would arguably have had little problem justifying the administration of the medication if it would do no harm; it may even have saved the person's life, particularly given the unavailability of medical advice. In reality, if there had *not* been an NP available on Vatulele the person would not have even been assessed, yet still would have had to make their own way to the nearest hospital on the mainland. It must be remembered what situation existed in many remote communities ***prior*** to implementation of the NP role. Numbers of remote Health Centres and Nursing Stations were left vacant and thus non-operational for months or even years because of the unavailability of staff, be they doctors, medical assistants, NPs or nurses. As a result, people in these communities have had to either rely much more on traditional medicines, traditional healers, birth attendants and community nurses, be prepared to make more frequent trips to another facility quite some distance away, or simply do nothing about health concerns that were not urgent or life threatening. The point being made here is that *without* local access to NPs, people in remote communities experienced a dramatically reduced level of comprehensive health care, and thus had poorer health as a result. A significantly unequal power relationship existed when compared to people in urban areas, which has been counterbalanced somewhat as NPs have been deployed to these previously unoccupied posts. Unfortunately, many remote communities still do not have an NP, MA or doctor and remain disadvantaged and disempowered in terms of their access to health care. At the level of social practice this remains a significant problem for people in those areas, and a major challenge for the Government as it strives to maintain its health workforce and ensure that a reasonable level of health care is made available to all Fijians, irrespective of where they live.

New workforce models required

Contention arising from shifting professional boundaries is not solely a characteristic of the medicine/NP relationship; for example, Gilbert (2001) has described the 'ongoing struggle' between pharmacy and medicine in South Africa, particularly in relation to the perceived right of medical practitioners to dispense drugs and the push by community pharmacists to prescribe medications for certain conditions. Booth & Hewison (2002) suggest that 'role overlap' between physiotherapy (PT) and occupational therapy (OT) has been the subject of debate for over thirty years. Furthermore, Smith, Roberts &

Balmer (2000) have proposed that as a component of the British National Health Service's current push to 'remove professional boundaries' (p. 397), PT and OT undergraduate education be combined to produce highly skilled, generic rehabilitation therapists. In a similar vein, Holmes (2001) has argued in favour of moving beyond multidisciplinary and interdisciplinary relationships to what he terms postdisciplinary practice, and for the development of a new 'breed' of generic mental health worker, whom he contends is more suited to the needs of the current workforce and the real life problems experienced by clients within mental health services. This notion of postdisciplinarity appears to resonate with the concept of post-professionalism described by Illich, Zola, McKnight, Caplan & Shaiken (1977) and more recently by Kritzer (1999), Meulenbergs, Verpeet, Schotsmans & Gastmans (2004) and Nancarrow and Borthwick (2005). These latter authors concur with Holmes' call for a radical change to the health workforce, and note that the services provided by various health professional groups are in a constant state of flux, as they expand and contract in response to a complex array of forces, for example changing societal expectations and perceptions of health and illness, new treatment modalities and technologies, and consumer-led, rather than profession-led services. The omnipresence of economic rationality and neo-liberal management philosophies are also credited as being highly influential in exerting pressure on traditional professional boundaries. Fairclough's model of CDA recognises that the order of discourse of health care is changed when discourses and genres from other spheres, such as those mentioned above, are incorporated (Phillips & Jorgensen, 2002). Health services in Fiji are changing, and this is evidenced by changes to the discursive practices that constitute the order of discourse. To this day, welfare discourse has predominated, wherein public health services are essentially provided free, or at minimal direct cost to the public. Despite this, there are indications within the Ministry of Health's discourse that presage a movement to a more neo-liberal order of discourse, as evidenced within a speech given in 2005 by the then Fiji Minister of Health. Patients were on several occasions called 'health consumers', and a philosophy involving a degree of cost recovery from users was something the Government 'believed' in (Naivalu, 2005). Notably, the Fiji Government has a history of owning and operating commercial companies, for example, Fiji's largest fish cannery (Pacific Fishing Company Limited,

PAFCO) is 99.5% state-owned and managed by the Ministry of Public Enterprises and Public Sector Reforms (Fiji Government, 2005).

Meulenbergs, Verpeet, Schotsmans & Gastmans (2004) propose that external forces such as these constitute a new form of 'institutionalization', wherein the relationship between the profession and professional is reshaped and the capacity of professions to be self-determining is reduced as power shifts away from the profession to external agencies and groups, such as the state or the public. Nancarrow & Borthwick (2005), drawing on the work of Malin (2000), suggest that the establishment and maintenance of legitimate boundaries of care remains elusive, "in an environment of state intervention centred on demands for employer-led training and the codification of knowledge through an imposed competence-based approach. In this arena, there is little possibility of self-determination when the development of knowledge is constrained by a managerialist agenda." (p. 903). The point being made is that health professional groups, including those with traditionally the most power and control over their work practices, such as medicine and dentistry, are becoming increasingly subject to the burgeoning power of external forces, and that these forces are radically shaping the workforce and the relationships between professional groups. In Fiji, where the Government employs and thus controls the majority of the health workforce and also funds health care, power is tightly maintained via the tiers of bureaucracy and through political governance. At the time of writing, Fiji was in the midst of ongoing political turmoil as a result of the coup d'etat of December 2006, the country's fourth in two decades, and which saw the elected Government ousted and replaced by an interim military regime. As alluded to earlier, the impact of these events on all sectors of Fijian society has been dramatic and far reaching, compounded by the substantial loss of 'human capital' as many tens of thousands of predominantly Indo-Fijians left the country (Reddy, Mohanti & Naidu 2004, p.1447). Being the most numerous and stable health professional group, nurses were variously called the 'backbone' and 'lifeline' of the health workforce by several of those that I interviewed.

From a critical perspective, changes to the social order are ostensibly issues of power and, from a Gramscian perspective, involve endeavours to secure a relationship of hegemony, in which a more powerful group 'wins the hearts and minds' of other, less

powerful groups in order to bring about change (Crossley, 2005 p. 114). In the context of this study, examples of change have occurred at a number of levels including those brought about by an acute shortage of medical officers following the coups d'etat, the resultant introduction of the NP role, delineation of the NP scope of practice, legislative amendment to incorporate the NP role, their deployment to various urban, peri-urban or rural centres, and the ensuing negotiation of new interprofessional relationships.

One response to these external pressures is for health professional groups to change their disciplinary boundaries, by shifting their sphere of practice to embrace new areas of work, or by taking over the tasks of other groups. Nancarrow & Borthwick (2005) describe 'consensual delegation' as being one process responsible for changing the boundaries of the health workforce. In relation to this study, the expanded disciplinary boundary and broad scope of practice of the NPs, with its elements of primary medical care, pharmacy dispensing, nursing, midwifery, health promotion and education and public health, is an example of such delegation. Movement of these nurses outside their traditional boundaries to take on practices normally within the domain of other groups is what these authors referred to as 'inter-disciplinary change' (p. 905). This is operationalised by what they call "Vertical substitution [which] involves the delegation or adoption of tasks across disciplinary boundaries where the levels or training or expertise (and generally power and autonomy) are not equivalent between workers." (Nancarrow & Borthwick 2005, p. 909). NP practices such as the prescription and dispensing of certain medications and other treatments, making a 'medical' diagnosis and ordering certain diagnostic tests, tooth extraction, circumcision and admitting patients to hospital or referring them to medical officers are several examples of vertical substitution. As mentioned previously, the catalysts for vertical substitution in Fiji included the lack of medical officers in rural areas; the perception both within and outside the medical profession that rural practice was a waste of valuable doctors, who should be placed within sub-divisional, divisional hospitals or be in private practice; a nursing workforce that was flexible, capable of and willing to embrace an expanded scope of practice, and a trend regionally and globally to explore new models of health care worker to meet a country's specific needs. Despite the relatively high degree of vertical substitution involving the delegation and adoption of knowledge and skills from a wide

variety of other health disciplines, the practice of NPs remains tightly controlled within clinical guidelines and regulatory frameworks, ensuring that they exist as a sub-specialty within the discipline of nursing. As such, they possess greater status and attract higher remuneration than many of their nursing colleagues yet will never achieve the formal status of medical officers, gain access to their career advancement opportunities or enjoy their financial rewards. This, I suggest, reinforces the domination of nursing by the State and the medical profession, despite the fact that in remote areas the NPs are effectively fulfilling a multi-dimensional role that incorporates a broad and eclectic blend of knowledge and skills. It is this unique blending of knowledge and skills that is the focus of the following discussion.

The NP role: a unique combination of ingredients

Food preparation, consumption, distribution and exchange are important socio-cultural component of Fijian society (Becker, 1995) and, as a reflection of its multicultural makeup, fare comprises "a blend of indigenous Fijian, Polynesian, Indian, Chinese and Western influences." (Jones & Pinheiro, 2000, p. 93). This blend of culinary cultures may usefully be used as a metaphor to describe the way in which the NP role has been created by the fusion of knowledge and skills from a variety of professional groups. Furthermore, just as ingredients are combined and prepared in different ways to create distinct flavours and food types for different occasions, so the NPs draw on their nursing, midwifery, medical, pharmacy and public health knowledge and skills in order to deal with the diverse clinical scenarios that constitute their practice. For example, when conducting an outreach clinic in a remote village the NP not only assesses and treats those who need care, but may also immunize babies or young children and assess their nutritional status, provide health education on a particular topic such as the prevention of communicable diseases, and visit people in their homes who are unable to come to the clinic. In emergencies, such as with a mother experiencing a complicated labour or a trauma case, a mercy flight may have to be arranged and the patient's condition managed by the NP until the plane or helicopter arrives. One NP stated that:

> *'It's the management of the inpatients because if we are going to put somebody there because the weather is bad, we cannot send the chopper or the boat is not coming then we have to remain with the patient. We will need*

> *to treat that patient so sometimes it's how we look after inpatients who are much sicker than those who just come with minor ailments, yeah. That requires a lot of knowledge and technicality in order to look after them well.'*
>
> (Petero, p. 8, 234-239)

There are also likely to be people who require tooth extraction and others that may need referral to a sub-divisional or divisional hospital for further diagnostic tests or treatment. Blood tests, urine samples or wound swabs may also need to be taken and sent to the laboratory at the sub-divisional hospital, which must be organised by the NP, the results followed up and appropriate treatment provided. This of course takes a number of days, particularly if the NP is on an outer island and a boat or plane has to be accessed to take the samples. As one NP on an outer island stated:

> *'For a week there are certain days that they* [patients] *come in. Ah, they are not ah, they don't come in all at once, so…like on Mondays I, I'll, we allocated that for ah Maternal Child Health. Two days, Mondays and Tuesdays are mainly for maternal Child Health. In Qamea we divided it into zones to make it easy. Er, there are two zones for Qamea, so they come in zones. And on those two days we give health education, immunization when they are at the centre and er on Wednesdays, ah that is the ante-natal clinic day. Because, er I, on Thursday why I call them on Wednesdays because on Thursdays there is a boat that comes to the mainland and er for, for first visits er ante-natal mothers we need to take bloods so that's why I do that on Wednesdays and put it in the fridge and then somebody to come and take it over to the mainland.'*
>
> (Simon, p. 8, 223-233)

Assessment of sanitation practices, waste disposal and vector control are also carried out by the NPs to minimise the risk of outbreaks of conditions such as diarrhoeal disease, Dengue fever and Filariasis (McMichael, Campbell-Lendrum, Corvalan, Ebi, & Githeko, 2003). Issues that are beyond their scope of practice also must be assessed and decisions made about the process of care. One NP I interviewed recounted instances where she had worked outside her scope of practice:

> *'OK yeah um, like scope of practice we are to issue death certificate, yeah those are the things that we are entitled to do but at times but at times in these situations, some emergencies I work out of my scope of practice. Like say for example for insulin, for this drug insulin, Ill tell an incident: we, we NP are not supposed to give insulin, just to prescribe it ourselves but I did in one emergency where I had a patient with very high sugar and then I did give it, that was going out of my scope of practice, but I did but then what happened I verified later on I picked up the phone and I told the doctor I gave this, I know it's not in my scope of practice. Secondly, with medical checkup we are not supposed to do that, medical checkup, you know.'*
>
> (Ema, p. 18, 509-517)

Other NPs also reported instances where they had worked outside their scope of practice, and these appeared to be mostly related to the administration of drugs. A NP working in a busy, peri-urban health centre highlighted this problem:

> *But other things like, er, managing cases here on your own, ahh, and the drugs that we use, it's very limited because we can only allowed [sic] to use drugs from the essential drugs list, we can't go beyond that. Now beyond that we have to get permission, mm. So that's the way it's limiting but I think they are still discussing along that line. We still have to get on the phone to ask somebody to prescribe Gentamycin ear drop or something because of the toxicity and all that but the culture and everything that you've done, you find that it's come back that you need to use Gentamycin but you can't do that, that is not allowed in the scope…*
>
> (Timoci, p. 11, 316-323)

It is worth noting that all medicines on Fiji's essential drugs list (EDL) are available free from hospitals and health centres. Those not on the list requires the person to pay full price at a private pharmacy which, for the majority of Fijians, is not an option. As Moulds (2004) notes, "The essential drugs list contains one or two representatives from

most drug groups: for instance, two beta blockers (atenolol and propranolol), one ACE inhibitor (enalapril), one H_2 antagonist (ranitidine), and most of the old (and cheap) antibiotics, for example penicillin, amoxycillin and gentamicin. Almost all the drugs on the list were introduced over 20 years ago and their patents have expired. This enables the central government pharmacy to purchase supplies at the lowest price available - often from generic manufacturers in India or Malaysia."

As mentioned earlier, telephone or two-way radio consultation with a medical practitioner is regularly required, and permission sought to proceed with the administration of a particular drug or diagnostic test that may be outside the range of their clinical protocols. Throughout these different exchanges, the NP is drawing on combinations of nursing, midwifery, public health, pharmacy and/or medical knowledge and skill to problem solve, educate, socialise, observe, listen to and discuss the broad range of health concerns within that particular village or settlement. These social interactions cut across a number of different dimensions of life, including the physical, psychological, emotional, biological, social, economic and cultural, and the NPs use spoken and written language and other forms of semiotic activity within these domains in the conduct of their roles. It is proposed that the articulation together of different discourses and genres, in new and different ways by the NPs in communicative events such as the running of a general outpatient clinic, the delivery of health education, or the provision of ante- and post-natal care, constitute examples of interdiscursivity (Fairclough, 1992). Moreover, the combining of discourses and genres in new and creative ways is, according to Phillips & Jorgensen (2002, p. 73), "both a sign of, and a driving force in, discursive and therefore socio-cultural change." One could conclude that the professional power of the NP is strengthened through these exchanges, as they 'play out' the social relationships that are constitutive of their roles.

As mentioned previously, a core goal of CDA is to identify relationships between language use, discursive practices and the wider social sphere. Chouliaraki & Fairclough (1999) view social life as being made up of practices, or "habitualised ways, tied to particular times and places, in which people apply resources (material or symbolic) to act together in the world." (p. 21). For example, the practice of conducting a health assessment, as an instantiation of the social practice of the NP, requires the use of

language in certain ways to elicit information from 'the patient'. During this exchange, the NP may be drawing on medical and nursing discourse, counselling discourse, or health education discourse. Resources such as a blood pressure machine, stethoscope, blood glucose monitor or thermometer are also used in the conduct of specific techniques to gather objective data in what Chouliaraki & Fairclough (1999, p. 21), drawing on Harvey's (1996) terminology, call 'moments' of practice. They propose that these 'moments' are dialectically related to each other and articulate together, for example within the practice of conducting a health education session. In so doing, the NP not only draws on the orders of discourse of education and health but contributes to the constitution of those orders of discourse (Phillips & Jorgensen, 2002).

At one level, these practices may appear relatively simple, yet they are linked to wider and more complex practices. For example, the data gathered by the NP during a health assessment must be documented and aspects of it entered daily into a computer record (Patient Information System, or PATIS), which can then be accessed by other health professionals and the government. As stated on the Fiji Government's website, the main objectives of PATIS are to:

1. Improve patient services and outcomes,
2. Improve overall patient and facility management,
3. Assist health service administration, and
4. Collect information for timely public health surveillance and health service monitoring.

(http://www.health.gov.fj/patisOverview.htm, undated)

It is evident that the practice of the NPs constitutes one component of a wider network of practices which include, for example, other health professionals, laboratory technicians, various government departments and non-government organizations. For example, the regular provision of basic supplies for use by the NP, such as dressings, medications and linen (which were frequently identified by the NPs as being in short supply) requires communication with and input from a range of individuals and groups. As Chouliaraki & Fairclough (1990, p. 23) note, "Relatively simple practices based on the co-presence of

people in particular places and times still exist in everyday life, but it is a feature of modernity that they are increasingly tied in with and dependent on more complex practices." Thus, the use of computers and reliance on other diagnostic technology such as that used within laboratories, reflect growing levels of sophistication and complexity within the NPs practice.

As discussed previously in this thesis, from a critical perspective these networks of practices within which the NPs are situated are characterised by relations of power. In relation to the current discussion, it is suggested that the demarcation of new professional boundaries, taking on of new roles and responsibilities via a process of vertical substitution, and diverse ways in which discourses and genres are being articulated by the NPs reflect "shifting dynamics of power and struggles over power." (Chouliaraki & Fairclough, 1999, p. 24). It is clear that the NPs have achieved greater professional power as a result of their expanded role, in terms of their increased control over more components of health care. At the level of professional practice, this represents a quantum leap forward for nursing and midwifery in Fiji, in terms of a legitimised, expanded role that previously was held by doctors or medical assistants. Yet, as described earlier in this thesis, significant frustration exists due to the lack of a suitable career structure, poor professional support, inadequate remuneration and little opportunity for continuing professional education. Clearly, the 'space' created by the absence of doctors in rural and remote areas has created new arenas of struggle for the NPs as they have fought to be accepted by their nursing and midwifery colleagues, other health professional groups and the general public. Despite this, nurses with aspirations to embrace an expanded role are taking up the challenges of practice as a NP, as evidenced by the following analysis of a recent newspaper article. The text sample was a newspaper article from the Fiji Times online, dated Thursday April 12, 2007 and entitled "Nurse broadens her horizon". This was selected because stories specifically about NPs rarely appear to receive coverage in the Fiji press and, more importantly, it exemplifies a number of the issues relevant to this study. The article focussed on one of the new graduates from the NP program, Mrs T., and her aspirations to extend her nursing practice. The article was a combination of statements by the journalist outlining some of the NP's nursing experience, together with direct quotes from the NP about completing

the NP program. Fairclough (1992, p. 107) refers to this a mix of ‘direct’ and ‘indirect’ discourse representation, indicating a switching back and forth between the ‘voice’ of the reporter, and that of the NP. A large head and shoulders photograph of the NP was the focal point of the first page of the story, and it showed her wearing the ceremonial garland of flowers commonly worn at times of celebration. The article stated that the NP was from ‘Naivakarauniniu in the district of Sanima on the island of Kadavu’, that she was aged 43, and that she was the mother of three children. Inclusion of these personal details appears to have been used to provide greater informality to the piece, and give the reader further insight into the personal life of the NP. Stating that ‘Mrs T. is thankful to her husband and children for supporting her throughout the course’ and ‘She says if it was not for their support and backing, she would not have achieved much.’, provides a further personal touch to the piece by including information about the family’s contribution to the NP’s success. At times the reporter referred to the NP as ‘she’ and at other times calls her ‘Mrs T’ (full surname included, used on eight occasions), seemingly to provide some variety but also to repeatedly foreground the personal identity of the NP.

Graduating as a NP was reported as being a ‘new chapter’ in her career and a ‘milestone achievement’, after sixteen years of practice as a nurse and having previously completed a basic public health course and also the eight month midwifery program. The article emphasised the passion that that this NP had for nursing, calling the memories she had of her nursing career thus far as being ‘exciting’, and that “Above all, she said she was privileged to work with patients and see them get better.” (Lalakato, 2007, p. 1). The article chronicled the hospitals, nursing stations and health centres in which she had worked as a nurse prior to commencing the NP program, most of which had been in rural or remote areas. Her new posting as a NP was also to be to a remote health centre.

She described the 13-month NP course as being very challenging and time consuming, particularly the reading and research that had to be completed throughout. Despite this, the NP’s view of completing the course was that it extended her nursing knowledge and skills, enabled her to ‘do new things in the field’ and that she was ‘really happy to have come this far.’ (Lalakato, 2007, p. 1). The NP stated that rural communities experienced a lot of emergencies which, if severe, would require the input of a doctor. If the doctor was busy or ‘there is none around’, then those patients would need to be taken to another

centre where there was a doctor. The article reported that "With her new role, Mrs T. says she can be useful in such times.", though it did not explain how. The reader was left to assume that the NP would be able to cover for the absence of a doctor in cases of emergency, which supports the view presented previously that NPs are increasingly substituting for doctors in rural areas of Fiji.

In terms of the discursive practices associated with the production, distribution and consumption of the above newspaper article, it appeared that the journalist had attended the NP's graduation ceremony, which from the photograph looked like it had been held at the Fiji School of Nursing. There, she had interviewed the NP, taken the photo and then later written up the piece for the hard copy and online versions of the newspaper. The article was actually published eight days after the day of the graduation, so it arguably had lost some of its 'freshness', or immediacy as a piece of news by that time. On the face of it, the article appeared to be written to mark the graduation of the new 'batch' of NPs, highlight the extended nature of the NP role, its rural orientation and the rigour of the preparatory program. Toward the end of the article, however, the focus shifts away from the NP to the provision of some general historical data about the NP program, for example that it commenced in 1998 and that the Fiji School of Nursing "has had five batches of intakes and produced 50 registered nursing practitioners in rural and urban areas." (Lalakato, 2007, p. 2). It then noticeably shifts focus again by stating that the program was "one of the best in the multi-skilling of nurses", and that it formed the "template and platform for launching other multi-skilling programs put together by the Ministry of Health." Use of the term 'multi-skilling' in relation to nursing and the NP program is very important here, for it implies a wider, political agenda aimed at developing a more flexible nursing workforce. Indeed, there is evidence to corroborate that this is firmly in train, with a Fiji Government press release of September 14, 2007 entitled "Ministry seriously looking at multi-skilling training for nurses", indicating that the Ministry of Health would be further expanding the roles of nurses "as part of plans to address some urgent areas of the health service in the coming years." Such role expansion was reported in the release to be in the areas of Ophthalmology training for Community Health Nurses and the development of 'a new cadre of Nurse Anaesthetist.' (Ministry of Information, 2007). The press release was directly linked to comments made by the

current Minister for Health when attending the 58th Session of the World Health Organization Regional meeting in South Korea in September 2007, and speaking on the topic of "Health System Strengthening". He reportedly 'made the observations after sharing his thoughts on Fiji's health system' at this meeting (Ministry of Information, 2007). There is evidence of intertextuality and an intertextual chain evident here (Fairclough, 1992), which focuses on the topic of the multi-skilling of nurses. The press release, the speech by the Minister of Health and the newspaper article about the NP are all closely linked in this regard. Transformation of the text has taken place as it has been presented in different formats, or text types, and then distributed, consumed and interpreted in different ways by different groups of people, such as those present at the WHO forum in Korea, or those who read the press release, which was posted on the Fiji Government's web site (http://www.fiji.gov.fj/publish/page_10057.shtml). Fairclough (1992) suggests that transformational relationships between text types may become 'lines of tension and change' (p. 133), as they are colonised by other discourse orders and genres. This is evident, for example, in the aforementioned press release where the Minister for Health stated that "In the global market with free movement of trade and manpower, the challenge faced by developing countries, such as Fiji, in maintaining a reasonable level of the health workforce is enormous." The blending of neo-liberal and economic discourses (reference to the 'global market', and 'free movement of trade') with those related to commodification and marketization of the workforce ('manpower', 'health workforce') as something that is bought and sold and is thus subject to competition, may be explained as reflecting the 'enormous' challenge confronting developing countries such as Fiji to maintain their professional workforce. Wealthier, developed countries thus take on the mien of predators, able to lure the best workers with offers of better pay and conditions, leaving poorer nations in a regressive spiral of workforce shortage and continued loss of investment in the preparation of skilled workers. When the Deputy Minister for Health was interviewed, he decried the lack of control over the workforce, stating that the Government was 'fighting a losing battle' in terms of engaging in sustainable human resource planning, maintaining a stable 'system', and preventing the 'poaching' of professionals by other countries such as Australia, New Zealand, America and the United Arab Emirates.

From a critical perspective these regional and wider, global processes may be understood as the exertion of various forms of power by one country over another, in the struggle to maintain human resources during an epoch of rapid economic growth and development. International labour migration trends have become a significant concern for all countries (Stalker, 2000) and as a microcosm of this wider global community Pacific island countries have developed increasingly permeable borders across which semi-professional and professional workers are moving in growing numbers (Connell & Brown, 2005). Firth (2006) and others have outlined a number of the key issues associated with these globalising processes, for example processes of economic reform within neo-liberal policy frameworks, the impact of free trade agreements, the vital role that remittances play as a primary source of a country's gross domestic product, and the continued dependence on foreign aid agencies to funding infrastructure and development projects. A number of so-called 'push and pull factors' have been identified as contributing to international nurse migration, for example the search for professional development, a better quality of life and increased personal safety (Kingma, 2001; 2006). Civil unrest, political instability, an increased risk of personal harm, increased violence in the workplace and the threat (or outbreak) of war have been identified as powerful push factors for the migration of professionals (Kronfol, Sibai & Rafeh 1992, cited in Kingma, 2001). Closer to home, Brown & Connell (2004) have explored the factors influencing migration practices of doctors and nurses from South Pacific Island Nations, which reflect burgeoning international recruitment drives aimed at attracting health professionals (World Health Organization, 2005).

In summary, it is evident that these powerful global forces are contributing to the workforce concerns currently facing the Fiji Government and are shaping media, political, economic and market discourses and associated discursive practices. It is outside the scope of this study to explore these issues further, however even based on this limited examination it is reasonable to assume that their pervasive influence will continue to exert pressure on the health workforce within Fiji. Viewed through a critical lens, one has to wonder what this multi-skilling agenda might mean in terms of shaping the future nursing workforce in Fiji. The creation of new specialty roles and expanded spheres of practice as a seemingly viable and logical response to the Government's need for a

flexible workforce in an emerging modernist society, potentially brings with it similar problems of nurses having little self-determination over the development of the profession in Fiji. Associated with this are feelings of being exploited, unsupported, inadequately remunerated and with little opportunity for career advancement or continuing professional education. Regulatory changes and new interprofessional relationships will be required to cater for these new roles, and issues surrounding clinical governance, risk management and the need for an evidence base to practice will have to be addressed if they are to be viable. These present significant challenges for the nursing profession in Fiji, and the need for strong nursing leadership will perhaps never be greater than in the ensuing decade.

An empowering role for nursing

It has been a key contention of this thesis that the expanded role of the NP is unlike that of any other health professional in Fiji. Research has shown that the impact of the role has been substantial and positive, with high levels of acceptance across Fijian society (Usher & Lindsay, 2003/4). Traditional stereotypes associated with the relationships between nurses and other health professionals, and nurses and their patients have been challenged and largely swept aside as the role has become rapidly integrated within the social and professional milieus in Fiji. Despite the many challenges associated with delivering the role, there is evidence that it has also been a source of empowerment for these nurses, and the wider profession of nursing and midwifery within Fiji. The concept of empowerment has been defined and conceptualised in a wide variety of ways within nursing (Rodwell, 1996; Kuokkanen & Leino-Kilpi, 2000; Corbally, Scott, Matthews, Mac Gabhann & Murphy, 2007; Bradbury-Jones, Sambrook & Irvine, 2008), midwifery (Matthews, Scott, Gallagher & Corbally, 2006), and also from a critical social theory perspective (Stevens & Hall, 1992; Fulton, 1997). It has been described in relation to health promotion and community development processes (Fleming, 2007; Laverack, 2003), NP roles (Almost & Laschinger, 2002), and as a goal for people who require health care (Nyatanga & Dann, 2002).

Clearly, empowerment continues to be a popular and important goal for health professionals, communities and individuals and, in the context of this study is thus closely linked to the assumptions, concepts and propositions of the critical theoretical

approach which underpin it. Moreover, as Blommaert (2005, p. 25) notes, critical discourse analysis must not only uncover the social dimensions of language use, but also bring about societal change, by "empowering the powerless, giving voice to the voiceless, exposing power abuse, and mobilising people to remedy social wrongs." This resonates with Fairclough's view of social emancipation (1989, p. 233), which focuses not only on language and discourse, but also "tangible matters such as unemployment, housing, equality of access to education, the distribution of wealth, and removing the economic system from the ravages and whims of private interest and profit." For Fairclough, critical language study (CLS) represents one (of many) modes of critical social analysis that has great potential to raise people's consciousness of oppression, and empower them to engage in struggle against it. Like CDA, CLS is above all concerned with relations of domination and power struggle and how such relations are linguistically embedded. He suggests that nurses would benefit from exposure to CLS, given that their roles appear to be increasingly shaped to meet the "purely instrumental criteria of bureaucratic rationality, such as 'efficiency' and 'effectiveness'." (p. 235). This is clearly the case for NPs in Fiji who, as civil servants, are subject to the goals of the public service and the Fiji Government's overriding objectives, which are to "increase the operational efficiency and effectiveness of the public service, and enhance accountability and transparency." (Government of Fiji: Ministry of Information, 2003; 2007). Within this framework, people are viewed as 'customers', and 'quality customer service' that achieves 'customer satisfaction' have become the new mantra. By incorporating private sector language, goals and practices within the public service, an agenda of reform and restructuring to produce greater economic efficiency has become the norm (Sharma & Hoque, 2002).

In this context, the role and function of the NPs may be interpreted as having been colonised by, and appropriated within the network of social practices of the Fiji Government's public service (Chouliaraki & Fairclough, 1999). By so doing, it is proposed that there has been a dialectical movement of discourses and genres from the NP's practice to that of the managerial discourse that now characterises the Fiji public service. Such movement, contends Chouliaraki & Fairclough (1999) inevitably raises issues of power and one could thus argue that the NPs are being disempowered by the

recontextualization of the health related discourses and genres aligned with their role, into that of the wider civil service. In a very real sense, therefore, their professional voice, practice and identity become lost within the rhetoric and structures of Government and its particular fiscally oriented objectives and priorities. Furthermore, being deployed to remote health centres means that the NPs work with little support infrastructure and with people from disadvantaged social groupings such as the financially poor, the elderly, those with disabilities and single mothers. Expensive and irregular transport services to, from and within rural and outer island communities, lack of access to essential services especially water and health services, poor education, landlessness and poor housing have also been found to be significant factors contributing to poverty in these communities (Fiji Government, 2005).

Conclusion

This chapter has unravelled and explicated a number of the ways in which the NP role is shaping, and being shaped by other health professional groups as well as health care itself. There is no doubt that the NP role has dramatically altered the divisions of labour across the health workforce, as boundaries have been re-drawn around traditional areas of 'doctor work', pharmacy 'work', 'nurse work', 'midwife work' and 'public health work'. It has been suggested that these boundaries are becoming more permeable and evanescent, as new conceptions of team work are established across these groups, and as the NPs have been deployed to a variety of clinical settings across the remote-urban continuum. It has been a contention that new articulations of practices evidenced within the NP role are inevitably accompanied by new linguistic formulations, and that these constitute spheres of struggle involving the shifting of interprofessional boundaries and discursive practices. The concepts of 'field', 'habitus' and 'voice', as linked to CDA's project by Chouliaraki & Fairclough (1999), were used to further illuminate the ways in which the role of the NP has been socially constructed, and how it is located within the wider social practice dimension.

The following chapter will present a discussion of a number of the key issues that have emerged as a result of the analysis provided in these three chapters. It will focus on the overarching topic of workforce development, and address issues such as:

- Educational preparation and continuing professional education;
- Strengthening the professional identity and voice of the NPs;
- Support structures for NPs;
- Evolving use of NPs in specialty areas, and across a range of clinical contexts, and
- Sustainability of the role.

This discussion will maintain the critical 'edge' employed throughout this thesis and will thus be oriented toward the goals of raising awareness, emancipation, empowerment and achieving change.

CHAPTER 7: FINDINGS, RECOMMENDATIONS AND FINAL REFLECTIONS

Introduction

Each of the previous three analysis chapters focussed on a major theme that was identified from the data. Fairclough's model of critical discourse analysis guided this analysis and enabled the identification of a number of sub-themes, which provided many new and important insights into the NP role in Fiji. This chapter draws together the key elements of this analysis and discusses a number of the key findings in relation to the original aims of this study. The significance of these findings is discussed and a number of recommendations are proposed. To conclude this study I offer suggestions for future research and include some final reflections.

Strengthening nursing and midwifery by addressing recruitment, retention and job satisfaction

The recruitment and retention of nurses and midwives has been a core issue for the WHO in the Western Pacific, Governments and senior nurses across the region for many years (WHO, 2002). Five key result areas have been identified by the WHO to strengthen nursing and midwifery, and they clearly equally apply to NPs. These areas are:

1. Health planning, advocacy and political commitment – National development and health plans provide for adequate nursing and midwifery services and expertise.
2. Management of health personnel for nursing and midwifery services – National employment policies are implemented for the nursing and midwifery workforce that are gender sensitive, based on healthy and safe work environments and conditions, provide for equitable rewards and recognition of competencies, and are linked to a transparent career structure.
3. Practice and health system improvement – Nursing and midwifery expertise is fully integrated into decision-making processes at all levels, and health systems utilise best available practices for the care of individuals, families and communities.
4. Education of health personnel for nursing and midwifery services – Competent practitioners with appropriate skill mix are available to deal effectively with the current and future challenges of practice.

5. Stewardship and governance – Stewardship and governance of nursing and midwifery services involve the government, civil society and the professions to ensure the quality of care.

(WHO, 2002)

Clearly, these areas do not stand alone and must be contextualised and applied within the specific situation, needs and capacity of countries such as Fiji. Given the current political situation, with an interim military-led government in place, reduction in foreign aid and investment and a sluggish domestic economy, it is fair to say that there are significant challenges to the realisation of the above key result areas, and for the health sector generally. On a positive note, the nursing workforce in the Western Pacific region has a strong relationship with nursing advisors at the WHO, as well as major nursing groups in Australia, New Zealand, Japan and Korea. Furthermore, the South Pacific Nurses' Forum (SPNF), which first met in 1982, and the more recently formed South Pacific Chief Nursing Officers' Alliance (SPCNOA), both meet biennially in different countries across the Western Pacific and have worked closely with other key organizations and groups in an attempt to address the many factors that negatively affect the recruitment and retention of nurses. These meetings are also attended by senior nurse advisors from the WHO as well as Government representatives, and thus are a vital mechanism for the development of new strategies that lead to action within countries in the region. I attended the SPCNOA series of meetings in 2006, which was held in tandem with the SPNF Forum in Apia, Samoa, and was able to get a first-hand view of the importance of these forums in not only strengthening links and networks among nurses in the region, but also in terms of setting policy directions in conjunction with Government and non-Government organizations. Importantly, the next forums are to be held in Fiji in late 2008, which will be vital not only in terms of Fiji's standing within the region but, more specifically, in the ability of its nursing leaders to demonstrate a cohesive voice to its Pacific neighbours.

It is clear that recruitment, retention and job satisfaction remain high priorities for NPs as an important subgroup within nursing. An important caveat to this is that because of their advanced, hybrid role there exists a ubiquitous potential for NPs to be 'lost' within general discussions and strategies for nursing, with the result that their specific needs are

overlooked. It is suggested that while many of their needs are broadly similar to those of nurses and other professional groups, the unique, multi-faceted nature of their role and their contexts and scope of practice require targeted strategies that lie outside the general purview of nursing and midwifery.

Stress and burnout have long been recognised as key factors contributing to health professionals leaving rural and remote areas, and also having a negative influence on recruitment, retention, and job satisfaction (Humphreys & Rolley, 1998; Struber, 2004). The majority of NPs interviewed in this current study consistently reported that their role was at times highly stressful, particularly due to heavy workloads, a lack of essential resources to do their job effectively, a lack of time off or locum relief, and feelings of professional isolation and a lack of support. No published studies could be found which described the rates, impact or reliever strategies for stress and burnout in NPs or nurses in the Western Pacific. Despite this gap in the research, the WHO has identified that poor working conditions, gender inequity, long hours and low wages are among the factors that contribute to burnout among nurses and midwives globally (WHO, 2002). More specifically, Armstrong (2004, p. 19), quoting Lutua, has reported that "Eight working nurses in Fiji have died in 2004 alone from stress related conditions, and these have stemmed from the workload nurses face." It is unknown if any of these nurses were NPs, but if true, these statistics are alarming and add substantial urgency to the need for greater support to be provided to nurses generally and NPs in particular. This study has drawn considerable attention to the substantial difficulties experienced by the NPs in the conduct of their role, especially those in remote communities who are frequently challenged by issues such as professional isolation, the unremitting and highly stressful nature of the job, a lack of resources and pressure to work outside their scope of practice. A number of these issues have been raised previously in WHO consultancy reports, but clearly remain significant concerns for the NPs.

Recommendation 1

That increased, tangible support be provided to the NPs in recognition of the vital role they play as leaders in health care provision in remote areas

The many challenges associated with being an NP in Fiji have been well documented within this thesis. For the role to be sustainable there is an urgent need to invest in

implementing support strategies for the NPs, particularly those in remote areas. Furthermore, as an important career pathway for nurses and midwives to pursue it is vital, for recruitment and retention purposes, that there be in place investment in the NP role by the Fiji Government that reflects their commitment to the development of the nursing and midwifery workforce and advanced practice roles. I have indicated in this thesis that the NPs must no longer be perceived as mere doctor substitutes or supplements; they are *pioneers* and *leaders* in terms of the unique level of health care they provide and without them health services in remote areas would be in crisis. Scarce medical resources must be judiciously utilised in high population centres and within clinical contexts that support the medical model of care. Rural and isolated island communities with small, dispersed populations are highly suited to a specialist generalist model of care that is enshrined within the scope of practice of the NPs. Nurse-led clinics have for many years been shown to be effective in a range of clinical specialty areas, including rheumatology, cancer care, heart failure, diabetes, orthopaedics, hypertension and sexual health (Loftus & Weston, 2001; Stromberg, Martensson, Fridlund & Dahlstrom, 2001; Denver, Barnard, Woolfson & Earl, 2003). Unfortunately, such clinics reinforce a fragmented approach to care akin to the medical, reductionist model, whereas the NP role described in this study represents a comprehensive, multi-dimensional model that reflects an holistic, whole of lifespan approach that incorporates the domains of prevention, education, health promotion, primary care, nursing, midwifery and public health. To be sure, the aforementioned clinics are inevitably found in large hospitals in wealthy, developed countries, the likes of which will never be seen in Fiji. The latter role in its current configuration is ideal for remote area practice in a developing country like Fiji, though as this study has demonstrated considerable challenges exist which must be addressed if the role is to be sustainable. In reality, the NPs perform a role of much greater scope than was originally intended. They are skilled in the diagnosis and management of a wide variety of clinical problems, and their practice includes health assessment, the ordering or performance and interpretation of basic laboratory tests, the diagnosis and management of common primary health care problems, the treatment of emergencies, the referral and/or co-management of complex secondary level care problems, the management and/or co-management of chronic diseases, maternal and child care, family and

individual counselling, promotion of healthy choices and preventative illness through health education, and epidemiological surveillance. The NPs also take on such tasks as removal of teeth, prescription and administration of emergency drugs particularly when working in hospitals, managing complicated pregnancies, and treating illnesses that would previously have been referred on to a doctor. One NP mentioned that they had bookings for thirty-five circumcisions during the upcoming school holiday break!

As they are now firmly established as the senior health professional in many remote health centres, the community has come to expect the NPs to perform in an advanced capacity akin to the role of a doctor. As described earlier within this thesis, many of the villagers actually call the NPs the Fijian name for doctor (vuniwai). This broad and expanded scope of practice presents a significant challenge to NPs in these areas. A number of the NPs interviewed during the review actually said they would go beyond what is outlined in their clinical protocols if they could not contact a doctor and if they knew what might possibly save a person's life. In fact, the NPs regularly reported going beyond what is allowed in their protocols by performing tasks such as circumcisions, yet it was identified that this has now become an expected part of their role. Evaluation of the scope of practice of these NPs so that they are protected against claims of negligence appears timely and essential for the sustainability and viability of the role. Regular review of their clinical protocols is also necessary to ensure that they remain accurate, current and reflective of the role of the NP in remote areas and other clinical contexts to which they are being deployed.

Describing nursing practice in the Western Pacific, the World Health Organization has noted that "the scope of nursing practice in each country of the Region has evolved based on the country's needs, resources, and cultural practices. The role of the nurse has varied from country to country and even from day to day depending partly on the availability of other health workers." (1998, page unnumbered). This effectively means that the boundaries within which nurses work are not only highly variable and therefore potentially ambiguous, but are also largely shaped by forces external to the profession. I would suggest that this has created dramatically unequal power relationships between governments, non-government agencies such as the World Health Organization and elite professional groups such as doctors on the one hand and nurses, particularly Nurse

Practitioners, on the other. Should we be surprised, therefore, that many Nurse Practitioners stated that they would become doctors if provided with the opportunity, as they believed they were already effectively practicing in that role? The allure of a better salary, improved conditions, greater influence and control over one's work is of course seductive, and made all the more so by the inequity that currently exists. Conversely, others felt that their advanced, autonomous nursing role provided them with enormous satisfaction, increased their collaboration with doctors, and meant that they were able to provide a greater level of service to the Fijian people and maintain their nursing and midwifery focus. Despite this, opportunities for NPs to pursue medical training at the Fiji School of Medicine with appropriate recognition of their prior learning and credit for their extensive education and experience appears to be a pathway worthy of serious consideration. If sponsored by the Government to complete this training, on successful completion they could be bonded to work in a regional hospital for five years in recognition of this investment and thus add a much needed medical presence.

Difficulties in developing a professional identity, and the need for support

As highlighted previously, the NPs in Fiji are widely dispersed geographically, with many working in remote mainland or island communities. This has contributed significantly to their difficulties in developing a cohesive 'voice', and been a significant barrier to their meeting regularly for continuing education sessions, for example. Such sessions have reportedly been sporadic at best, and have had to be funded by the NPs themselves, as no financial support for these important meetings appears to have been forthcoming from the Fiji Government or the FNA. Moreover, there has been no special interest or sub-group of the Fiji Nurses' Association formed for, or by, the NPs and they have not held or been collectively involved in a Conference that focuses on the issues that confront them in their practice. It is suggested that these factors constitute substantial barriers to the development of a professional profile for the NPs, and contributed to their disempowerment as an advanced group of nurses and midwives.

By stark contrast, since 1983 remote area nurses (RANs) in Australia, who most closely resemble the NPs in terms of their remote context and scope of practice, have been able to join a professional organization that represents them specifically, and also advocates for the health and well being of remote communities. The Council of Remote Area

Nurses of Australia, Incorporated (CRANA) is a politically powerful lobby group, and has for many years been able to secure financial support for its activities and programs via grants from the Commonwealth Government of Australia. It has its own website, <http://www.crana.org.au>, runs a well attended conference annually and has developed Competency Standards for RANs. It also facilitates a number of education courses across Australia and overseas on topics such as Remote Emergency Care and Emergency Maternity Care, and coordinates a Diploma/Masters program in Remote Health Practice in conjunction with Flinders University, which is run out of the Centre for Remote Health in Alice Springs (Wyber-Hughes, 2007). Importantly, CRANA is one of 27 member bodies of the National Rural Health Alliance (NRHA), which is "the peak body working to improve the health of Australians in rural and remote areas" (NRHA, 2007). Thus, it has a voice at the national level in conjunction with many other key stakeholders involved in rural and remote health issues.

CRANA also established and maintains the Bush Crisis Line (BCL) and support services, which commenced in 1997. The BCL is a free telephone service providing counselling and debriefing by trained psychologists to multidisciplinary health professionals and their families working in remote and small rural communities throughout Australia. Manned 24 hours a day, 7 days a week, the service is a vital component of the health infrastructure in remote areas (Ellis & Kelly, 2005). Given the stressful nature of the role of NPs in remote areas, their isolation and diverse clinical role, it would seem appropriate to at least explore a similar support and advisory mechanism, possibly run out of the School of Nursing at Tamavua. The NP tutors at the School appeared to informally fulfil such a role, as one stated during interview:

> *'They just ring and we advise, okay why don't you call this one and discuss your problem. Sometimes even if they are lost, they have tried headquarters and then, er, it's not the people, headquarters are not forthcoming they don't get what they want so they just call us, 'we have been having this problem, I've called this one', I said 'okay, we can only tell you what we think is best and then what you have to do on your own.'*

> *I used to do that a lot when I was in the islands, and when I don't have anything or if I am busy and after a long day I can't move any more, I don't have any more power to do any other work even to write, I just pick up the phone and talk to this one and (laughs) talk to that one, yes, and so I mean sometimes like I'm left on my own there are two nurses that work with me when they are not there or like at one time both of them were sick and they weren't here and I had to do all the things I had to do their work and mine. So when there are no patients then I'll be just alone in the clinic with nobody else to talk to so that's the time you want to pick up the phone and talk…'*
>
> (Petero, p. 19, 550-554; p. 19-20, 573-580)

Though informal, such communication appeared to be an important support mechanism for this NP tutor, particularly when they were working out in the field as a NP. Current support strategies used by the NPs (apart from that described above), the reasons *why* NPs might need to contact someone for support (as opposed to their usual telephone consultations with medical officers), and the extent to which they seek support is unknown, and thus would seem a potentially fruitful area for further research.

CRANA also joined the Australian Rural Nurses and Midwives (ARNM), the National Rural Faculty of the Royal Australian College of General Practitioners (RACGP) and Services for Australian Rural and Remote Allied Health (SARRAH) in adopting the *Australian Journal of Rural Health* as its official journal. This journal provides an important multidisciplinary medium whereby original research, short reports and stories from the field (called 'Grazings' in the Journal) can be published.

In Queensland, remote area nurses, doctors and Indigenous health workers use a text entitled the 'Primary Clinical Care Manual' (PCCM), which has been developed to "promote and support compliance with the Health (Drugs and Poisons) Regulation 1996 by Registered Nurses (RN) and Indigenous Health Workers (IHW)". This valuable text incorporates clinical guidelines and health management protocols which are essential for the implementation of drug therapy protocols for clinicians working in isolated areas without a resident medical officer.

(http://www.nt.gov.au/health/docs/cdc_theprimaryclinicalcaremanual.pdf)

Collectively these resources, links and activities have contributed to raising the profile of RANs, legitimised and delineated their role and scope of practice, given voice to their needs and aspirations as a professional group, and firmly established them within the wider workforce of health professionals in rural and remote areas. Simultaneously, the health care needs of people in remote communities, particularly the Indigenous, have been brought to the fore. Given that this latter group have the poorest health outcomes of all Australians, this is clearly an important organization that serves a vital function. Interestingly, a popular 6-week television drama series was filmed in the Torres Strait region of Australia, entitled RAN (Remote Area Nurse), which went to air in 2006. It showcased not only the physical beauty of the region and its people, but also publicised elements of the role of RANs that work in Indigenous communities. Even though it was a dramatization, the series served to inform the public about the health needs of Indigenous people in remote communities and the difficulties and challenges faced by health professionals who work in these areas.

In recent years, the Australian Nurse Practitioners Association (ANPA) has been established which provides an important professional voice for NPs and other key stakeholders, such as academics. Chapters are being established in each State and Territory and educational forums are being provided that focus upon specific issues in these jurisdictions. A regular newsletter is provided with membership and an annual, national conference is held to showcase the latest research and developments in relation to NPs in Australia and overseas. These provide important opportunities for networking and the development of professional relationships across Australia and internationally.

Recommendation 2

Recognise the importance of raising the professional profile for the NPs and develop a formal mechanism by which this can be achieved

In the context of the NPs in Fiji, it would seem appropriate to develop an organization or sub-group of the Fiji Nurses Association that addresses their specific needs and provides support, possibly using CRANA or the ANPA as exemplars of what can be achieved. Government involvement and leadership would be required to instigate such an organization, but there is clearly an opportunity and urgent need to develop a collective voice and identity for the NPs as they struggle to establish themselves professionally

within the health workforce in Fiji. An important contribution to the achievement of this goal is to promote the importance of research and scholarship among the NP fraternity. Formal research training and mentorship from experienced nurse researchers with established publication records would be vital, particularly for these NPs who culturally have a more oral tradition of communication. Practical workshops on how to get published and the establishment of a culture of inquiry are two essential ingredients for the development of scholarship among the NPs. Recognising the importance of telling their unique stories and contributing to the global discourse about NPs would not only hold great instrumental value in terms of raising their professional profile, but also have substantial intrinsic value because of the knowledge and skills gained as part of the research and publication process. In the spirit of empowerment, it is absolutely essential that the research agenda be directed and 'owned' by the NPs, to prevent its 'colonisation' by outside entities. This constitutes a significant challenge for the NPs and wider nursing workforce in Fiji, though with appropriate leadership, vision and support it is my view that the scholarship potential that currently is unrealised can be developed. This would have an empowering effect for these NPs, and give voice to their concerns and the realities of their practice as a professional group within the global community of scholars that read and utilise published research. Moreover, it would be a significant step forward in the maturation of the professions of nursing and midwifery within Fiji, and demonstrate leadership to its near neighbours in the Pacific region. Development of resources for NPs including a text similar to the PCCM would also prove invaluable in supporting an evidence base to their practice and much needed information to complement their clinical protocols. Sponsorship of a couple of the NPs to attend a conference in Australia would also be very useful in terms of being exposed to colleagues in the region, obtaining insights into how NP roles are developing in nearby countries and hearing the latest research findings.

Recommendation 3

Explore the suitability of developing a competency framework that reflects the NP scope of practice in Fiji

Unlike Australia and New Zealand**,** Fiji does not currently have a competency framework against which the NP's practice is benchmarked. Such a framework has also been used in

the former two countries by education providers to develop Masters level courses to prepare NPs for practice. For example, the NP program developed at James Cook University's School of Nursing, Midwifery and Nutrition has used this framework to inform curriculum development. While the limitations of competency based education within nursing have been well documented (Chapman, 1999) and the assessment of clinical competency in nursing raises significant continuing concerns (Watson, Stimpson, Topping & Porock, 2002), it has nevertheless been embraced almost universally in most developed countries. Furthermore, it has been used by regulatory authorities "to determine the eligibility of registered nurses seeking authorisation as nurse practitioner in Australia and New Zealand." (ANMC, 2004, p. 90). Now that competency standards for nurses have been developed and adopted for undergraduate nursing education in Fiji (Usher, Nadakuitavuki, Rabuka, Tollefson & Luck, 2004), it would seem logical to underpin courses such as the NP and Midwifery programs with a similar framework. Those developed by the ANMC (cited above) could be readily adapted by key stakeholders in Fiji and integrated into the curriculum, which would then also provide a basis for regulation and a framework for continuing professional development. Importantly, it would constitute a much needed link between the curriculum and the clinical protocols, and add a hitherto absent set of benchmarks against which the practice of NPs could be assessed. This would align NPs in Fiji more closely with their counterparts in countries like Australia, New Zealand and the United States, and also create greater transparency and accountability regarding their role. These are potentially empowering issues for the NPs, and would serve to further legitimate their role and raise their professional profile within Fiji and across the Western Pacific region. The implementation of such an initiative should involve the NPs themselves, with technical support sought from the WHO in conjunction with experts from Australia and/or New Zealand. Funding from one of the aid agencies such as AusAID would be required, together with support from the Fiji Government. Such a project is one of a number of strategies required to progress the growth and development of the NPs in Fiji, which in my opinion has been hamstrung by a lack of support, poor recognition and a myopic vision for their capacity and potential as leaders and agents of change.

Recommendation 4

Promote the importance of continuing professional education for NPs and support its delivery

Life-long learning and continuing professional education/development (CPE/CPD) within nursing and midwifery have long been recognised as impacting positively on the care provided by these professionals (Perry, 1995; Mitchell, 1997; Teasdale, 2001; Lawton & Wimpenny, 2003), though as Ellis & Nolan (2005, p. 98) caution, "the success of CPE is context and time dependent, and pivotal to an understanding of success is the need to take account of the complexities that impact on the practice environment." Indeed, there appears to be a lack of empirical evidence demonstrating that CPE directly enhances the care delivered to patients (Jordan, 2000), despite a number of literature reviews analysing its effectiveness (Furze & Pearcey, 1999; Griscti & Jacono, 2006). Moreover, significant gaps have been identified in the methodological approaches to healthcare education (Attree, 2006), and ongoing controversy exist surrounding mandatory versus voluntary CPE and the former's links to licensure in countries such as the United States (Hewlett & Eichelberger, 1996; Roberts, 1997). Resources for such activities are scarce, and employers must increasingly invest carefully and strategically in order to maximise the benefit for both the nurses and the organization (Joyce & Cowman, 2007).

The *Nurses, Midwives and Nurse Practitioners Rules, 1999* states that "A nurse practitioner must endeavour to keep reasonably up to date with new developments affecting his or her knowledge and skills to practice as a nurse practitioner and conduct research appropriate for a nurse practitioner." (Fiji Islands Government, 1999, p. 277). This rule indicates that NPs have a responsibility to engage in continuing professional education (CPE) for the purpose of maintaining their competence to practice as NPs. They are also required to conduct research relevant to their role and function. Unfortunately, to date there have been few opportunities and little if any funding available to engage in such activities, and certainly there has been no identifiable research strategy or agenda established for, or by, the NPs. It is also unclear who should be responsible for organising these activities.

A program of CPE activities should be funded, designed and delivered with appropriate support from the Ministry of Health, FSN, FNA, Fiji School of Medicine or the University of the South Pacific (USP). Given the legislative requirement for the NPs to maintain their knowledge and skills, it is reasonable to suggest that a strategy for continuing education be developed based on the findings of a targeted learning needs analysis. These processes should be facilitated by staff within the Fiji School of Nursing, in conjunction with the Fiji School of Medicine and Ministry of Health, with funding from agencies such as AusAID and technical support provided by the WHO. The type of CPE offerings, mode of delivery, cost and development of a professional portfolio all need to be explored. This project could be applied to the many other Pacific Island countries (PICs) that have NPs (or other similar mid-level practitioners), as part of a regional strategy aimed at enhancing the professional development of these advanced nurses. Integration of electronically delivered educational courses offered via the Pacific Open Learning Health Net (POLHN, <http://polhn.org/>) is another option available to nurses in most PICs. A number of Universities in countries such as Australia, New Zealand and Japan also offer both Distance Education and face-to-face courses and programs that would be of relevance to the NPs, and could be readily adapted to the Fiji context. Furthermore, recognising the experience and qualifications of the NPs and granting substantial credit within Masters level, NP courses via creation of specific educational pathways would enhance their learning and enable them to achieve similar qualification as their NP colleagues in countries like Australia. It is also suggested that, given the primary care function of the NPs, they gain access to relevant workshops offered by the Fiji School of Medicine. This would enhance interprofessional relations with their medical counterparts, and ensure greater consistency and focus regarding health care information. Given the urgent need to increase the job satisfaction of the NPs, enhance their career development and maintain the currency of their knowledge and skills, strategies to increase their access to continuing professional education appears to be of paramount importance. Barriers currently include a lack of funding to support such activities and provide backfill whilst the NPs are ‘offsite’; the geographically widely dispersed deployment of the NPs means that they have to travel to the main island of Viti Levu to attend face-to-face or e-Learning activities; an absence of incentives to reward

the completion of CPE activities, such as increased remuneration, free journal membership or text books. These are by no means insurmountable if there is a will and a vision to progress this important area.

Conclusion and final reflections

It is clear that the NP role has been implemented as a health workforce strategy under the direction of the Fiji Government and with support from the WHO. Many problems have been discussed throughout this thesis which, when viewed through a critical lens, represent instances of profoundly unequal relations of power that juxtapose the empowerment that accompanies this advanced nursing and midwifery role. Despite these problems, NPs present a clear demonstration that with appropriate education, nurses are able to provide a comprehensive, advanced, safe and cost-effective level of health care. For remote areas that are chronically under served by medical officers, NP-led health care has proven to be a successful model by which comprehensive, quality health can be provided. As Stark & Omi (1999, p. 273) state: "For many years nurses in developing countries have 'led the way' in bringing these essential services to poor rural communities..." The ethical imperative supporting the NP role in these circumstances is clear and unequivocal. We in Australia can learn much from countries like Fiji in relation to the NP role. While acknowledging the totally different circumstances that prevail, there remains the need to address the gross inequities in health status that exist within Australia, particularly for those people who reside in rural and remote communities. We would do well to move on from the issues surrounding professional boundaries and ownership of skills and epistemologies, and focus on meeting these significant and well-documented health needs. The fundamental need to maintain an adequate level of health service provision amid physician shortages, political instability and economic downturn has created the environment in which the NP role has become established and since flourished.

This study has described at length a number of important issues that pertain to the introduction and development of the NP role in Fiji. It has been suggested that health workforce models predicated on medical pre-eminence and the associated efficacy and cost effectiveness of medical substitute or supplementary roles must be critically analysed. Advanced nursing roles such as that of the NP are empowering for nursing and midwifery and constitute cost-effective, safe and legally supported models of care not only in remote or isolated island locations but also within regional, peri-urban and urban settings. Anecdotal evidence indicates that the care provided by NPs in these settings has

been effective in terms of patient outcomes, although further research needs to be undertaken to quantify the impact upon health care outcomes across the diverse range of clinical contexts in which the NPs practice. This study has also drawn attention to the different resource, scope of practice, professional support and interprofessional relationship issues that exist for NPs in remote areas. The remote context adds a significant dimension to the delivery of the role which is not experienced by NPs in other settings. NP-led health services in remote areas are clearly meeting an important need in terms of the provision of comprehensive care, yet these nurses in particular are interacting with the poorer and more disadvantaged communities in Fiji. People in these areas rely heavily upon traditional medicines for certain illnesses because they are cheap and readily available, though their efficacy remains unproven and lacks an evidence base. It has been proposed that the role of the NP marks a point of intersection and tension between the domains of traditional medicine and mainstream, allopathic approaches and that the NPs in rural areas were frequently confronted with patients that used TM. This, it was suggested, presented a significant challenge in terms of the advice and treatments given to patients by the NPs, both of which are grounded in the Western, scientific model of nursing, midwifery, medicine and health care which is strongly advocated by the WHO and now predominates in Fiji. This has been highlighted as a significant issue for the NPs in this study and remains a potentially fruitful area for further research.

As a critical researcher, it is accepted that issues of power and power relations, whatever form they may take, have consciously or otherwise permeated the discourses and practices surrounding health care provision and the development of the Nurse Practitioner role within Fiji. Such relations have been maintained through combinations of political, professional, educational, cultural, religious and economic processes, and are embedded historically within the provision of health care and the practice of nursing and midwifery within contemporary Fijian society. No data concerning the Nurse Practitioners in this (or any other) study is value free; on the contrary, this study has been approached on the understanding that all communications were value laden. These include, of course, my own personal values as well as those of the participants who constitute the case. Ideological influences, mediated through communicative acts, artefacts and symbols, are always present and pervasive and thus constantly exert influence on the cognitive, verbal,

written, interpersonal and visual processes and products concerning Nurse Practitioners in Fiji. As promoters of health, health educators and providers of direct care, the NPs exert both collective and individual influence over their patients through their many therapeutic interactions. Thus, in a Foucauldian sense, they exert governance and power and act politically, in that through these interactions they shape the population for economic and social purposes. Such influence is historically embedded within the establishment of formal nursing practice within Fiji. These factors have, I believe, dramatically re-shaped existing professional boundaries and positioned the NPs as clinicians who, by straddling a number of such boundaries are, it is suggested, more than the sum of their parts. While they are far from being the pre-Enlightenment polymaths referred to by Holmes (2001), they are also not near the upper end of the typology of uni, multi-, inter-, or trans-disciplinary models of health care and education described by authors such as Dyer (2003) and Hall & Weaver (2001). They are, however, pioneers in the sense that they are breaking new ground in the provision of health care by nurses in rural and urban areas of Fiji and creating a unique history during a time of significant social and political turmoil within that country. Not surprisingly, this has created a raft of new challenges as they endeavour to fill the void created by the migration of many doctors following the coups d'etat of 1987, 2000 and 2006.

A brief, yet necessary link to postcolonial theory was provided earlier within this thesis, which added a further historical and political dimension to the discussion regarding power and the hegemony of Western practices evident within health care. Increasing rural-urban migration in Fiji was highlighted as an important factor currently shaping the demographic profile of communities in both these areas, and impacting on health services as a result. Increasing levels of poverty among people in remote areas where NPs are located directly influences their health, and thus shapes the practice of the NPs who provide care 'from the cradle to the grave'. Amid a health workforce in crisis, it has been argued that the NPs require substantial support in order to develop a professional profile and voice that acknowledges the unique, multifaceted nature of their role. Development of a robust continuing professional development strategy has been advocated as a necessary mechanism for enhancing job satisfaction, recruitment and retention.

Nurse Practitioners in Fiji are today a vital component of the health workforce. These nurses have a vital, complex and highly autonomous role, yet work closely with other members of the health care team (particularly doctors) in order to deliver health care to Fijians in rural and remote locations, as well as to the many tourists that visit the idyllic locations for which Fiji is best known. There has been little *overt* evidence of the professional "turf wars" that have often plagued the evolution of Nurse Practitioner roles in Western countries such as Australia. Indeed, this study has shown that they appear to be well respected by the medical fraternity in that country, to the extent that they are also used to replace medical officers when they take leave from smaller hospitals. This has created significant tension, however, and NPs frequently reported feeling exploited by being asked to engage in such practices.

Clearly, the NPs constitute a small but potentially very powerful group of nurses in Fiji, at least within the clinical contexts in which they practice. Little is known outside Fiji about the NP role in that country, but it is anticipated that this study and the planned publications and conference presentations provides much needed information and insights regarding their development and vital role they play within the health workforce across the Western Pacific region.

In conclusion, this study has provided many important answers to the original research question: "What can be learnt from NPs and key stakeholders in Fiji that will contribute to improving the professional role and function of Fijian NPs, and increase their recognition and effectiveness within the health workforce?" Furthermore, as the four main aims of the study have been addressed, numerous new insights have been gained into the ways in which the role is evolving as a vital component of the nursing and broader health workforce in Fiji. The critical lens used throughout this study has enabled unequal power relations to be identified and described, and Fairclough's discourse analytic framework enabled important links to be made between texts, discursive practices and wider social processes.

Much more research needs to be done, however, and I conclude this thesis by suggesting that the following areas are important priorities.

Areas for further research

1. The rates of, and circumstances under which formal or informal consultation between the NPs and physicians takes place in Fiji is unknown, and constitutes an important area for further research.

2. Exploration of the intersection between NP practice and traditional approaches to health care is urgently needed given the increasing interest in traditional and complementary therapies across the Western Pacific region.

3. NP-led models of health care in remote areas require investigation both in minority and majority world countries, given the chronic shortage of physicians in these areas and the need to move beyond the notion of NPs being medical substitutes. The burgeoning health workforce crisis lends particular urgency to the need for such research.

4. The health outcomes for people in such communities who predominantly are the recipients of a NP-led model of care warrants close attention via research conducted in partnership with appropriate personnel in Fiji. This study has drawn attention to the midwifery and health promotion dimensions of the NP role in remote areas, yet little is known about such practices. The findings of such studies would contribute important and hitherto unavailable information regarding the impact of NPs throughout the Western Pacific region.

5. NPs in Fiji are increasingly being utilised in specialty roles and in urban hospital contexts. Further research is urgently needed that explores issues such as educational preparation, scope of practice, skill mix and patient outcomes in relation to such roles.

6. The impact of sustained political instability upon health, health systems and the health workforce requires further investigation, particularly given the increasing globalisation of the workforce and escalating shortage of nurses. Collaborative, multi-site research into new roles and models of care is required across countries in the Western Pacific region that will provide practical ways in which these vital problems may be addressed.

7. As highlighted earlier in this thesis, postcolonial theory offers a highly relevant perspective by which to explore the health system structures in Fiji. Useful insights can be gained by critically examining the ways in which existing inequalities associated with race, culture, politics and power impact upon the roles of the NPs, and limit opportunities for Indo-Fijians to take up these roles.

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Appendix A: Consent Form

ADMINISTRATIVE DOCUMENTATION HAS BEEN REMOVED

DETAILS OF CONSENT:

This project aims to investigate the role of Nurse Practitioners in Fiji, focussing on how the role has evolved in relation to other health professionals in Fiji. Each participant in the study will be interviewed for approximately 1 hour. The interviews will be audio-taped and additional hand written notes taken by the researcher as necessary. The interviews will be semi-structured, enabling participants to respond to the questions in a more open-ended manner. Photographs will be taken of each participant to assist me to match them correctly with their interview. The photos will not be published and will be destroyed once the project is completed. The outcomes of the research will contribute to the fulfilment of the requirements of a Doctor of Philosophy degree at James Cook University. It is anticipated that data gathered within this project will generate several publications.

CONSENT	
The aims of this study have been clearly explained to me and I understand what is wanted of me. I know that taking part in this study is voluntary and I am aware that I can stop taking part in it at any time and may refuse to answer any questions. I understand that any information I give will be kept strictly confidential and that no names will be used to identify me with this study without my approval.	
Name: *(printed)*	
Signature:	**Date:**

Appendix B

Participant Information Sheet for Individual Interviews

ADMINISTRATIVE DOCUMENTATION HAS BEEN REMOVED

ADMINISTRATIVE DOCUMENTATION HAS BEEN REMOVED

Appendix C – letter to Fiji Ministry of Health

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