

FROM THE EDITORS - Margaret McMillan and Jane Conway

EXPLORING CULTURAL DIVERSITY

In the AJAN guest editorial Dr Mee Young Park from Korea has been invited to share her study findings about Korean nurses' role in patient education. Her editorial presents an interesting overview of a nursing profession attempting to reconcile its history and traditions with contemporary society and modernising agendas.

The issues in both the global and national contexts should cause us all to take time for reflection on personal and professional practices in this country where cultures are becoming more diverse.

In Western societies, just like any other, there is a sense of loss when strong traditions are threatened. There is no excuse for the ethnocentric in our practice when cultural diversity is the norm within our client bases. Cultural sensitivity is more than an element on our checklists. It requires development and demonstration of a set of attributes that indicate cultural competence. It requires close examination of how we think, how we as nurses develop strategies to manage situations in a way that meets the client's needs and maintains standards of care.

We need to examine political, economic and social determinants of health and ask whether any aspects of these diminish cultural sensitivity and inclusiveness in nursing care. We also need to ask ourselves questions about the extent to which our education programs explore cultural diversity, cultural inclusion and safety, and the influence practice settings have on the enactment of these concepts by asking the questions:

- Do nursing education programs prepare culturally competent professionals?
- Does the increasing complexity of care situations diminish nurses' capacity to negotiate for the maintenance of safety in care?
- How culturally inclusive (or exclusive) are our standards of care?

All parties, in responding to the modern conundrum of excessive demands on capacity to do with delivery of health services coupled with demanding societal situations, nonetheless have shown an amazing resilience. In a work culture where jobs and personal and professional partnerships are not always there for life there is an additional level of complexity added to care planning and implementation. Nurses are the frontline respondents to challenges such as these.

The editorial also caused us to reflect on the trend in society for caring to take on other formal dimensions hitherto not known to health professionals such as nurses. For example, the ageing demographics are creating demands on men as well as women in a different way than they might have expected in their youth. Older men are caring for their debilitated partners. Nurses involved in the care triumvirate

of client/family and professional are dealing with carers who are unprepared for although not uncommitted to these roles.

Contributions in this *AJAN* focus on patterns of decision-making among different groups of nurses, the maintenance of processes that ensure standards, reliability and quality in patient outcomes and matters of cultural sensitivity and inclusiveness.

Hoffman, Duffield and Donoghue examine the extent to which nurses' participation levels match their aspirations to be more involved in decision-making. Gaskin, O'Brien and Hardy focus on standards of practice in mental health nursing and report on a study which audits the reliability of a tool that monitors nursing behaviours and reflects a level of consistency with a set of competency standards.

Culture, cultural sensitivity and self-determination are key concepts in a number of other articles. Usher, Babuka, Nadakuitavuki, Tollefson and Luck highlight the extent to which developments in nursing practice and education mirror those in other countries across the world. Fijians are clearly giving thought to the relevance of competency standards and the leadership within the profession that can emerge from formalising the advanced skills inherent in the nurse practitioner role. Buist, Morse, Durkin and Milgram deal with a study on cross cultural comparisons which show different outcomes for clientele experiencing post-natal depression in two different Australian metropolitan healthcare/regions. Issues of social isolation and access problems emerge as challenges for health planners and providers.

Some of the complexities of exploring options in patient care and acting on the wishes of patients are explored by Shanley and Wall. They note the importance of the role that nurses play in palliation, their espoused commitment to patient autonomy and the implications for utilising, to the utmost, the finely tuned communication skills that are required in these sensitive care situations.

Issues arising from contributions to this edition include:

- **Obligation overload** - Where does our responsibility lie? Clinical obligations around symptom management are often immersed in beliefs about holistic care in all patient care situations.
- **Emotional strain** - Where does strain become growth? Nurses, as a result of a number of challenges, have to avoid believing they can fix that which is bordering on the unmanageable and utilise their networking proficiency which is potentially underutilised both within the team and beyond the immediate care situations.

GUEST EDITORIAL - Dr Mee Young (Clare) Park Cheju Halla College, South Korea

THE IMPACT OF CULTURE ON CARE

In 2003 I undertook a study to explore how nurses in Korea might more meaningfully engage in patient education. The study successfully demonstrated that nurses engaging in an action research project could improve their practice. Nevertheless, a number of factors were identified that impacted on nurses' capacity to implement change. Any change in practice needs to be contextually based and demands that practitioners be involved if it is to be successful and sustained. While the Korean nursing context shares many similarities with other countries, it also provides a particular set of challenges to those who recognise a need to closely align practices with client's needs, especially in patient education. It is this set of challenges that I wish to reflect upon in this invited editorial.

While the phraseology of patient education is well accepted and the importance of it was clearly perceived by nurses in Korea, the practice of patient education has not improved much over time. Despite the fact that nurses are often regarded as the health care professionals best able to provide effective patient education, their capacity to do this has been frequently questioned and it has been suggested that, in general, nurses do not believe they deliver patient education at a satisfactory level. Nurses' practice of patient education often remains limited to unplanned and informal approaches, and dependent on the nurses' individualised style.

Recently, the Korean Nurses Association (2000) recognised the role of patient educator as one of the nurses' important professional responsibilities and has stressed the importance of this role. This recognition is indicative of the increasing emphasis placed on this role in Korean clinical settings. However, there is inadequate organisational support for nurses as patient educators. Although nurses in the study believed that patient education was an important element of their practice, they felt that there was a need for more systematic change in the approach to patient education in an acute setting.

As occurs in other countries, almost 80% of the total number of practising nurses in Korea are clinical nurses working at medical institutions including general hospitals, medical clinics or midwifery clinics. More than 95% of the total number of clinical nurses are working at institutions located in urban areas. A nursing shortage is problematic in Korea and, although current medical law regulates health care providers to keep 2:5 as a nurse/patient ratio, less than 30% of organisations comply

with this regulation according to research conducted in 1997 (Korean Clinical Nurses Association 2000). The supply of doctors and dentists is close to that of other developed countries but the supply of nurses is low compared to that of the United States (US), Japan and England. In fact, the nursing ratio to the population of 10,000 was significantly lower than that in other countries. Therefore, basic care such as hygiene care and feeding is inevitably delivered by family carers (or carers employed by patient's family) who are allowed to stay with patients 24 hours a day.

Several authors have pointed out that concepts (such as patient education) are culturally bound and are transmitted from one generation to another by examples and customs that are often implicit in behaviours. Nurses' practice of patient education is intimately linked with their perception of their role and place in society. Perhaps the most significant factor to impact on the capacity for nurses to change their practice is the broader societal view of nurses and nursing. This has historically been dominated by hierarchical and patriarchal views.

The geographic location of Korea has influenced its expression of culture, its identity, and people's values and beliefs. Korean society has gone through rapid changes on a socio-politico-economic level; people's values and beliefs have also been in the process of transformation. This has been characterised as a conflict between hierarchy (the old way of life) and individualism (a new way of life).

Hierarchy has been the dominant way of life for over two thousand years in Korea. It is 'a way of life whose social relations, defined by strictly defined social roles and strong group identification, create vertical relationships whether between two individual persons and groups or within a group setting' (Kim 1998). In a hierarchical society, individual autonomy is limited and the person is hemmed in by the confining nature of the social roles and groups. Each individual person is linked to others through social roles defined in accordance with one's status as determined by heredity, age, gender, marital status etc. Since these reciprocal social roles establish ties between people, it eventually forms a web of social relationships in which each relationship is clearly prescribed.

Korean culture is a collective culture. Koreans tend to relate themselves to another within the context of group (Han and Choi 1998). They take for granted the duties

and obligations that come as a result of their identification with the group, for example the health sector. Koreans often use the collective words 'we' or 'our' to identify themselves within the group to which they belong, for example, our family, our school, and our country. This strong group identification promotes values that emphasise social harmony, consensus and personal sacrifice by subordinating their own self-interests to the group. In Korean society and in sub-sets of society such as the health service, it is very important to morally fulfil the duties and obligations to those to whom one is bound in a relationship. Maintaining one's face, personal loyalty, sincerity and harmonious relationships, are the basic values and beliefs rooted in the strictly defined social roles. Therefore, Koreans instinctively attempt to order their relations hierarchically in order to find out how to behave towards one another. This hierarchical relationship is constantly reinforced through the use of honorific language and the adherence to social etiquette. Individuality within a group is discouraged and it is seen as a cause of social disharmony or a form of selfishness.

While hierarchy still has a strong hold over Koreans, over the last few decades individualism has been rapidly internalised in the life of the so-called new generation of Korea. This shift brought profound consequences for social relations and eventually impacted on values and beliefs. Since individualism values the spheres of individual freedom operating on the principle of equality, it is incompatible with the concept of hierarchy. With the wearing down of 'firm and lasting ties' inherent in a social structure based on the hereditary status of traditional Korea, individuals become independent of one another in order to exercise their freedom of choice. Thus, conflict exists between hierarchy and individualism.

As Korea became a modernised society, women became more educated, their participation in the workforce increased and women's contributions to society became more valued. Patriarchy, however, still remains, though it has a different face today and is not as obvious as before. It still influences women's lives in modern society through socialisation in family, education and

workplace situations. While young women are educated and influenced by Western cultures, they have grown up with parents who still hold to the traditional idea of 'Nam-jon Nyo-bi': men are superior to women. Boys are taught to be tough and socially active whereas girls are taught to be feminine and to stay at home to be loved. Through this process, women become passive and find the significance of their lives in the achievements of others such as a husband and children. On the surface, school and society as the agencies of socialisation appear to have largely eradicated the consciousness of discrimination based on gender. In reality, it is pervasive and covert and still presents a significant problem. Therefore, just as the relationship between hierarchy and individualism is in conflict, so do patriarchy and the women's movement towards equality unsteadily co-exist and often create conflict in family, organisational, social and political spheres in Korea.

Given these sociological constraints, I have been challenged to examine the extent to which nurses can become more autonomous and effective as patient educators, when their role is so strongly influenced by hierarchy and patriarchy. I have also been caused to question the extent to which allegedly empowering research processes such as action research can coexist with management and health care practice that is less responsive to or cognisant of the need for change. I have also been caused to reflect on the sensitive interface between individualism as a mechanism to provide stimulus for change and the collective action as the mechanism for achieving and sustaining change.

REFERENCES

- Han, G.S. and Choi, S.J. 1998. *Socio-psychological characteristics of Koreans: Findings of their interpersonal behaviours*. In I.K.S. Academy (Ed) Korea and Korean Culture. Four Seasons. Seoul: 161-196.
- Kim, J.W. 1998. *The Korean political culture in conflict: Hierarchy vs individualism*. Sejong Research Institute. Seoul.
- Korean Nurses Association. 2000. *Clinical research 1995-1999*. Unpublished.

BARRIERS TO CLINICAL DECISION-MAKING IN NURSES IN AUSTRALIA

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ABSTRACT

Research aims

The aim of this study was to examine whether nurses in Australia participated in clinical decision-making to the extent they desired. Some factors that could be inhibiting or promoting participation in clinical decision-making, namely educational level, occupational orientation (role values), level of appointment and area of practice (medical/surgical) were also examined.

Method

A quantitative, correlational study examined the relationship between nurses' occupational orientation, educational level, area of specialty and decision-making. T-tests were used to identify significant differences between the decision-making nurses say they have and that which they say they want.

Major findings

Nurses holding a professional role value participated more in clinical decision making than those holding a paramedical role value. Nurses practising in surgical areas participated less in decision-making than those in medical areas. While a higher educational level was not associated with greater participation in clinical decision-making, it was linked to wanting more participation in this process.

Conclusion

Important issues arising from the study need to be addressed. Nurses who are better educated are not making decisions to the extent to which they aspire. Surgical nurses participated less in decision-making than medical nurses and holding professional values can lead to greater decision-making participation.

INTRODUCTION

In recent years globally there has been an increasing emphasis in the health industry on customer-focused care and improved patient outcomes. Health care is now a consumer product subject to the same forces of consumerism as other industries - better patient outcomes at less cost (Bradshaw 1995). This emphasis on consumerism and the provision of cost-effective care has led to an examination of skill mix (Spilsbury and Meyer 2001) in some settings and even the suggestion that the use of the registered nurse (RN) is too costly (Bradshaw 1995). Researchers such as Huber and Oerman (2000) Stetler et al (2000) and Spilsbury and Meyer (2001) have suggested that evidence to date is not sufficient to show the critical role that professional nursing plays in achieving quality outcomes, particularly the invisible aspects of nursing care such as clinical judgment and decision-making (Huber et al 2000). In contrast, Kriariksh and Anthony (2001) state there is an established association between quality of patient outcomes and nurses' decision-making and that a way to enhance the quality of patient outcomes is to increase nurses' participation in decision-making regarding nursing interventions.

Clinical decision-making is the process that nurses use to gather and evaluate information to make a judgment that results in the provision of professional patient care (White et al 1992). Research into clinical decision-making has been examined by studying cognitive processes, as well as how decisions are made, and the factors that affect clinical decision-making such as stress, education and experience. It is generally assumed that nurses in clinical practice have the skills, ability and freedom to make decisions regarding nursing interventions and that university level preparation aims to provide nurses with the skills necessary to make sound clinical decisions (du Toit 1995). However, it appears that despite higher educational levels, there are still barriers in clinical

practice that prevent nurses participating in decision-making to the extent they want. If, as reported, effective nurse decision-making improves patient outcomes, it is necessary to begin to understand the barriers that prevent nurses participating fully in this critical aspect of their practice.

LITERATURE REVIEW

The processes that nurses use in clinical decision-making have been investigated using different methods. To date researchers have examined the cognitive processes involved in decision-making using think aloud protocols (TAP) (Grobe et al 1991; Aitken 2000; Aitken and Mardegan 2000), decision analysis (Panniers and Walker 1994) and content analysis (Tschikota 1993). Nurses are believed to use a hypothetico-deductive cognitive model in decision-making, where nurses gather information, make a hypothesis and then gather cues to eliminate or support the hypothesis (Westfall et al 1981; Thompson 1999; Taylor 2000). Decision-making has also been studied using participant observation and interviewing. Intuitive processes have been described by Benner and Tanner (1987) as a process of decision-making used by nurses. Intuition is believed to be a knowing without rationale and is believed to develop through experience (Benner and Tanner 1987; Dreyfus 1992; Benner et al 1999; Buckingham and Adams 2000).

Nurses' values and beliefs about whether they should make decisions influence their decision-making behaviour (Augoustinos and Walker 1995). Values contain both an affective and cognitive dimension and serve as criteria for decision-making (Berggren et al 2002). A role is a person's pattern of behaviour that results from the constructs that a person holds (Feist 1994) to a specific position in society (Augoustinos and Walker 1995). In nursing, the values and beliefs held by nurses towards their work and occupation constitute their occupational ideology. These beliefs and values are shaped by societal and institutional norms and internalised by nurses (Lauri and Salantera 1995). The work values held by individual nurses will have been shaped by socialisation processes within and external to nursing (du Toit 1995; Yung 1996) and internalised to form nurses' values to work. An example of socialised role development is seen where nurses take a passive role when working with medical staff leading to a lack of independent judgements by nurses (Oughtibridge 1998).

Rhodes (1985) outlined three role values that nurses hold and related these to participation in decision-making. Those who hold 'paramedical' role values and see themselves as physicians' helpers act subserviently and often do not make independent decisions regarding everyday nursing care (Rhodes 1985). Those who hold 'bureaucratic' values believe that the hospital organisation should make decisions for them and also do not often make independent decisions (Rhodes 1985). On the other hand, those nurses who hold 'professional' values and a

belief in autonomous decision-making are willing to participate in clinical decision-making (Rhodes 1985).

Nurses worldwide are reporting that they want to be able to participate in decision-making more than they currently do. In Israel, Misener et al (1996) found nurses wanted more decision-making authority, responsibility and control and that there was a discrepancy between the decision-making in which nurses actually participated and those in which they wanted to participate. This finding was attributed to the authoritarian management style common in Israel. Wulff (1991) also found differences in the amount of decision-making in which nurses participated in the United States of America (USA) and what they wanted to participate in, stating that they want to be able to participate more.

The participation in decision-making in this study was mainly correlated to personal characteristics. However, Wulff (1991) also found that some job attributes, such as nurse leadership style, affected participation in decision-making. A study which examined the type of decisions nurses can make and what kind they want to make, found that nurses frequently did not independently or consistently make patient care decisions in those areas identified as belonging to the nursing domain such as rest, nutrition, elimination and mobility (Prescott et al 1987). These authors concluded that nurses' characteristics such as education, experience, and interpersonal styles affect clinical decision-making. The magnet hospital research, also in the USA, has demonstrated links between nurse decision authority and greater retention and job satisfaction, with nurses choosing to work in areas with greater decision authority (Scott et al 1999; Curley 2002; Ritter-Teitel 2002). In Australia, O'Connell and Warlow (2001) state that nurses often feel they are in situations where they are unable to change aspects of patient care and that nurses lack autonomy within hospital systems. However, these researchers did not examine whether nurses want more decision authority.

Nurses are being educated at the tertiary level to use skills such as problem solving, critical thinking and reflection to develop good clinical decision-making abilities. However, despite nurses being equipped with the necessary skills to make decisions regarding patient care, they still feel their participation in clinical decision-making is being constrained (Misener et al 1996). In Australia, du Toit (1995) found that student nurses at a university were being socialised into professional roles with independent decision-making being an important aspect of that role, which led to a high willingness to make clinical decisions. Several authors echo this sentiment that students are socialised into roles at university and also learn roles in the workplace (Yung 1996; Beecroft 1999; Wade 1999; Cullen 2000). One important aspect of the professional role of nurses is the belief in autonomous nursing practice that can be expressed as greater participation in clinical decision-making. University educated nurses also appear to be socialised to value autonomy and in turn, expect a high

level of involvement in clinical decision-making (du Toit 1995).

The amount of autonomy that nurses have varies from hospital to hospital and unit to unit, as does the extent to which nurses can make decisions (Prescott et al 1987). Clinical autonomy is a role characteristic that is socially constituted and so a nurse's position in a ward may act to constrain their clinical autonomy and decision-making (Cash 2001). Much variability exists in both the decisions nurses can make and the extent to which nurses want to make decisions, and there may be barriers to nurses' clinical decision-making as a result of the type of hospital or ward in which they work. Nurses working in areas such as community health, critical care and mental health are more independent decision-makers (Bucknall and Thomas 1996). In England differences in participation in decision-making were found between nurses on medical and surgical wards, with medical wards having less need for frequent medical intervention and greater need for skilled nursing care, leading to greater self-confidence and autonomy in practice for medical nurses (Adams et al 1997). The differences in nursing autonomy between medical and surgical wards were due to the nurses on the medical wards needing to implement skilled nursing interventions more frequently (Adams et al 1997). Surgical nurses had less uncertainty to tolerate and had fewer chances to develop self-confidence and autonomy in their practice (Adams et al 1997). There has been little research in Australia concerning similarities or differences in medical/surgical wards.

A nurse's level of appointment has also been shown to affect participation in clinical decision-making. Bucknall and Thomas (1996) examined both the frequency with which nurses reported they made decisions and the relationship between level of appointment and decisions made. They concluded that nurses practising at a higher level made more decisions than those practising at a lower level, which supports the work of Schutzenhofer et al (1996). Lower levels of appointment may act as a barrier to participation in clinical decision-making. This might be quite appropriate in some cases.

METHOD

In this study decision-making was defined as those decisions made by nurses in their usual clinical practice and incorporated aspects such as activities of daily living, wound dressings, medication administration, emotional support and referrals to other services. The frequency with which nurses make such decisions was assessed and correlated to a number of factors. The study used a correlational design to examine the relationships between selected factors and decision-making by nurses in Australia.

Instruments

Two questionnaires, one that identified role values (occupational orientation) and one that assessed decision-

making were used after Rhodes (1985) granted permission. A pilot study was conducted to determine the suitability of the questionnaires for Australian conditions following which the wording of the questionnaires were modified slightly. The occupational orientation (role values) questionnaire consisted of 26 items making up three sub-scales that tested:

- i) professional role values: for example 'Nursing duties should be defined by the nursing profession' eight items;
- ii) paramedical role values: for example 'Nursing duties should be defined by the medical profession' nine items; and,
- iii) bureaucratic role values: for example 'The area management should decide what work nurses should do.' nine items (Rhodes 1985).

Each item of the scale had a five-point Likert scale ranging from strongly agree (5) to strongly disagree (1).

The decision-making questionnaire consisted of two subscales, one for perceived decision-making and one for normative decision-making. This inventory consists of 23 items for the perceived subscale and 23 items for the normative subscale. Each item on the decision inventory has a five point Likert scale with scores ranging from five (strongly agree) to one (strongly disagree). The 23 items on the subscales are related to decisions nurses make in aspects of daily patient care and cover areas such as nurse initiated medications, bathing, feeding, mobility and pressure area care. An example for each subscale is provided:

Perceived: 'I decide when to discontinue charting.'

Normative: 'I should be able to decide when to discontinue charting.' (Rhodes 1985)

Reliability and validity

The reliability of the questionnaires was evaluated using Cronbach's alpha. Item to scale correlations were obtained from the pilot study. The occupational ideology scale had Cronbach's alphas greater than or equal to 0.7. On the bureaucratic scale the Cronbach's alpha was 0.602. Removal of one item increased this to 0.695, so this item was discarded. For the second questionnaire on decision-making, the Cronbach's alpha for the perceived decision-making scale was 0.74 and the Cronbach's alpha for the normative decision-making scale was 0.745. Both scales were used in the study without alteration. Face validity was achieved by changing the wording slightly in three items on the occupational scale to reflect Australian conditions.

Sample

The sample consisted of all RNs working in medical or surgical areas in three hospitals in one area health service. Participants were recruited by posting out questionnaires to all RNs on each ward selected for the study. Mailing

out the questionnaires was staggered and non-consecutive so as to reduce interaction between participants. No follow-up was attempted. The sample size was 174 RNs.

Ninety-four completed questionnaires were returned giving a response rate of 58%. The mean age of the sample was 33.5 years; 7% of the sample was male and 93% was female; the average length of experience in nursing was 11 years; 47% worked in medical areas and 46% in surgical areas; 82% were RNs, 5% were appointed at Clinical Nurse Specialist (CNS) level, 4% at Clinical Nurse Consultant (CNC) and 5% at Nurse Unit Manager (NUM) level. Education levels held were Hospital Certificate (15%), Graduate Certificate (13%), Diploma of Nursing (47%), Bachelor of Nursing (2%) and Master of Nursing (1%).

Analysis

Data were analysed using descriptive statistics, correlations and t-tests. Pearson's correlations were used for relationships where both variables were normally distributed and where interval level data were obtained. This included the relationship between occupational orientation and decision-making. Spearman's correlations were used for non-parametric and ordinal level data. This included the relationship between level of appointment and decision-making. For analysis of the relationship between area of practice and decision-making, the two areas were treated as dummy variables in Spearman's correlation, with medical areas designated 0 and surgical 1. Two-tailed tests of significance were used which were set at $p < 0.01$.

A t-test was used to determine if the scores for perceived decision-making (decision-making that nurses report they have) and normative decision-making (decision-making that nurses report they want) were significantly different at a $p < 0.01$.

Ethical issues

Anonymity was protected, as participants were not required to identify themselves. Consent was implied if participants returned completed forms as indicated on the covering letter. Participants were informed as to what was required by the cover sheet and the researcher was available to answer questions. Responses to the questionnaires are kept in a locked cabinet, data are in an aggregated form to protect participants' privacy, and the computerised data file is password protected.

Results

The role values (occupational orientation) of nurses were ascertained using the occupational orientation scale. The total possible score for both the professional and paramedical scales was 45 and 40 for the bureaucratic scale. The highest mean score for the role values was for professional values followed by bureaucratic values and paramedical values (see table 1).

Perceived and normative decision-making were ascertained using the decision-making inventory. The total score for each was 115. The mean score for the perceived

Table 1: Means and standard deviations for role values

Scale	Mean	SD
Professional value	37.5	+3.7
Paramedical value	14.7	+4.4
Bureaucratic value	24.5	+3.9

scale was 78.7 (see table 2), well above the midpoint of 57 indicating that nurses perceive they make decisions reasonably frequently on the items. The mean score on the normative scale was 87.6 (table 2), again well above the midpoint, and also higher than the perceived decision scale. The t-test showed a significant difference between the scores on the perceived decision-making inventory and the normative decision-making inventory. The scores for the normative decision-making scale are significantly different from and higher than those of the perceived decision-making scale. The findings indicate that nurses believe they should be able to participate more in decision-making than they currently do.

Correlations between decision-making (perceived and normative) and the factors examined showed that some factors were restricting participation in decision-making while others were increasing participation (see table 3).

Table 2: Means, standard deviations and t-tests for decision-making inventory

Perceived decision-making	Mean 78.7 SD +13
Normative decision-making	Mean 87.6 SD +11.4
t-test paired: $t = -5.978$, $df = 93$, $sign. (two tailed) = 0.000$	

There was a significant positive relationship between professional values and perceived decisions $r = 0.332$, $p < 0.01$ (see table 3), and professional values and normative decisions $r = 0.358$, $p < 0.01$. Professional values led to an increased participation in decision-making and a desire to participate further. There was a significant positive relationship between education and normative decision-making ($r = 0.561$, $p < 0.01$). Those with higher levels of education wanted to participate more in decision-making. There was also a significant positive relationship between level of appointment and perceived decisions ($r = 0.338$, $p < 0.01$). Those holding higher levels of appointment participated more in decision-making.

There was a significant negative relationship between paramedical values and perceived decisions ($r = -0.250$, $p < 0.01$) (see table 3). Holding paramedical values was related to decreased participation in decision-making. There was also a significant negative relationship between area of clinical practice and perceived decision-making, $r = -0.309$, $p < 0.01$, with those in surgical areas participating less than those in medical areas.

Table 3: Significant correlations between decision-making and occupational orientation, educational level, level of appointment and area of practice

	Perceived decisions	Normative decisions
Professional orientation	0.332* 0.000	0.358* 0.001
Paramedical orientation	-0.250* 0.007	-0.327* 0.001
Educational level	not significant	0.561• 0.000
Level of appointment	0.338• 0.000	not significant
Area of practice	-0.309• 0.001	not significant

Key: top number = correlation coefficient; bottom number = significance; * Pearson's correlation; • Spearman's correlation

Limitations

Some caution may be needed when applying these findings more widely because the study was undertaken with a sample from one area health service only. Secondly, the sample was a convenience rather than random sample, which increases the risk of bias, thus again limiting generalisability.

Discussion

This study identified a significant difference between the scores for perceived and normative decision-making. Nurses reported that they wanted more decision-making authority than they currently have. This finding supports the results of research by Misener et al (1996) and Wulff (1991) and adds weight to the assertion of O'Connell and Warlow (2002) that nurses report being unable to affect aspects of care. Nursing should be concerned that these nurses feel they cannot make decisions to the extent they want. More research needs to identify what other aspects of the clinical environment are preventing participation in decision-making. The discrepancy between the actual decision-making and desired level of decision-making warrants consideration by medical and nurse managers as ward structures may be too hierarchical to accommodate nurses' desires to make decisions concerning patient care.

The educational level was not correlated with perceived decision-making, but was strongly positively correlated with normative decision-making (decisions nurses want to make). This is an interesting finding as one of the aims of tertiary level preparation was to produce professional nurses with effective decision-making skills (Pardue 1987; Watson 1994). It would appear that the Australian education system is preparing nurses who believe decision-making is a part of their role, but they are unable to undertake this responsibility to the extent they believe they should.

The study also found that holding a professional occupational orientation increases decision-making participation, whereas holding a paramedical orientation

restricted decision-making behaviours. Those nurses holding a professional occupational orientation do not believe that others should make all their decisions, and they are willing to take on the role of decision-maker in clinical practice in areas of concern to nursing. If nurses see themselves as professional, they will act accordingly and be more willing to make decisions. The finding that professional role values are related to greater participation in decision-making supports the work of Misener et al (1996) and is an important finding. In the Misener et al (1996) study participation in professional activities was related to feelings of personal control and greater participation in decision-making.

The finding that professional occupational orientation is related to decision-making is similar to overseas findings (Rhodes 1985; Misener et al 1996; Scott et al 1999; Curley 2002; Ritter-Teitel 2002). These results are particularly important, as they appear to be relatively constant across countries. If nurses hold values to their work that can be shaped by their socialisation into nursing, then a concerted approach is needed to socialise nurses into holding professional values with a belief in their ability to carry out independent decision-making regarding nursing interventions. Adamson et al (1995) state that nurses are aware of their subordinate position in health care and their subsequent lack of autonomy in decision-making. Furthermore they believe that many nurses no longer consider that their role is merely to follow orders. This idea needs to be strengthened to increase nurse participation in decision-making about fundamental aspects of nursing care in order to improve patient outcomes.

Nurses holding a higher level of appointment also participated more in decision-making and equally, the converse is true: A lower level of appointment was linked to lower levels of participation in decision-making, supporting the work of others (Schutzenhofer and Musser 1996; Bucknall and Thomas 1996). Schutzenhofer and Musser (1996) report findings that would suggest that there is a link between grade, autonomy and independent decision-making. Bucknall and Thomas (1996) believe that autonomy and independent decision-making are synonymous, and that practising at higher levels as well as holding a professional occupational orientation leads to nurses being more autonomous in decision-making. The findings in this study reinforce those of other researchers (Bucknall and Thomas 1996; Beecroft 1999; Ritter-Teitel 2002) and support the assumptions underlying advanced practice roles, that is, such roles lead to more professional autonomy and hence greater participation in clinical decision-making. However, this finding could also be indicative of the barriers to decision-making in hierarchical organisations, where the decision-making discretion is with more senior staff, not with nurses at the bedside. Those holding lower levels of appointment may feel constrained in decision-making by the authority of those in more senior positions and they may be less

willing to participate in decision-making. However, interestingly there was no correlation between level of appointment and normative decision-making (wanting to be able to make more decisions). Nurses practising at lower levels did not report wanting to be able to make more decisions. They appear to accept their status in the hierarchy and the amount of decision-making authority they have, which is in contrast to the better-educated nurses who want more decision-making authority.

There were differences in clinical decision-making by nurses according to the area of practice with those in medical wards participating more than those in surgical wards. This corresponds to the findings of Adams et al (1997) in England. This interesting finding needs more research to uncover why medical nurses participate more in clinical decision-making about nursing care than surgical nurses.

REFERENCES

- Adams, A., Bond, S. and Hale, C. 1997. Clinical specialty and organizational features of acute hospital wards. *Journal of Advanced Nursing*. 26(6):1158-1167.
- Adamson, B.J., Kenney, D.T. and Wislon-Barnett, J. 1995. The impact of perceived medical dominance on the workplace satisfaction of Australian and British nurses. *Journal of Advanced Nursing*. 21:172-183.
- Aitken, L. 2000. Expert critical care nurses' use of pulmonary artery pressure monitoring. *Intensive and Critical Care Nursing*. 16:209-220.
- Aitken, L. and Mardegan, K.J. 2000. Thinking aloud: Data collection in the natural setting. *Western Journal of Research*. 22(7):841-853.
- Augoustinos, M. and Walker, I. 1995. *Social cognition. An integrated introduction*. London: Sage Publications.
- Beecroft, P.C. 1999. Nursing practice and autonomy. *Clinical Nurse Specialist*. 13(5):213-214.
- Benner, P., Hooper-Kyriakidis, P. and Stannard, D. 1999. *Clinical wisdom and interventions in critical care*. Philadelphia: W.B. Saunders.
- Benner, P. and Tanner, C. 1987. Clinical judgement: How expert nurses use intuition. *American Journal of Nursing*. 87:23-31.
- Berggren, I., Begat, I. and Severinsson, E. 2002. Australian clinical nurse supervisors' ethical decision-making style. *Nursing Health Science*. 4(1-2):15-23.
- Bradshaw, P.L. 1995. The recent health reforms in the United Kingdom: Some tentative observations on their impact on nurses and nursing in hospitals. *Journal of Advanced Nursing*. 21(5):975-979.
- Buckingham, C. and Adams, A. 2000. Classifying clinical decision making: Interpreting nursing intuition, heuristics and medical diagnosis. *Journal of Advanced Nursing*. 32(4):990-998.
- Bucknall, T. and Thomas, S. 1996. Clinical decision-making in critical care. *Australian Journal of Advanced Nursing*. 13(2):10-17.
- Cash, K. 2001. Clinical autonomy and contractual space. *Nursing Philosophy*. 2(1):36-41.
- Curley, M.A. 2002. Experienced nurses + autonomy = better patient outcomes. *Pediatric Critical Care*. 3(4):385-386.
- Cullen, G. 2000. Autonomy and the nurse practitioner. *Nursing Standard*. 14(21):53-56.
- Dreyfus, H. 1992. *What computers still can't do*. New York: Free Press.
- du Toit, D. 1995. A sociological analysis of the extent and influence of professional socialisation on the development of a nursing identity among nursing students at two universities in Brisbane, Australia. *Journal of Advanced Nursing*. 21:164-171.
- Feist, J. 1994. *Theories of personality*. USA: Brown and Benchmark.
- Grobe, S.J., Drew, J.A. and Fonteyn, M.E. 1991. A descriptive analysis of experienced nurses' clinical reasoning during a planning task. *Research in Nursing and Health*. 14:305-314.
- Krairiksh, M. and Anthony, M.K. 2001. Benefits and outcomes of staff nurses' participation in decision-making. *The Journal of Nursing Administration*. 31(1):16-23.
- Huber, D. and Oermann, M. 2000. Outcomes from the view in the bed. *Outcomes Management for Nursing Practice*. 4(1):1-2.
- Lauri, S. and Salantera, S. 1995. Decision-making models of Finnish nurses and public health nurses. *Journal of Advanced Nursing*. 21:520-527.
- Misener, T.R., Haddock, K.S., Gleaton, J.U. and Ajamieh, A.R.A. 1996. Toward an international measure of job satisfaction. *Nursing Research*. 45(2):87-91.
- O'Connell, B.O. and Warlow, P.J. 2001. Challenges of measuring and linking patient outcomes to nursing interventions in acute care settings. *Nursing Health Science*. 3(3):113-117.
- Oughtibridge, D. 1998. Under the thumb. *Nurse Manager*. 4(8):22-24.
- Panniers, T.L. and Walker, E.K. 1994. A decision-analytic approach to clinical nursing. *Nursing Research*. 43(4):245-249.
- Pardue S.F. 1987. Decision-making skills and critical thinking ability among associate degree, diploma, baccalaureate, and master's prepared nurses. *Journal of Nursing Education*. 26(9):354-361.
- Prescott, P.A., Dennis, K.E. and Jacox, A.K. 1987. Clinical decision making of staff nurses. *Image: Journal of Nursing Leadership*. 19(2):56-62.
- Rhodes, B. 1985. Occupational ideology and clinical decision-making. *International Journal of Nursing Studies*. 22(3):241-257.
- Ritter-Teitel, J. 2002. The impact of restructuring on professional nursing practice. *Journal of Nursing Administration*. 32(1):31-41.
- Scott, J. G., Sochalski, J. and Aiken, L. 1999. Review of magnet hospital research: findings and implications for professional nursing practice. *Journal of Nursing Administration*. 29(1):9-19.
- Schutzenhofer, K.K. and Musser, D.B. 1996. Nurse characteristics and professional autonomy. *Image: Journal of Nursing Scholarship*. 26(3):201-205.
- Spilsbury, K. and Meyer, J. 2001. Defining the nursing contribution to patient outcome: lessons from a review of the literature examining nursing outcomes, skill mix and changing roles. *Journal of Clinical Nursing*. 10(1):3-14.
- Stetler, C., Morsi, D. and Burns, M. 2000. Physical and emotional patient safety: A different look at nursing sensitive outcomes. *Outcomes Management for Nursing Practice*. 4(4):159-166.
- Taylor, C. 2000. Clinical problem-solving in nursing: Insights from the literature. *Journal of Advanced Nursing*. 31(4):842-849.
- Thompson, C. 1999. A conceptual treadmill: The need for middle ground in clinical decision making theory in nursing. *Journal of Advanced Nursing*. 30(5):1222-1229.
- Thompson, C., McCaughan, D., Cullum, N., Sheldon, T., Thompson, D. and Mulhall, A. 2003. *Nurses' use of research information in clinical decision making: A descriptive and analytical study*. Final report: NHS R & D Project. Centre for Evidenced Based Nursing: University of York.
- Tschikota, S. 1993. The clinical decision-making processes of student nurses. *Journal of Nursing Education*. 32(9):389-398.
- Watson, S. 1994. An exploratory study into a methodology for the examination of decision-making by nurses in the clinical area. *Journal of Advanced Nursing*. 30:351-360.
- Wade, G.H. 1999. Professional nurse autonomy: Concept analysis and application to nursing education. *Journal of Advanced Nursing*. 30(2):310-318.
- Westfall, U.E., Tanner, C.A., Putzier, D. and Padrick, K.P. 1986. Activating clinical inferences: A component of diagnostic reasoning in nursing. *Research in Nursing and Health*. 9:269-277.
- White, J.E., Nativio, D.G., Kobert, S.N. and Engberg, S.J. 1992. Content and process in clinical decision-making by nurse practitioners. *Image: Journal of Nursing Scholarship*. 24(2):153-157.
- Wulff, K.S. 1991. *Nurse participation in unit decisions*. Doctoral dissertation. Seattle University 1993152076.
- Yung, H.H. 1996. Role conception and role discrepancy: A comparison between hospital based and degree nursing students in Hong Kong. *Journal of Advanced Nursing*. 23(1):184-191.

CONSUMER NOTES CLINICAL INDICATORS: DETERMINING INTER-RATER RELIABILITY WITH MULTIPLE RATERS, NOMINAL CATEGORIES AND SEVERAL CASES

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Key words: inter-rater reliability, rater agreement, mental health

ABSTRACT

A method of determining inter-rater reliability when there are multiple raters, nominal rating categories and several cases is described and applied in the development of an instrument for auditing the ANZCMHN (1995) standards of practice for mental health nursing in New Zealand. Clinical statements (n=41) from the O'Brien et al (2002a, 2003) study, which reflected nursing behaviours contributing to the achievement of the standards of practice, were used to audit consumer files. During two Phases, the clinical indicator statements were refined and rules for judging the achievement of each statement from case note documentation were established. The resultant statements have adequate inter-rater reliability for the assessment of nursing practice with respect to the ANZCMHN (1995) standards of practice.

INTRODUCTION

The Australian and New Zealand College of Mental Health Nurses (ANZCMHN 1995) has developed six broad standards of practice for mental health nursing in New Zealand. O'Brien et al (2002a, 2003) developed an instrument that facilitates the measurement of these standards by determining the presence or absence of clinical indicators of pivotal mental health nursing behaviours in consumer case notes: the Consumer Notes Clinical Indicator (CNCI) audit booklet (O'Brien et al 2002b). An important stage in the development of this instrument was the establishment of the internal reliability of each clinical indicator statement. The internal reliability, determined by the measurement of the inter-rater reliability of each clinical indicator statement, was strengthened during a two-stage pilot study. This paper focuses on how the inter-rater reliability of each clinical indicator statement was assessed, the method of improving reliability, and the outcome of the rating process.

Literature review

In a multi-stage research project, O'Brien et al (2002a, 2003) developed clinical indicators for the ANZCMHN (1995) New Zealand standards of practice. In the first stage, two focus groups of experienced mental health nurses who identified as Maori and non-Maori, respectively, generated nursing behavioural statements that contributed to the fulfilment of the standards of practice. The use of two focus groups, which included participants from different ethnic backgrounds (Maori and non-Maori), reflected the bicultural focus of the research. Maori are the indigenous people of New Zealand and, although they represent 16.4% of the New Zealand population (Statistics New Zealand 2001), are over-represented as consumers of mental health services

(Ministry of Health 2002). The behaviours identified in the two focus groups were separately content analysed and worded as clinical indicator statements. The statements were then assessed to determine whether they were likely to be found in nurses' documentation in consumer case notes. Those statements that were unobservable in consumer case notes were included in a second instrument, the Professional Practice Audit Questionnaire (PPAQ) (O'Brien et al 2002c), the development of which is reported elsewhere (O'Brien et al 2002a; Gaskin et al 2003).

In the second study, the clinical indicator statements were included in a 3-round Delphi process to rate the importance of each statement to the fulfilment of their respective standard (Hardy et al in press). Maori and non-Maori nurses and consumers were the participants. Criteria for consensus and importance were used to judge the appropriateness of each clinical indicator statement for measuring the standards of practice. At the completion of the Delphi process, 41 clinical indicator statements met the consensus and importance criteria, and were accordingly incorporated into the draft CNCI audit booklet (O'Brien et al 2002a, 2003).

Inter-rater reliability

An instrument's internal reliability refers to how consistent it is in measuring a specific attribute (Polit and Hungler 1999). The inter-rater reliability of an instrument is a measure of its internal reliability. Accordingly, many methods to compute inter-rater reliability have been developed (Banerjee et al 1999; Agresti 1992). These methods have been successfully used when there are two raters, for example, Kappa (Cohen 1960) and intraclass Kappa (Bloch and Kraemer 1989); dichotomous rating categories, for example, tetrachoric correlation coefficient (Pearson 1900); ordinal data (Nelson and Pepe 2000; Szalai 1993); interval/ratio data (eg Shrout and Fleiss 1979); or a large number of raters or ratings, for example, Kappa_{SC} (Szalai 1998), log-linear models (Tanner and Young 1985), and latent-class models (Agresti 1992; Uebersax and Grove 1990).

There is not a measure of agreement, however, when there are multiple raters, several nominal categories for the raters to choose from, and more than one situation being rated, as was the case in the present study, in which there were multiple consumer files. One way to measure inter-rater reliability in this situation is to calculate the proportion of agreement between raters. Although this method has been criticised for not taking into account rater agreement by chance (Cohen 1960), this problem dissipates with increases in the number of nominal categories, raters, or cases to be rated. The binomial distribution can be used to test the statistical significance of the agreement between multiple raters, when there are several nominal categories and more than one case.

Although the determination of statistical significance is useful as an indication of whether the agreement between raters could be attributable to chance, the effect of increases in the number of nominal categories, raters, or cases to be rated leads to lower levels of agreement being found to be significant. Accordingly, the magnitude of agreement between raters should also be used in determining the adequacy of agreement between raters. Based on their observations from the literature in which inter-rater reliability measures have been reported, Shaughnessy and Zechmeister (1997) suggested that agreement of 0.85 or better is acceptable.

In the O'Brien et al (2002a) study, occurrence of the observable clinical indicator statements in consumer files was assessed during two Phases of a pilot study. The objective of this pilot study was to increase the reliability of the statements to consistently measure important aspects of mental health nursing practice. This paper reports on the method used to assess inter-rater reliability, the way in which inter-rater reliability was improved, and the inter-rater reliability of the statements.

METHOD

Consumer files

Consumer files (Phase 1, n=8; Phase 2, n=7) that met the inclusion criteria of 'consumers who had had an episode of care within the last 12 months for at least two days as an inpatient, or at least two months in community care' were audited in the pilot study.

Measure

The draft CNCI audit booklet consisted of observable clinical indicator statements (Phase 1, n=41; Phase 2, n=25) that emanated from the Delphi stage of the O'Brien et al (2002a, 2003) study. Although O'Brien et al found that 86 clinical indicator statements were important to mental health nursing practice, some of these statements could be merged as they covered the same behaviour and other statements were transferred to the PPAQ because they could not be observed in consumer case notes. This refinement produced a smaller set of 41 statements for inclusion in the present study. Clinical indicator statements applied during the pilot study are listed in table 1. The status of each clinical indicator statement was recorded on a four-point nominal scale as present, absent, not applicable, or not rated. The rating, not applicable, was given when the particular clinical indicator statement was not relevant to the consumer whose notes were being audited. For example, some clinical indicator statements were only relevant to consumers who identified themselves as being Maori. The rating, not rated, was used when a rater decided a clinical indicator statement could not be clearly applied to a file. This rating indicated that the clinical indicator statement needed to be reviewed.

Procedures

The study was conducted in two Phases at a North Island District Health Board Mental Health Service (MHS), with each Phase lasting two days. Four raters were involved in the first Phase. In the second Phase, three raters were involved, two of whom also participated in the first phase. In both Phases, the raters were members of the O'Brien et al (2002a, 2003) research team.

Staff at the MHS randomly selected the files that were used in the research, in line with the inclusion criteria. The researchers independently assessed each file for documented evidence of each clinical indicator statement having occurred, or not having occurred. At the end of each day of the pilot, the ratings of clinical indicator statements in each file were assessed to determine the extent to which the ratings of the statements were the same. Differences between raters on the assessment of clinical indicator statements were discussed. When consensus was reached about how a clinical indicator statement should be interpreted, this information was recorded so that rules for each clinical indicator statement could be established for the final instrument. Clinical indicator statements were removed from the instrument if they were found to be too ambiguous to be consistently interpreted in the same way or if it was found that the nursing behaviour could not be observed in consumer case notes. If the clinical indicator statements were not observable in case notes they were transferred to the PPAQ (O'Brien et al 2002a, 2003).

Analysis

The magnitude of agreement between raters, and the statistical significance of the agreement, were calculated for each day of the two pilot study Phases. The magnitude of agreement between raters for each clinical indicator statement was calculated by averaging the agreement on each file. The statistical significance was determined, using the binomial distribution, by calculating the probability that the magnitude of agreement occurred by chance. That is, the probability that the raters agree by chance (P_a) over a series of files can be expressed as the mean of the probability of agreeing by chance on each file:

$$P_a = \frac{\sum_{i=1}^F (p_r)_i}{F}$$

where p_r is the probability of rater agreement on a single file and F is the number of files. The probability of rater agreement on a single file (P_r) follows a binomial distribution with $n - 1$ raters and $y - 1$ raters in agreement. Therefore, the probability of P_a or greater agreement between raters (P_g) occurring is:

$$P_g = \sum_{i=y-1}^{n-1} (p_a)_i$$

If the value obtained for P_g is less than 0.05 then, by convention, it has met the generally accepted level for

statistical significance (Polit and Hungler 1999). The stricter level of 0.01 is often used when erroneously rejecting that the null hypothesis has important consequences.

RESULTS

Of the 41 clinical indicator statements that were included on the first day of Phase 1, 16 statements were removed because of ambiguity, repetition of other statements, or lack of observability in consumer case notes. Of the remaining 25 clinical indicator statements, 21 had inter-rater reliability values of 0.85 or better. The magnitude of agreement between raters on each clinical indicator statement, for each day, are shown in table 1.

DISCUSSION

During the process of pilot testing clinical indicator statements for use in an audit tool, 25 statements emerged as being of potential value for measuring the six ANZCMHN (1995) standards of practice. Using Shaughnessy and Zechmeister's (1997) suggestion that a benchmark level of rater agreement of 0.85 appears to be supported by the literature, 21 of the 25 clinical indicator statements, on both days of Phase 2, could be classified as having adequate agreement between raters. Some of the clinical indicator statements, however, remained problematic at the end of Phase 2 of the pilot study.

Of particular concern were the first two clinical indicator statements, 'Tangata whaiora is given a choice of whether they want their cultural issues addressed,' and 'If tangata whaiora has identified specific cultural issues, then access to relevant cultural support is provided for all issues.' On the second day of Phase 1, full agreement between raters in rating these clinical indicator statements only occurred on one of the three files. On another file, raters totally disagreed on the rating of the latter clinical indicator statement. The confusion related to the identification of the consumers' ethnicity. To address consumers' cultural issues, the mental health nurse must establish whether consumers want their ethnicity acknowledged and their cultural needs met. Given the salience of these clinical indicator statements to the New Zealand mental health context, rules were established to increase the consistency with which these statements were rated as having occurred or not having occurred, from the documented evidence in consumer files.

These rules increased the consistency with which the raters interpreted the clinical indicator statements. The rules for finding occurrences of clinical indicator statements enabled raters to discuss each occasion of discovery and provided parameters for their discovery. When it was not clear whether or not a clinical indicator statement had occurred, as a result of the ambiguity of the statement itself or poor quality of documentation in case notes, raters were able to use the rules of discovery as points of departure to argue the case for inclusion, or to exclude on the basis of insufficient evidence.

Table 1: Mean percentage of inter-rater reliability of ratings of consumer notes clinical indicator statements in pilot study

Clinical Indicator Statement	Phase 1		Phase 2	
	Day 1	Day 2	Day 1	Day 2
¹ Tangata whaiora (consumers) are given a choice of whether they want their cultural issues addressed.	56.25	87.50**	75.25*	78.00*
¹ If tangata whaiora has identified specific cultural issues, then access to relevant cultural support is provided for all issues.	50.00	93.75**	91.75**	66.67
¹ If a deficit in the provision of culturally safe practice has been identified, then there is evidence of change.	81.25**	75.00**	100.00**	100.00**
¹ The nurse supports tangata whaiora decision to utilise rongoa (Maori medicine/therapies).	100.00**	87.50**	100.00**	100.00**
¹ Maori cultural assessment for Maori tangata whaiora has been conducted.	100.00**	87.50**	100.00**	100.00**
¹ Maori mental health nurses and/or cultural advisors have been consulted regarding care of Maori tangata whaiora and/or whanau (family).	100.00**	100.00**	100.00**	100.00**
² The nurse has sought informed consent of tangata whaiora.	56.25	75.00**	91.75**	89.00**
² Tangata whaiora has been informed of their legal rights.	56.25	81.25**	83.50**	89.00**
² Consultation about treatment has taken place with whanau and/or significant others.	62.50*	87.50**	100.00**	78.00**
² Tangata whaiora has been informed of support services.	93.75**	75.00**	91.75**	89.00**
² Goals are set and reviewed in partnership with tangata whaiora.	56.25	62.50*	83.50**	100.00**
² Tangata whaiora has been given the opportunity to provide feedback on nursing care.	87.50**	81.25**	91.75**	89.00**
² Maori tangata whaiora has been asked if they would like a Maori mental health nurse as their advocate.	100.00**	87.50**	100.00**	100.00**
² The mental health nurse has observed and supported Maori tikanga/kawa (traditional beliefs/practices).	100.00**	87.50**	100.00**	100.00**
³ There is a documented nursing assessment.	75.00**	93.75**	91.75**	78.00*
³ Where restrictions are placed on the tangata whaiora's freedom, there is evidence in the case notes of regular nursing review.	56.25	62.50*	100.00**	89.00**
³ There is a completed nursing care plan.	68.75*	81.25**	100.00**	100.00**
³ There is a rationale for nursing care.	50.00	93.75**	91.75**	100.00**
⁴ The nurse has provided information to tangata whaiora about his/her care.	75.00**	68.75*	100.00**	89.00**
⁴ There is a relapse prevention program based on the principles of recovery.	93.75**	81.25**	100.00**	100.00**
⁴ Available health and social resources have been used to support tangata whaiora in the community.	93.75**	75.00**	100.00**	100.00**
⁴ Nurses collaborate with significant others in providing wellness education.	75.00**	81.25**	100.00**	100.00**
⁴ The nurse has provided mental health promotion that focuses on tangata whaiora strengths and wellness.	93.75**	93.75**	91.75**	89.00**
⁴ The nurse has provided a health promotion intervention that reflects relevant personal issues.	75.00**	62.50*	100.00**	100.00**
⁶ There is a partnership between the nurse and the multidisciplinary team.	75.00**	75.00**	83.50**	89.00**

Note: The number of raters during Phase 1 and Phase 2 were 4 and 3, respectively. Files (n=4) were rated on each day of the two Phases, except on day 2 of Phase 2 when a smaller number of files were rated (n=3). *p<0.05 **p<0.01.

¹Tangata whaiora' is the Maori term that refers to all consumers, users, and patients of the mental health service. The term 'Maori tangata whaiora' refers to mental health consumers of Maori ethnicity.

¹²³⁴⁶ relate to ANZCMHN (1995) Standards of Practice 1, 2, 3, 4, and 6, respectively, indicating the ANZCMHN Standard to which each statement most applies.

The dissonance between raters, caused by difficulty in identifying cultural issues, illustrates the importance of having clearly defined rules for determining whether or not a clinical indicator statement has occurred in a file.

Disagreement between raters can occur because of inter-rater differences or variability in methods of rating (Shaughnessy and Zechmeister 1997). Mainly because of greater sophistication in the method of rating the status of clinical indicator statements, agreement between raters increased over the two Phases. Increased levels of agreement may also have been caused by a training effect, as the raters became more familiar with looking for the clinical indicator statements in consumers' files (Judd et al 1991). Steps taken to increase rater agreement were:

- the elimination of value-laden words;
- the development of rules for interpreting the status of each clinical indicator statement;
- the recording of specific nursing behaviours from consumers' case notes that would indicate a clinical indicator statement had been achieved;
- the recording of where evidence of each clinical indicator statement might be found in consumer case notes;
- the development of precise definitions of key terms or phrases within the clinical indicator statements; and,

- the provision of clear rationales for each statement to illuminate the basic principles inherent in the clinical indicator statements and their importance to quality mental health nursing practice.

An Audit Guidebook (O'Brien et al 2002d) was developed for use in conjunction with the CNCI audit booklet. A page from the Audit Guidebook is reproduced in figure 1 to illustrate the level of detail regarding rules and rationale for determining occurrence of each clinical indicator statement. Such detailed information facilitated the improvement of the inter-rater reliability of the clinical indicator statements.

A factor that affected the level of rater agreement, over which the raters had no control, was the varying quality of nurses' documentation in consumer case notes. There was only partial evidence of achievement of clinical indicator statements in some files because of poor documentation by nurses, and, in other cases, it was not possible to discern whether specific entries in the case notes were nurses' notes because there was no designation identification for the entry. Incomplete or ambiguously recorded entries in the case notes increased the degree of rater interpretation and judgement that was required regarding clinical indicator statement occurrence.

The method used in this study to determine inter-rater reliability may be appropriate in other situations where conventional methods are inappropriate. Like all measures of inter-rater reliability, however, obtaining an

Figure 1: Audit guidelines for CNCI 1.

CNCI 1: Tangata whaiora/consumer is given a choice of whether they want their cultural issues addressed.	
Rationale	All tangata whaiora/consumers have the right to choose to have cultural issues addressed; nurses should be mindful of sexual orientation, gender, age/generation, ethnicity or migrant experience, religion/spirituality, occupation and socio-economic status and disability.
Definition of Terms	Choice - The opportunity to make a decision in any direction without coercion, inducement or imposed bias. Right of self determination. Cultural issues - All of the issues identified by tangata whaiora/consumers that arise from cultural identity/background. Addressed - Demonstrates that the nurse has taken action to enable the person the opportunity to make a choice about cultural issues. Cultural issues are acknowledged and responded to within the episode of care.
Type of Indicator	A critical rate-based event assessing whether choice of having cultural issues addressed is provided or not.
Suggested data sources	Clinical nursing notes - clinical progress notes, nursing assessment forms and care plans; and nursing cultural assessment documentation. The range of cultural issues for example, could include a person with HIV, a young person with a cultural identity crisis, or a person identifying as a particular ethnicity.
Numerator	Number of files where tangata whaiora/ consumer has been given a choice of cultural issues being addressed.
Denominator	Total files audited
RULE:	If 1 is YES, also answer 18. Clinical notes must provide clear evidence of a choice being given to identify cultural issues and this includes the nurse's recording of an issue such as ethnicity. A person has the right to identify or not identify their particular ethnicity.

From *Clinical indicators for mental health nursing standards of practice in Aotearoa/New Zealand: Consumer notes clinical indicators audit guide*. (p.6), by O'Brien et al 2002b, Palmerston North: Massey University. Copyright 2002 by Massey University. Adapted with permission.

adequate number of ratings is important. With an adequate number of ratings the statistic is useful when there are multiple raters and nominal rating categories. This method only gives an indication of the likelihood that the agreement was due to chance, however. Attention should also be paid to the magnitude of agreement because this statistic is vital for determining whether a measure can be used consistently across cases.

CONCLUSION

This paper has presented a method for determining the inter-rater reliability of a measure when there are multiple raters, nominal rating categories, and several cases being rated. Application of this inter-rater reliability method, in the O'Brien et al (2002a, 2003) pilot study, confirmed the reliability of the 25 clinical indicator statements in the CNCI audit booklet (O'Brien et al 2002b) as measures for the achievement of mental health nursing practice standards. When auditing consumer case notes for documented evidence of specific nursing practices having occurred, inconsistencies between raters were greatly reduced by the determination of strict rules regarding what constitutes 'achievement' of the clinical indicator statements, and clear definitions of all terms. The reliability of measures that audit consumer case note documentation will be strengthened when nurses document their practice more clearly, and include their designations with their signatures in the files. Further research is recommended to establish national benchmarks of the rate of occurrence of the clinical indicators in clinical practice, and to ascertain what low and high rates of occurrence mean in terms of consumer outcomes.

REFERENCES

- Australian and New Zealand College of Mental Health Nurses Inc. (ANZCMHN). 1995. *Standards of practice for mental health nursing in New Zealand*. Greenacres. South Australia: ANZCMHN.
- Agresti, A. 1992. Modelling patterns of agreement and disagreement. *Statistical Methods in Medical Research*. 1:201-218.
- Banerjee, M., Capozzoli, M., McSweeney, L. and Sinha, D. 1999. Beyond kappa: A review of interrater agreement measures. *The Canadian Journal of Statistics*. 27:3-23.
- Bloch, D.A. and Kraemer, H.C. 1989. 2x2 kappa coefficients: Measures of agreement or association. *Biometrics*. 45:269-287.
- Cohen, J. 1960. A coefficient of agreement for nominal scales. *Educational and Psychological Measurement*, 20:37-46.
- Gaskin, C.J., O'Brien, A.P. and Hardy, D.J. 2003. The development of a professional practice audit questionnaire for mental health nursing in

- Aotearoa/New Zealand. *International Journal of Mental Health Nursing*. 12:259-270.
- Hardy, D.J., O'Brien, A.P., Gaskin, C.J., O'Brien, A.J., Morrison-Ngatai, E., Skews, G., Ryan, T. and McNulty, N. In press. The Delphi prioritisation of New Zealand mental health nursing clinical indicators: A bi-cultural study. *Journal of Advanced Nursing*.
- Judd, C.M., Smith, E.R. and Kidder, L.H. 1991. *Research methods in social relations*. 6th edn. Fort Worth, TX: Holt, Rinehart and Winston.
- Ministry of Health. 2002. AIM: Advice to the Incoming Minister of Health. Retrieved October 11, 2002 from <http://www.moh.govt.nz>.
- Nelson, J.C. and Pepe, M.S. 2000. Statistical description of interrater variability in ordinal ratings. *Statistical Methods in Medical Research*. 9:475-496.
- O'Brien, A.P., O'Brien, A.J., McNulty, N.G., Morrison-Ngatai, E., Skews, G., Ryan, T., Hardy, D.J., Gaskin, C.J. and Boddy, J.M. 2002a. *Clinical indicators for mental health standards of practice in Aotearoa/New Zealand: A report to the Health Research Council of New Zealand*. Palmerston North. New Zealand: Massey University.
- O'Brien, A.P., O'Brien, A.J., McNulty, N.G., Morrison-Ngatai, E., Skews, G., Ryan T., Hardy, D.J., Gaskin, C.J. and Boddy, J.M. 2002b. *Clinical indicators for mental health nursing standards of practice in Aotearoa/New Zealand: Consumer Notes Clinical Indicators audit booklet*. Palmerston North. New Zealand: Massey University.
- O'Brien, A.P., O'Brien, A.J., McNulty, N.G., Morrison-Ngatai, E., Skews, G., Ryan T., Hardy, D.J., Gaskin, C.J. and Boddy, J.M. 2002c. *Clinical indicator statements for mental health nursing standards of practice in Aotearoa/New Zealand: A guide to the Professional Practice Audit Questionnaire*. Palmerston North. New Zealand: Massey University.
- O'Brien, A.P., O'Brien, A.J., McNulty, N.G., Morrison-Ngatai, E., Skews, G., Ryan T., Hardy, D.J., Gaskin, C.J. and Boddy, J.M. 2002d. *Clinical indicators for mental health nursing standards of practice in Aotearoa/New Zealand: Consumer Notes Clinical Indicators audit guide*. Palmerston North. New Zealand: Massey University.
- O'Brien, A.P., O'Brien, A.J., Hardy, D.J., Morrison-Ngatai, E., Gaskin, C.J., Boddy, J.M., McNulty, N., Ryan, T. and Skews, G. 2003. The New Zealand development and trial of mental health nursing clinical indicators - A bicultural study. *International Journal of Nursing Studies*. 40:835-861.
- Pearson, K. 1900. Mathematical contribution to the theory of evolution VII: On the correlation of characters not quantitatively measurable. *Philosophical Transactions of the Royal Society of London. Series A: Containing papers of a mathematical or physical character*. 195:1-47.
- Polit, D.F. and Hungler, B.P. 1999. *Nursing research: Principles and methods*. 6th edn. Philadelphia: Lippincott-Williams & Wilkins.
- Shaughnessy, J.J. and Zechmeister, E.B. 1997. *Research methods in psychology*. 4th edn. New York: McGraw-Hill.
- Shrout, P.E. and Fleiss, J.L. 1979. Interclass correlations: Uses in assessing rater reliability. *Psychological Bulletin*. 86:420-428.
- Statistics New Zealand. 2001. Resident Maori population estimates as at 30 June 2001. Retrieved December 21, 2001 from http://www.stats.govt.nz/domino/external/web_prod_serv.nsf/8048d3976fd325824c2567e2000de0fc276502b12a6e113bcc256942008080608FILE/alltbls5.xls.
- Szalai, J.P. 1993. The statistics of agreement on a single item or object by multiple raters. *Perceptual and Motor Skills*. 77:377-378.
- Szalai, J.P. 1998. K_{appbc} . A measure of agreement on a single rating category for a single item or object rated by multiple raters. *Psychological Reports*. 82:1321-1322.
- Tanner, M.A. and Young, M.A. 1985. Modelling agreement among raters. *Journal of the American Statistical Association*, 80:175-180.
- Uebersax, J.S. and Grove, W.M. 1990. Latent class analysis of diagnostic agreement. *Statistics in Medicine*. 9:559-572.

METROPOLITAN REGIONAL DIFFERENCES IN PRIMARY HEALTH CARE OF POSTNATAL DEPRESSION

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ABSTRACT

This study examines the psychological and social aspects of the transition to motherhood by primiparous women, including care received, in two regions of suburban Melbourne, Australia. Two hundred and thirteen women were recruited from antenatal clinics in the regions and completed questionnaires at 24 weeks gestation, six weeks, four months and nine months postpartum. Maternal child health nurses were also asked to complete questionnaires on services in their region. Rates of distress decreased over time in the eastern affluent established region, but increased in the western rapidly developing region. For women in both regions, satisfaction in their relationship with their partners decreased. A previous history of mental illness, lower social integration and cultural background were predictors of distress. Nurses in the west reported high stress and less satisfaction from their clientele. Results highlight the need for health planning related to childbirth in developing regions.

INTRODUCTION

In the past 10 years there have been major changes in the delivery of obstetric services. A recent Victorian (Australia) survey showed that shared care, between obstetricians and general practitioners, had increased from 2 to 16%, private maternity admissions had fallen from 59 to 36%, and length of stay had reduced, with some 38% of mothers leaving on day one compared to 20% in 1989 (Brown et al 2001).

The current literature is undecided on whether these changes themselves are linked to a risk of depression (Hickey et al 1997; Brown et al 1998). Research does show a number of major categories of risk factors that predispose vulnerable mothers to depression following childbirth, which may be impacted on by these service changes. These include stressful life events, marital discord and lack of support (O'Hara et al 1991; O'Hara and Swain 1996; Dennerstien et al 1989).

Some studies have identified low socio-economic status and low educational attainment (O'Hara and Swain 1996; Campbell et al 1992) as other risk factors for postnatal depression. Moreover, these may influence depression independently (Gurel and Gurel 2000; Bergant et al 1999). These findings are in keeping with landmark studies on social factors linking social class and having three children under the age of 11 years, (Brown et al 1977), with increased risk of depression. Other studies have shown associations with poor social network, low education and neglectful mothers (Wadsby et al 1996; Coohy 1995). Of concern, these risk factors may also impede access to supports when, and if, they are available. These are also the families who are least able to access supports (Coohy 1995).

Up to 50% of Victorian mothers reported that after discharge they were not able to access the support they needed (Brown et al 2001). It is unclear whether this is because of lack of knowledge of the supports by women or their health professionals, or lack of suitable resources, but women with postnatal depression appear to be the most likely to be unsatisfied (Webster et al 2001). Given that postnatal depression affects around 14% of Australian mothers (Brown et al 2001; Dennerstein et al 1989) this is worrying, as studies suggest lack of support is an important risk factor, and is likely to prolong distress (O'Hara and Swain 1996). Studies also suggest a detrimental effect of maternal depression on mother-infant relationship and child outcome so this has a potentially wide-ranging impact (Beck 1998; Murray et al 1996). The most needy women, from impoverished social backgrounds and families with poor parenting role models, are the most at risk of both depression and the longer-term poor outcomes for the child (Buist 1998; Buist and Janson 2001).

Research findings suggest that depression postpartum can be readily identified by community nurses (Cox et al 1987; Elliot and Leverton 2000; Milgrom et al 2002) and that general practitioners are also able to identify and manage depression (Holden et al 1989). However, it appears this only occurs if the health professionals have specific training, which in postnatal depression is particularly important given mothers who are depressed may present for reasons external to their own needs eg infant health problems (Mandl et al 1999). Treatment studies in postnatal depression are limited, but suggest that similar interventions to those for depression are effective, including psychological therapies and antidepressant medication, but also stress the need for ongoing support (Mandl et al 1999; Milgrom et al 2002; O'Hara et al 2000; Appleby et al 1997; Hendrick et al 2000).

However, many of these studies are often divorced from what is practical and feasible in a clinical setting, either because they use research and psychology staff not available outside the scope of the study, or because the training requirements are too stringent and unrealistic in the light of the work load of clinical staff. In Victoria, Australia, the key health professional involved with most, if not all, postnatal women is the maternal child health nurse, who has generally had some training in the assessment of postnatal depression and in many cases screen routinely (Buist et al 2002). Through the birth registry, all babies born are attempted to be visited at least once; whilst many women also see their general practitioner, some see an obstetrician for their postnatal check, and mental health issues are not always identified (Hearn et al 1998).

This research project aims to look at the influence of social factors in the women's psychological transition to motherhood and the maternal and child health nurse's (MCHN) ability to identify and refer mothers with postnatal depression. It was hypothesised that the two

regions' differing socioeconomic profiles and support available would impact on the mother's psychological wellbeing. Another paper reports on the outcomes of the MCHN identification and attempts to improve it (Morse et al 2004).

METHOD

This study involved 243 women recruited from antenatal clinics at four major public obstetric hospitals in Melbourne, covering two regions, one western, one eastern. According to the Australian Bureau of Statistics 1996 Census of Population and Housing the residents in the western region have a median income ranging from \$201-\$345 per week, a mean age of 31 years and 38% speak a language other than English at home. This region was characterised by rapid, recent development, with new housing estates and the recent introduction of a new public maternity hospital, with few general medical practitioners (GPs) and no private psychiatrists at this time. The eastern region was characterised by established maternity hospitals (private and public) and established housing and major shopping centres, with general medical practices and private psychiatry consulting suites located close by. In the eastern region, residents have a median income ranging from \$313 to \$420 per week, a mean age of 35 years and 15% speak a language other than English at home.

All MCHN who serviced the eastern and western areas involved were also invited to participate. Human research and ethics committees at each of these hospitals and the universities of the chief investigators approved the project.

Participants

Participants were English speaking, first time mothers (n=243), in a relationship with the father of the infant for one year or more, with no major past psychiatric history that was currently being treated, attending their first antenatal appointment.

Interviews were conducted at 24 weeks gestation, and for those mothers who were identified as depressed, follow up interviews were also conducted and referrals given at nine months postpartum. Measures were completed at 24 weeks gestation (Time 1 by interviewer), six weeks postpartum (Time 2 by MCHN), four months (Time 3 by post with telephone contact) and nine months postpartum (Time 4 by post and selected interviews).

Measures

Interview (Time 1 and 4 - selected cases)

Mothers were interviewed using a semi-structured interview, assessing demographic details (age, occupation, marital status, education, partner's education and occupational status) and inclusion criteria.

Measures completed by mothers (Time 1-4)

Mothers were asked to complete the following measures:

The Edinburgh Postnatal Depression Scale (EPDS) (Cox et al 1987) is a widely used 10 item-screening tool developed for postpartum depression with high validity and specificity, also standardised in an Australian population (Murray and Carothers 1989). This was administered by the MCHN at Time 2 at six weeks postpartum. A threshold score of ten was utilised to indicate distressed mood or dysphoria; this has been shown to have 89-90% sensitivity and 82-84% specificity for detection of distressed/depressed cases in community samples (Cox et al 1987; Boyce et al 1993; Murray and Carothers 1989; Harris et al 1989; Murray and Cox 1990) and has also been validated for antenatal use (Murray and Cox 1990). Those mothers who had high EPDS scores (>10) at any assessment were interviewed at Time 4 by a psychiatrist and follow up where appropriate was offered.

The Social Provisions Scale (SPS) (Cutrina 1984) covers six components of social support: integration, reassurance of worth, reliable alliance, guidance and opportunity for nurturing. High scores on subscales indicate that the respondent receives that provision from her current social relationships. Several studies have demonstrated the construct and discriminant validity of the scale and good test retest reliability (Cutrina 1984).

The Experience of Motherhood scale (Astbury et al 1994) measures the self-perceived level of coping and emotional well being associated with the experience of motherhood in mothers with small children. Mothers rate their agreement with 20 statements on a four-point scale. Internal reliability has been found to be good with alpha of 0.79.

Mothers responded on five-point Likert scales on two sub-scales of the Parenting Stress Index (PSI) (Abidin 1983). High Scores on the 'Child Reinforces Parent' sub-scale indicate that the parent does not experience her child as a source of positive reinforcement. Internal consistency for this sub-scale is excellent 0.97. High scores on the 'Parent Attachment' sub-scale indicate that the parent does not feel a sense of emotional closeness to the child, and/or the parent feels unable to read and understand the child's feelings and/or needs. The PSI has shown good concurrent, construct, and discriminant validity, with good test retest reliability across a number of studies.

The Short Form of the Spanier Dyadic Adjustment Scale (DAS) (Spanier 1976) developed on Australasian samples, is a seven item five-point scale that purports to measure spousal adjustment and satisfaction with the relationship quality. Internal consistency is high with alpha=0.90.

Measures completed by mothers and service providers (Time 4)

All MCHNs were asked to complete a service satisfaction survey. This inquired into services available for mothers with postnatal depression in their area, the ease of accessing these services and how helpful they were. Women were also asked about services they had accessed and how satisfied they were with these.

Data analysis

A number of chi-square analyses and independent t-tests were conducted to examine whether there were any differences between mothers in the east and west on any of the separate demographics measured, and on the care they received from professionals in the postnatal period.

First, a series of repeated measures, ANOVAs, were conducted on the psychological and psychosocial measures reported by all mothers at each assessment. Then we focused on those who were distressed (EPDS >10) in pregnancy and in the first six weeks after birth. To do this a separate series of repeated measures, ANOVAs, was conducted on the psychological and psychosocial measures at each assessment on this distressed group.

All variables were normally distributed except SPS-Reliable Alliance, which had a skewness of just greater than two, however transformations did not alter distribution significantly.

Forward logistic regressions were also performed, controlling for sector and distress at Time 1 and 2 and identifying predictors of distress at Times 3 and 4.

RESULTS

The study recruited 243 women. Twenty-four mothers completed the first assessment only and six others were incomplete, resulting in 213 women being included in the final analysis. There were 137 women in the west and 76 women from the east. Seventy three percent of western and 80% of eastern region mothers returned all questionnaires. Over time there was a greater attrition rate in the west; at Time 2, 95% (n=130) mothers in the west and 92% (n=70) in the east returned questionnaires, at Time 3, 86% (n=118) in the west and 92% (n=70) in the east, at Time 4, 79% (n=108) in the west and 91% (n=69) in the east.

Demographics

Though there was no difference between mothers in the west and east on maternal age (26.7 years in the west, 27.3 years in the east), educational or occupational levels, there were differences on definition of marital status. More mothers were in a defacto relationship in the east, and mothers in the west were more likely to report being 'engaged'. Mothers and their partners in the west and east differed on occupation with both genders in the west more likely to be in semiskilled clerical/trade work and in the east, in professional occupations (table 1).

Table 1: Maternal demographics

	west n=105-137 % (n)	east n=76 % (n)
Marital status		
Married	77 (106)	77 (58)
Engaged	12** (16)	1 (1)
Defacto	11** (15)	22 (17)
Education		
≥ Bachelor degree	15 (21)	24 (18)
Certificate/Diploma	22 (30)	17 (13)
Trade/Apprenticeship	3 (4)	4 (3)
Secondary	60 (82)	55 (42)
Unemployed	31 (42)	26 (20)
Occupation		
Professional	9 (9)	27* (15)
Semi-professional	24* (24)	21 (12)
Clerical/Trade	58* (57)	41 (23)
Other	9 (9)	11 (6)
Ethnic background		
Australasian	84 (115)	88.2 (67)
Asian	6.5 (9)	2.6 (2)
European	6.5 (9)	7.9 (6)
Other	3 (4)	1.3 (1)

Key: top number = correlation coefficient; bottom number = significance;

* Pearson's correlation; • Spearman's correlation

Chi Square tests cp west to east

* p<0.05; ** p<0.01

Psychological distress

Rates of distress (EPDS >10) remained stable in the mothers from the west over time. In contrast, rates of distress in the mothers from the east reduced markedly from the antenatal assessment to six weeks postpartum and then to three months postpartum, with a slight increase at the nine-month postpartum assessment. Significantly more women in the west were continuously in the distressed range across assessments (table 2). Mothers from the west had lower rates of distress antenatally, but higher than mothers in the east at all postnatal assessments; this reached statistical significance at three months postpartum (p<0.01), when the cut off for a likely major depressive illness was considered, using EPDS scores >12 - rates ranged from a low of 12.4% antenatally to a high of 13.6% at the three-month postnatal review in the mothers from the west, and 11.1% antenatally to 7.2% six weeks postnatally from those in the east.

When group mean EPDS scores were assessed on a time by sector repeated measure ANOVA, an effect of both time (p<0.01) and sector (p<0.05), without interaction was found. Posthoc univariate analyses showed a significantly higher mean score in the west at Time 1 and Time 3.

Six mothers scored an EPDS >18, and all were referred to the specialist service (all by the research assistant). Only the mothers in the east (two) took up this offer; the mothers in the west refused, citing distance as a barrier.

Social functioning

A series of repeated measure ANOVA were conducted using the Social Provisions Scale (SPS) (Cutrina 1984) and the Dyadic Adjustment Scale (DAS) (Spanier 1996) (table 3). Significant group differences were found for four SPS subscales. Means scores indicated that the mothers from the east had higher scores on the SPS-social integration and the SPS-reassurance of worth between the groups at Time 3, and the SPS attachment at Time 1 and Time 3. All but two subscales (reassurance of worth, reliable alliance) decreased significantly over time but with no group by Time interactions.

The mothers' DAS scores reduced significantly (decrease in marital function) in both groups from Time 1 to Time 4 and Time 3 to Time 4, with no difference between groups and no group by Time interaction. For the male partners there was a significant reduction in scores on the DAS from Time 1 to Time 4, and from Time 3 to Time 4.

Parenting role

Repeated measures (ANOVA) were conducted on the EMQ and the two subscales of the PSI. There were significant reductions over time in the EMQ and the PSI-reinforce parent for both groups but between group difference using the posthoc Bonferroni adjustment (p<0.025) on the EMQ at Time 3 only, the higher score indicating more difficulties were reported in the mothers from the west.

No difference was found between mothers in the west and east on help-seeking behaviour or satisfaction with services. The MCHN was the person most likely to be asked for help, with infant sleeping difficulties being the most common reason, followed by feeding difficulties. Eighty two per cent of mothers from the west and 81% of mothers from the east were fairly or very satisfied with the assistance received.

Predictors of distress

Using logistic regression, predictors of distress at Time 3 were examined (55% correct classification of distressed cases, 98% correct classification of non-distressed cases) and found that only a previous history of mental illness (other than major current psychiatric disorder, which was an exclusion criteria) was significant. Those with a history of mental illness were nearly nine times more likely to be distressed at Time 3, (OR 8.853, 95% CI, 0.825; 95.044). Of the variables that were controlled for, previous distress levels at Time 1 and Time 2 significantly predicted distress at Time 3, but group membership and sector were not significant.

When examining predictors of distress at Time 4 (71% correct classification of distressed cases, 98% correct classification of non-distressed cases) these included self-reports of lower social integration (SPS), older age (>30 years) and a previous history of mental illness. Mothers

with a past history were 168 times more likely to be distressed at Time 4 (OR 168.46, 95% CI: 7.95; 3533.3) than those without a past history. Asian born mothers were less likely to be distressed, (OR 0.027, 95% CI: 0.001; 0.996), and those born in miscellaneous regions other than Australasia, Asia and Europe were almost 13 times more likely to be distressed, (OR 12.736, 95% CI: 0.907; 170.63). Those women who were married were less likely to be distressed (OR 0.051, 95% CI: 0.006; 0.536). Of the variables that were controlled for, only distress at Time 1 significantly predicted distress at Time 4, while group membership, sector, and distress levels at Time 2 were not significant.

Maternal and child health nurses

Thirty-one MCHNs from the west and 11 from the east were involved in the study; responses were received from only 11 (33%) in the west and seven (75%) in the east. All were positive about their involvement in the study. Seven nurses from the west and three nurses from the east had at least one woman with an EPDS score of 13-17; five nurses from the west and one nurse from the east were involved with at least one woman with an EPDS score of 18 or more. Eight of the MCHNs from the west were dissatisfied or very dissatisfied with the current supports for PND provided in their region, with concerns about lack of services and long waiting periods for admission featuring strongly in their qualitative reports. Six of the nurses from the east were satisfied with the supports in their region, with five commenting on the recent improvements in care provided by GPs. Nine of the nurses from the west rated 13 aspects of their job as very demanding; the nurses from the east reported only two aspects. At the time of this study a New Initiatives Project was implemented by the Victorian Department of Human Services (Australia), providing increased funding for vulnerable families. It would have been expected that the west would have benefited, and client numbers were reported to be stable, further suggesting the importance of the lack of external supports.

DISCUSSION

In this paper the psychological and social aspects of primiparous postnatal mothers and service delivery by MCHNs in two different regions of suburban Melbourne, Victoria, were examined.

At the outset, these mothers and their partners from each region differed on occupational level and definition of marital status. The latter may be of relevance though the actual percentage in the two groups who were married was identical. The difference seems to arise from the preferred terminology of *de facto* versus *engaged*. This may reflect different attitudes or relationship stability but can only be speculated upon. That being married reduced the risk of distress by half in the predictive model suggests some importance of marital status and fits with

O'Hara and Swain's (1996) redefinition of what type of social support and stability is important. Otherwise the groups were comparable on age, ethnic background, and education. Rates of distress using the EPDS of >10 were high (nearly a third of women) antenatally for both groups, in keeping with other studies using the Edinburgh Postnatal Depression Scale antenatally. This finding raises the possibility that it is identifying antenatal anxiety as much as depression (Evans et al 2001). Of note, the groups differed on their close social ties and ability to make use of them, the mothers in the east appearing more supported.

Postnatally, rates of distress remained high in the west (24.8% to 28% west compared with 11.4% to 33.3% east) across all assessments, with more mothers who were distressed at more than one assessment (7.3% to 14.7% in west compared with 1.5% to 8.6% in east), though numbers were low in the east. The actual means of the EPDS for the distressed group tended to be higher in the east (4.6 to 14.6 in the east, 6.6 to 13.5 in west) but this may be because of a higher retention rate in these mothers. This may mean that in the west, mothers who dropped out may have had a higher level of depression - which would further broaden the gap between the two areas.

Ethnicity was seen to be a strong prediction of postnatal distress; those from Asian backgrounds being less likely to be distressed, which might reflect the close knit social structure and support of these communities, or also that they are more established in the community. Alternatively, stigma in these cultures may mitigate against admitting depression and the tools used may not have been appropriate to these cultures (the English version of the EPDS being used). This effect of Asian ethnicity differs from an earlier study (Morse et al 2000) carried out in the same east region of the city where those who self-identified as of non-specific Asian background were significantly more likely to be distressed/depressed. Other migrants were at significantly higher risk of distress, possibly reflecting lack of supports for newer arrivals in the country.

Mothers in the west also continued to rate lower most aspects of their social networks than the mothers from the east. They struggled more with adjustment to motherhood at Time 3; it may well be that this would also have continued to be significant at Time 4 but at this time the attrition rate was double that of the mothers in the east and between-group findings must be viewed carefully. These difficulties adjusting to motherhood appears consistent with the greater distress and lower capacity to utilise supports. In both western and eastern groups, the male partners rated deterioration in marital satisfaction occurring postpartum.

Despite these differences, mothers in the west were not differentiated from the eastern mothers on the subscales of the PSI. This may be because the two subscales, which were only used as an indicator, were not sufficiently sensitive; this would also have been affected by the high

attrition rate in the west. Use of the whole scale may have been beneficial, but cumbersome given the length and the other questionnaires completed. Scores on the EMQ suggested that mothers from the west reported more difficulties in adjusting to motherhood, indicating also that this is an area worth further examination.

One of the main limitations was the substantial attrition rate of respondents. It may be that the most distressed were represented in this group and thus have been missed. In the case of the MCHNs, from those who did respond, there are suggestions that the low response rate from the nurses in the west was due to work stress and overload. Of concern also, was the lack of referrals of those more distressed mothers to specialist services as in all cases referral was carried out by the research assistant. This may relate to the design of the study, the reluctance of the mothers or again, to the high workload of the nursing staff. Further evaluations of the level and causes of stress in the MCHN, given the regional differences, would have been worthwhile and a direction for potential future research.

Oldenburg (1972) noted that tackling socioeconomic health inequalities represented one of Australia's most challenging public health issues. It still appears to be the case. Relatively minor inequalities were evident in the mothers in these areas prior to childbirth, but differences became accentuated following the arrival of their child as reflected by distress levels. Given the major difference in the supports of the regions identified by the MCHN, these findings may suggest the importance of supports in mediating the distress. The major difference between these two regions was the wealthier, older population and established obstetric and auxiliary services in the east, versus a new maternity hospital and a relatively isolated, rapidly growing region in the west, which has been slow to attract medical and health practitioners and establish

services. In this study, the health care needs of the mothers in the west were not being met and as a result the transition to parenthood by these mothers was problematic or compromised, with the potential for ongoing ramifications of marital problems and child behavioural and/or cognitive delays (Beck 1998). The importance of supports may also be a key issue that needs closer examination, particularly in those mothers from other cultural backgrounds.

In the planning of obstetric services, the region had managed with the delivery needs, but has failed to take into account the emotional needs of mothers. This dissociation between the physical obstetric needs and the emotional needs of motherhood in services has been noted before (Oldenburg 1972) and has been highlighted in a recent survey of mothers (Brown et al 2001) where nearly half the mothers were unhappy with their postnatal support. In regions where there are fewer services, this dissatisfaction is likely to be higher. Our findings, along with Brown et al's 2001 survey results, suggest an urgent need for obstetric services to work in conjunction with psychological services, for optimum outcomes from an early planning level onwards.

Future directions

This study highlights some of the specific needs and difficulties for mothers having children in lower socioeconomic areas where supports are limited. Two recent postnatal tragedies of suicide and infanticide, one in this western region, and another in a similar satellite new suburb of Melbourne, have highlighted the issues of social isolation and difficulties for these women to access supports. Further examination of these needs is indicated - and an examination of how best to meet them.

Table 2: Rates of distress on EPDS between west and east

	West mean EPDS (sd)	West % distressed (n)	West % cts distress (n)	East mean EPDS (sd)	East % distressed (n)	East % cts distress (n)
26 weeks	6.9 (4.6)	(137)	Time 1	6.1 (4.5)	(72)	Time 1
EPDS >10	13.1 (2.9)	26.3 (36)	26 (36)	12.3 (2.1)	33.3 (24)	33.3 (24)
6 weeks pp	7.0 (4.8)	(130)	Time 1 and 2	5.7 (4.0)	(70)	Time 1 and 2
EPDS >10	13.5 (3.4)	25.4 (33)	12.3 (16)	12.3 (2.2)	18.6 (13)	8.6 (6)
3 mths pp	6.7 (4.5)	28** (33)	Time 1, 2, 3	5.6 (4.4)	(70)	Time 1,2,3
EPDS >10	12.6 (2.3)		10.2 (12)	14.6 (5.0)	11.4 (8)	4.3 (3)
9 mths pp	6.6 (4.7)	(109)	Time 1, 2, 3, 4	4.6 (4.6)	(68)	Time 1, 2, 3, 4
EPDS >10	13.2 (2.8)	24.8 (27)	7.3 (8)	13.6 (3.1)	16.2 (11)	1.5 (1)
EPDS >10			11.9 (13)			Time 2, 3, 4, 1.5 (1)
EPDS >10			14.7 (16)			Time 3 and 4, 1.5 (1)

Chi square analysis * $p < 0.05$; ** $p < 0.01$

Table 3: Repeated measures ANOVAs - Means of psychosocial and parenting factors across eastern and western sectors

	Time 1 mean (SD)		Time 3 mean (SD)		Time 4 mean (SD)		Sector F value
	west	east	west	east	west	east	
Social Provisions Scale							
Attachment	14.48 (1.71)a	15.04 (1.21)b	14.01 (-1.65)a	15.05 (1.84)b	13.71 (2.14)	14.30 (2.19)	9.66**
95% CI	(-1.04, -0.07)		(-1.65, -0.42)		(-1.27, 0.09)		
Social integration	13.59 (1.58)	14.13 (1.65)	12.98 (2.03)a	13.86 (2.05)b	13.13 (2.06)	13.77 (2.01)	7.40**
95% CI	(-1.04, -0.03)		(-1.52, -0.24)		(-1.28, 0.01)		
Reassurance of worth	13.16 (1.61)a	13.78 (1.77)b	13.05 (2.05)a	14.03 (1.82)b	13.10 (2.14)	13.69 (1.71)	9.08**
95% CI	(-1.15, -0.10)		(-1.60, -0.36)		(-1.20, 0.03)		
Reliable alliance	14.86 (1.67)	15.10 (1.50)	14.87 (1.58)	15.25 (1.26)	14.70 (1.83)	15.30 (1.44)	3.99*
95% CI	(-0.74, 0.27)		(-0.84, 0.08)		(-1.13, -0.07)		
Guidance	14.80 (1.46)	15.16 (1.37)	14.60 (1.87)	15.01 (1.56)	14.26 (1.97)	14.73 (2.14)	3.25
95% CI	(-0.81, 0.09)		(-0.97, 0.14)		(-1.11, 0.17)		
Opportunity for nurturance	12.12 (1.87)	12.38 (2.16)	12.86 (2.27)	13.52 (1.86)	13.01 (2.23)	13.61 (2.30)	3.50
95% CI	(-0.88, 0.37)		(-1.32, 0.02)		(-1.30, 0.10)		
Short Form -DAS	31.26 (5.14)	32.61 (4.95)	31.19 (5.15)	32.29 (4.19)	30.45 (5.10)	30.24 (6.11)	1.10
95% CI	(-2.97, 0.27)		(-2.64, 0.44)		(-1.55, 1.98)		
Exp of motherhood			39.86 (6.78)a	36.50 (6.10)b	37.50 (6.99)	35.78 (6.35)	7.32**
95% CI			(1.31, 5.42)		(-0.41, 3.84)		
PSI- child doesn't reinforce parent			9.19 (2.88)	8.87 (2.50)	8.19 (2.97)	7.59 (2.69)	1.54
95% CI			(-0.56, 1.18)		(-0.31, 1.50)		
PSI- Lack of parental attachment			11.16 (3.18)	10.86 (2.85)	11.26 (3.32)	10.52 (3.23)	1.24
95% CI			(-0.67, 1.26)		(-0.30, 1.78)		

Note: Means within same measurement occasion with different subscripts were statistically different (Bonferroni corrected alpha =.025)

*p<0.05, **p<0.01, ***p<0.001

REFERENCES

- Abidin, R. 1983. Parenting Stress Index. *Paediatric Psychology Press*. Virginia. USA.
- Appleby, L., Warner, R., Whitton, A. and Faragher, B. 1997. A controlled study of fluoxetine and cognitive-behavioural counselling in the treatment of postnatal depression. *British Medical Journal*. 314(4):932-936.
- Astbury, J., Brown, S., Lumley, J. and Small, R. 1994. Birth events, birth experiences, social differences and depression after birth. *Australian Journal of Public Health*. 18:176-184.
- Beck, C. 1998. The effects of postpartum depression on child development: A meta-analysis. *Archives Psychiatric Nursing*. 1:12-20.
- Bergant, A., Heim, K., Ulmer, H. and Illmensee, K. 1999. Early postnatal depressive mood: Associations with obstetric and psychosocial factors. *Journal of Psychosomatic Research*. 46(4):391-394.
- Boyce, P., Stubbs, J. and Todd, A. 1993. The Edinburgh Postnatal Depression Scale: Validation for an Australian sample. *Australian and New Zealand Journal of Psychiatry*. 27:472-476.
- Brown, S., Darcy, M. and Bruinsma, F. 2001. *Victorian Survey of Recent Mothers*. 2000. Centre for Mothers and Babies. Latrobe University.
- Brown, G.W., Harris, T. and Copeland, J.R. 1977. Depression and loss. *British Journal of Psychiatry*. 130:1-18.

Brown, S., Lumley, J. and Small, R. 1998. Early obstetric discharge: Does it make a difference to health outcomes? *Paediatric and Perinatal Epidemiology*. 12:49-71.

Buist, A. 1998. Childhood abuse, postpartum depression and parenting difficulties: A literature review of associations. *Australian and New Zealand Journal of Psychiatry*. 32:370-378.

Buist, A., Bamett, B., Milgrom, J., Pope, S., Condon, J., Ellwood, D., Boyce, P., Austin, M.P. and Hayes, B. 2002. To screen or not to screen - that is the question in perinatal depression. *The Medical Journal of Australia*. 7/10/2002:S101-S105.

Buist, A. and Janson, H. 2001. Childhood abuse, parenting and postpartum depression: A three year follow up study. *Child Abuse and Neglect*. 25:909-921.

Campbell, S., Cohn, J., Flanagan, C., Popper, S., and Meyers, T. 1992. Course and correlates of postpartum depression during the transition to parenthood. *Development and Psychopathology*. 4:29-47.

Coohey, C. 1995. Neglectful mothers, their mothers and partners: The significance of mutual aid. *Child Abuse and Neglect*. 19(8):885-895.

Cox, J., Holden, J. and Sagovsky, R. 1987. Detection of Postnatal Depression: Development of the 10-item Edinburgh Postnatal Depression scale. *British Journal of Psychiatry*. 150:782-6.

Cutrina, C.E. 1984. Social support and stress in the transition to parenthood. *Journal of Abnormal Psychology*. 93:378-390.

- Dennerstein, L., Leher, P. and Riphagen, F. 1989. Postpartum depression - risk factors. *Journal of Psychosomatic Obstetrics and Gynaecology Supplement*. 10:53-65.
- Elliott, S. and Leverton, T. 2000. Is the EPDS a magic wand? A comparison of the EPDS and health visitor report as predictors of diagnosis on the Present State Examination. *Journal of Reproductive and Infant Psychology*. 18:79-95.
- Evans, J., Heron, J., Francomb, H., Oke, S. and Golding, J. 2001. Cohort Study of depressed mood during pregnancy and after childbirth. *British Medical Journal*. 323:257-260.
- Gurel, S.A. and Gurel, H.G. 2000. The evaluation of determinants of early postpartum low mood: The importance of parity and inter-pregnancy interval. *European Journal of Obstetrics and Gynecology*. 91:21-24.
- Harris, B., Hucke, P., Thomas, R., Johns, S. and Fung, H. 1989. The use of rating scales to identify postnatal depression. *British Journal of Psychiatry*. 154:813-817.
- Hearn, G., Iloff, A., Jones, I., Kirby, A., Ormiston, P., Parr, P., Rout, J. and Wardman, L. 1998. Postnatal depression in the community. *British Journal of General Practice*. March:1064-1066.
- Hendrick, V., Altshuler, L., Strouse, T. and Grosser, S. 2000. Postpartum and non-postpartum depression: Differences in presentation and response to pharmacological treatment. *Depression and Anxiety*. 11:66-72.
- Hickey, A.R., Boyce, P.M., Ellwood, D. and Morris-Yates, A.D. 1997. Early discharge and risk for postnatal depression. *Medical Journal of Australia*. 167:244-247.
- Holden, J., Sagovsky, R. and Cox, J. 1989. Counselling in a general practice setting: Controlled study of health visitor intervention in treatment in postnatal depression. *British Medical Journal*. 298:223-6.
- Mandl, K., Tronick, E., Brennan, T., Alpert, H. and Homer, C. 1999. Infant health care use and maternal depression. *Archives of Pediatrics and Adolescents*. 153:808-813.
- Milgrom, J., Negri, L., Ericksen, J., Martin, P., DePaola, C. and McNeill, M. 2002. (In submission). A randomized, controlled trial of non-pharmacological interventions for postnatal depression. *British Journal of Psychiatry*.
- Morse, C., Buist, A. and Durkin, S. 2000. First time Parenthood: Influences on pre and postnatal adjustment in fathers and mothers. *Journal of Psychosomatic Gynaecology*. 21:109-120.
- Morse, C., Durkin, S., Buist, A. and Milgrom, J. 2004 Improving the postnatal outcomes of new mothers. *Journal of Advanced Nursing*. 95(a):1-11.
- Murray, D. and Cox, J. 1990. Screening for depression during pregnancy with the Edinburgh Depression Scale. *Journal of Reproductive and Infant Psychology*. 8:99-107.
- Murray, L. and Carothers, A. 1989. The validation of the Edinburgh Postnatal Depression Scale on a community sample. *British Journal of Psychiatry*. 154(81):3-7.
- Murray, L., Fiori, C., Hooper, R. and Cooper, P. 1996. The impact of postnatal depression and associated adversity on early infant interactions and later infant outcome. *Child Development*. 67:2512-2516.
- O'Hara, M., Schlechte, J.A., Lewis, D. and Varner, M. 1991. Controlled prospective study of postpartum mood disorders: Psychological, environmental and hormonal variables. *Journal of Abnormal Psychology*. 100(1):63-73.
- O'Hara, M., Stuart, S., Gorman, L. and Wenzel, A. 2000. Efficacy of interpersonal psychotherapy for postpartum depression. *Archive of General Psychiatry*. 57:1039-1045.
- O'Hara, M. and Swain, A. 1996. Rates and risk of postpartum depression - A meta-analysis. *International Review of Psychiatry*. 8:37-54.
- Oldenburg, D.P. 1972. *The detection of psychiatric illness by questionnaire*. London. Oxford University Press.
- Spanier, G. 1976. Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and Family*. Feb:15-29.
- Wadsby, M., Sydsjo, G. and Goran, C. 1996. Children of psychosocial risk mothers: Life events, social interaction and behaviour problems at the age of eight. *Scandinavian Journal of Social Medicine*. 24(4):227-236.
- Webster, J., Pritchard, M., Linnare, S., Roberts, J., Hinson, J. and Starrenburg, S. 2001. Postnatal depression: Use of health services and satisfaction with health-care providers. *Journal of Qualitative Clinical Practice*. 21:144-148.

NURSING AND THE DEVELOPMENT OF NURSING EDUCATION IN FIJI

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ABSTRACT

Fiji is one of Australia's Pacific neighbours. Nursing and nurse education in that country is at an exciting stage of development. The Ministry of Health in Fiji has recently introduced new nursing initiatives and is about to introduce a new pre-registered nurse curriculum in 2004. The introduction of the new curriculum will pave the way for the Fiji School of Nursing to merge with the Fiji School of Medicine, part of a more inclusive goal for healthcare education in Fiji. Other initiatives such as the introduction of the nurse practitioner role and nursing competencies have assisted nursing in Fiji to move towards this goal. This paper will explore these new developments in nursing as well as provide an historical account of the development of nursing education in Fiji.

INTRODUCTION

Fiji is a close neighbour to Australia. It is located in the western South Pacific Ocean. The archipelago of Fiji consists of 330 islands of which about 100 are inhabited. The capital, Suva, is on the largest island, Viti Levu - 'Big Island' (Fiji Today 2000). Fiji is once again becoming a popular tourist destination for Australians and many Australians live and work there. The Australian Government supports a number of AusAID ventures in Fiji, including the recently announced Health Sector Improvement Program that has a specific focus on the development of the Fiji School of Nursing. The development of nursing and nurse education in Fiji has taken many different and exciting paths. Currently, the Fiji School of Nursing is about to move into a new era with the introduction of a new basic curriculum in 2004. This will be the first step towards having their course recognised by a tertiary education provider. This paper will provide an overview of the health system in Fiji with particular emphasis on nursing. It will then outline the history of nurse education and provide an overview of the new developments in nursing and nurse education in that country. The paper will also examine the current role of the Fijian nurse regulatory authority.

Description of Fiji

The Fiji Islands is a sovereign democratic state that, prior to the 1987 coup, was a member of the Commonwealth. In 1987, the Fiji Islands officially left the Commonwealth and became a republic. The government is composed of a President, Prime Minister, House of Representatives and Senate. The executive

authority is invested in the President who is appointed by the Great Council of Chiefs (Fiji Today 2000). Fiji is a diverse society. The population of 814,000 is made up of 50.8% indigenous Fijian, 43.7% Indian and 5.5% of people from other backgrounds (WHO 2001a). The religion of the country reflects the cultural diversity. Christians comprise 52.9%, Hindu 38.1%, Muslim 7.8%, Sikh 0.7% and other 0.5%. Almost all indigenous Fijians are Christian with the majority of those being Methodist or Roman Catholic (WHO 2001a).

Description of Ministry of Health

Nursing in Fiji comes under the direct control of the Fiji Ministry of Health (MOH). The Government of Fiji, the principal funder and provider of health services in Fiji, provides preventive, promotive, curative and rehabilitative health services to all citizens via the MOH. All Government health services are free to the public and funded through general taxation. Health services are organised at national, sub-divisional and area levels. The nation is divided into three divisions: Central/Eastern, Western and Northern. The curative services at divisional level are provided by three divisional referral hospitals: Colonial War Memorial Hospital for the Central/Eastern Division in Suva, Lautoka Hospital for the Western Division and Labasa Hospital (on Vanua Levu) for the Northern Division (WHO 2001a). Private health care in Fiji, although limited, is available. Private hospital care in Suva is available at either a modern 40-bed general hospital or a small seven-bed Catholic Church-owned maternity hospital. There are also a number of doctors and dentists who work on a fee-for-service basis.

Disease prevention and health promotion are priorities in Fiji. The primary health care model operates primarily through the operation of a system of health centres located strategically throughout the islands. Most health centres have a doctor attached but some may have the services of a nurse practitioner only (Usher 2001). In rural areas, a more limited service provides for the people's health care. These services are run out of nursing stations, staffed by primary care nurses in most cases. In some of the more remote nursing stations a nurse practitioner may be in attendance.

The health care workforce in Fiji

Currently there are approximately 300 doctors and 1,750 registered nurses (RNs) in Fiji (Fiji MOH personal communication) and a large proportion of the operational budget for health goes towards human resource provision. External migration of health professionals continues to be a problem for the MOH in Fiji (Haddad and Williams 2001). For example, one third of Fiji's doctors left after the two coups in 1987 (Cameron 1989) and another 46 left soon after the 2000 coup (Gounder, January 13, 2001). Large numbers of nurses have also migrated during these turbulent years.

RNs are employed in hospitals, health centres and nurses' stations throughout Fiji. Nurses working in

hospital facilities provide acute care for hospitalised patients as well as providing care to the community via outpatient clinics. Fiji has a well developed primary health care model and the public can receive treatment from nurses and doctors at health centres situated throughout the islands. Nurses' stations are staffed only by RNs and these tend to be located in the more isolated and rural areas of the country. However, there is a fundamental shortage of health care workers.

Retaining highly skilled health workers is also an ongoing problem (WHO 2001b). In order to address the shortages the MOH has introduced a number of strategies, such as the medical assistant model and the Primary Care Provider (PCP), with limited success. Medical assistants were trained at the Fiji School of Medicine (FSM) between 1975 and 1984, with the intention of forming a separate cadre of service providers to fill medical practitioner vacancies at health centres in the rural areas of Fiji (Downes 2001). This strategy proved ineffective. Downes (2001) outlines that as part of the phasing out of medical assistants, a further trial focussing on mid-level provider was undertaken. This role did not prove to be viable either and was phased out after five years.

The introduction of the nurse practitioner (NP) program in 1999 has been one successful strategy that has helped to provide health services to people in remote areas of Fiji (Usher 2001). This workforce strategy has seen health care become more readily available, particularly for people living in the more remote locations of Fiji (Downes 2001). Experienced RNs, who already have midwifery and public health qualifications, are selected to undertake a comprehensive 14-month course. This course includes theory related to pathophysiology, clinical interventions, pharmacology, clinical diagnosis, and patient management. An extended period of attachment to and assessment by a medical officer in an emergency department of a major hospital in Fiji is undertaken (Usher 2001). The NPs work under the guidance of a set of clinical protocols developed by the Fiji Ministry of Health. NPs have already had a significant impact on the availability of a sustainable health care workforce to the people of Fiji, particularly those living in the more remote islands and inland rural areas (Usher and Lindsay in press; Haddad and Williams 2001).

History of nurse education in Fiji

Nurse education initially began in Fiji in 1893 with the first staff nurse completing a nursing program in 1897. In 1907 the first six Fijian nurses qualified and worked as community nurses. The original nursing program conducted in Fiji was of six months duration. The program later increased to one year, then 18 months, two years and finally three years and three months by 1940. The Lautoka School of Nursing was established in 1925 and remained as a school of nursing until 1987 when it merged with the Central Nursing School (now known as the Fiji School of Nursing, FSN) as a means of

centralising nursing education in Fiji. The first qualified tutor was appointed at the Central Nursing School, Tamavua, in 1946 and the Central Nursing School was formalised in 1954 (Nadakuitavuki and Nagasima 1988).

Tutor staff at the nursing schools used a Fiji designed nursing curriculum for the education of nurses. From 1955, the New Zealand basic nursing course was taught alongside the Fiji program until it was phased out in 1979. A new curriculum for nursing was introduced at the FSN in 1983 and continues to guide the education of entry level nurses today. Post basic education in midwifery and public health commenced in 1964 and has been reviewed and re-developed on a number of occasions since that time (Nadakuitavuki and Nagasima 1988).

The next significant event in the education of nurses in Fiji was the opening of the new FSN buildings at Tamavua, Suva. This occurred on 27 February 1987. The buildings were made possible by the generosity of the Japanese government and the government of Fiji. This new building provided a central focal point for all nurse education in Fiji (Nadakuitavuki and Nagasima 1988).

Contemporary Fiji nurse education

Today, nursing education in Fiji continues to be offered at the Tamavua site and results in approximately 80 graduates per annum. The basic course has a practice-based curriculum that underpins the diverse and expert clinical practices of the Fiji School of Nursing diplomates. Entry into the diploma course may be granted after successful completion of 12 years of education and a pass in compulsory units of English and biology. Currently the School has approximately 500 pre-registered nurse students enrolled in the current three-year program with a staff establishment of 25 lecturers. The role of the lecturer extends beyond didactic classroom learning and includes a significant proportion of work in the clinical area. The clinical responsibilities focus on clinical skills assessment for the basic program students. These students are supported financially by the government and contribute to the nursing workforce in Fiji. The FSN currently conducts post basic courses in midwifery, public health and for nurse practitioners. They are also currently offering post basic bachelors degrees, as well as intensive care and coronary care graduate certificate courses in collaboration with the School of Nursing Sciences at James Cook University, Australia.

It has been over 10 years since the current basic FSN curriculum was reviewed (Biscoe 2000). However, FSN is in the final stage of developing a new curriculum for implementation in 2004. This curriculum, being developed with assistance from the School of Nursing Sciences at James Cook University, is being prepared at a tertiary level as part of the goal to merge the FSN with the Fiji School of Medicine. This is part of a larger plan to eventually merge these two groups to become the education provider for all health care courses in Fiji,

under the auspices of the University of the South Pacific (Biscoe 2001).

Nurse regulation in Fiji

Nurses, midwives and nurse practitioners are registered under the Nurses, Midwives and Nurse Practitioner's Act of 1999 that was originally established in 1948. The Act is principally designed to regulate activities in the conduct of education of nurses and midwives in Fiji and provide registration. The Act also constitutes a Board that is responsible for overseeing the work of the registrar and for making decisions related to accreditation of courses. The Permanent Secretary of Health is the Chairman of the Board and the Principal of the FSN is the educational representative to the Board (Fiji School of Nursing 2002). The Director of Nursing Services, employed by the Ministry of Health, is the Registrar under the Act. Licensing is mandatory and is valid for life unless revoked. The registrar is responsible for assessment of all new applications to practice, including those from overseas nurses. At present there is no requirement for continuing education. However, this and an annual registration fee are being considered by the Nurses, Midwives and Nurse Practitioner's Board of Fiji for implementation in the near future. The Board has also adopted an amended form of the South Western Pacific Nurse Competencies (2002) for use in Fiji. These competencies have been used to guide the development of the new FSN nursing curriculum.

CONCLUSION

Nursing in Fiji faces many of the same challenges as nursing in Australia in the continuing struggle to fill nursing vacancies and the ongoing burden of migration of their educated nurses to other countries. The initiatives developed by the Ministry of Health and the Fiji School of Nursing, such as the nurse practitioner program, have gone some way towards providing a more sustainable health delivery workforce, particularly for people residing in more remote or rural locations. The adoption of the new competency standards for nursing and the writing of the new basic nursing curriculum for introduction in 2004 will take this further in ensuring that standards are consistent and that nurses are competent professionals able to practice across different geographic locations and the diverse cultures that constitute Fiji.

REFERENCES

- Biscoe, G. 2000 *Feasibility study of the proposed amalgamation of the Fiji School of Medicine and the Fiji School of Nursing*. Report to the World Health Organisation. WHO Western Pacific Office. Suva: Fiji.
- Cameron, B. 1989. Teaching in Fiji: Practicing medicine, coping with coups. *Canadian Medical Association Journal*. 140:833-835.
- Downes, E. 2001. *Fiji nurse practitioner, nurse education and practice*. Mission Report: WHO Regional Office for the Western Pacific.
- Fiji School of Nursing Information Booklet. 2002. Unpublished document. Fiji School of Nursing. Tavevua: Fiji.

Fiji today 2000. 2000. Ministry of Information. Government printer. Government of Fiji. Suva: Fiji.

Gounder, C. 2001. Dr Tuqa denies report. *The Fiji Daily Post*. January 13 2001.

Haddad, M.B. and Williams, J.L. 2001. *Achieving health for all through community partnership: The key roles of nurse practitioners in Fiji*. Atlanta. Georgia. USA.

Ministry of Health (MOH) of Fiji. 2000. Ministry of Health. Available: http://www.fiji.gov.fj/m_health/index.html [downloaded 12 October 2002].

Nadakuitavuki, R. and Nagasima K. 1988. *Fiji School of Nursing General Information*. Unpublished manuscript. Fiji School of Nursing. Tavevua: Fiji.

Usher, K. 2001. *Study on the impact of the nurse practitioner services*. Mission Report: WHO Regional Office for the Western Pacific.

Usher, K.J. and Lindsay, D. In press. 2004. The nurse practitioner role in Fiji: Results of an impact study. *Contemporary Nurse*. 16(1/2).

World Health Organization. 2001a. *The structure and sustainable delivery of essential public health functions in the Western Pacific Region*. Country Report Fiji Islands: WHO Regional Office for the Western Pacific.

World Health Organization. 2001b. *Proposed Countries Program Budget 2000-2001*. Geneva: World Health Organization. Available from URL: www.wpro.who.int/public/policy/budget/country/07_FIJ.html. Downloaded 27/11/2002.

PROMOTING PATIENT AUTONOMY AND COMMUNICATION THROUGH ADVANCE CARE PLANNING: A CHALLENGE FOR NURSES IN AUSTRALIA

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ABSTRACT

Many older people unable to give informed consent receive life-prolonging treatments in hospitals and nursing homes, even though these treatments may lead to a reduced quality of life and may not be consistent with what the people would choose if they could make their wishes known. Advance care planning provides an opportunity for a person to discuss and communicate their wishes about future care with significant others such as their family, treating doctor and other members of their health care team. Advance care planning has not been discussed explicitly in the Australian nursing literature. This article suggests that nurses can play a stronger role in promoting and facilitating advance care planning, through a number of roles consistent with mainstream nursing practice.

INTRODUCTION

Advance care planning (ACP) is a process of communication between a person and the person's family members, health care providers and important others about the kind of care the person would consider appropriate if the person cannot make their own wishes known in the future (Martin et al 2000). This would typically occur if the person develops dementia, suffers a severe cerebrovascular accident or becomes unconscious for whatever reason.

While ACP is directly linked to end-of-life treatment, the focus of this paper is on the process of developing advance care plans rather than on the management of end-of-life care, as in palliative care.

ACP is an important issue because many people will be in the situation of not being able to make decisions for themselves as they approach the end of their life. Advances in medical knowledge and life-sustaining technologies have meant that death has become a process or continuum in which life can be significantly prolonged (Schlenk 1997).

When asked, most people are clear that they would prefer to preserve a good quality of life rather than to have an extended life without regard to quality (Steinberg et al 1997; Miles et al 1996; Gamble et al 1991; Ebell et al 1990). However, there is no guarantee this will happen in the final stages of life. Decisions made to either aggressively treat illness and prolong life or undertreat illness will not always be consistent with what the person would have wished (Taylor and Cameron 2002; Haynorn 1998; Martin 1997; Perrin 1997). This is especially the case for people with cognitive or functional impairment who do not have family members who are able to advocate for them (Moody et al 2002; Meier 1997).

ACP brings end-of-life treatment out in the open and promotes an active communication over time about the issues between the patient, their loved ones and the health care team (Prendergast 2001; Martin et al 2000). This increases the chances that the persons' wishes will be understood and acted on when they cannot speak for themselves. It also lifts, from the family and healthcare staff, the burden of responsibility of having to make decisions for someone else when they are not sure what the person would want.

Nursing literature outside Australia has canvassed a range of issues to do with ACP and has suggested that nurses have an important role in promoting advance care planning for their patients (Feldt 2000; Sawchuk and Ross-Kerr 2000; Haynor 1998; Martin 1997; Parkman and Calfee 1997; Perrin 1997; Schlenk 1997; Johns 1996).

However, ACP is an issue that has had little attention within Australia in either the health care practice setting or literature. A review of the Australian health care literature on ACP and associated topics indicates a small number of articles in the medical (Taylor and Cameron 2002; Mador 2001; Hawkins and Cartwright 2000; Parker and Cartwright 1999; Waddell et al 1997; Waddell et al 1996) and social science (Cartwright 2000; Steinberg et al 1997) arenas.

After reviewing the published literature, Taylor and Cameron (2002, p.475) argue that 'the available evidence suggests that ACP in Australia has been poorly implemented and that many patients may remain disenfranchised in regard to their end-of-life medical management'.

Although nurses are managing end-of-life care as part of their core business, issues around ACP have not been explicitly addressed in the Australian nursing literature, with a scant number of references found (McLaughlin 2000; Cartwright et al 1997; Chiarella 1994). The aim of this paper is to promote reflection and discussion about the role of nurses in Australia in ACP. While the issues are relevant for all nurses, they are most relevant to those working with patients who have chronic and late stage illnesses.

The article will begin by providing background information on several legal mechanisms associated with ACP, including the current application of these mechanisms in Australia. The article will then propose a number of specific roles that nurses can play in promoting ACP amongst patients. These roles include communication facilitator, risk identifier, emotional supporter, advocate, healthcare agenda setter, educator and researcher.

LEGAL MECHANISMS ASSOCIATED WITH ADVANCE CARE PLANNING

Advance care directives

An advance care directive (ACD) is a document in which a person gives instructions about their future health care; it comes into effect only when the person is no longer capable of making their own decisions (NSW Committee on Ageing 1999). ACDs may also be referred to as 'living

wills'. Typically the directive is designed as a form with a series of questions about either core values or levels of treatment that the person would want under certain conditions. It is usually suggested that people complete these with their doctor and lodge copies with the doctor as well as close family members and their local hospital.

Much of the literature on ACD comes from the USA, where they are legally mandated. The Patient Self-Determination Act 1991 requires all publicly funded health services to inform patients about advance directives, honour the instructions in these directives, have clear policies and procedures to support this, and train staff and educate the public about advance directives (Parkman and Calfee 1997).

ACDs were promoted as a means of assuring that people's end-of-life wishes would be acknowledged and acted upon. Unfortunately, the early optimism about ACDs has not been reflected in the results of research on their effectiveness. A range of authors (Teno et al 1997; Perrin 1997; Miles et al 1996; High 1993; Danis et al 1991) have highlighted a number of limitations associated with ACDs:

- In spite of many people showing an interest in them, the majority of people do not go on to complete a directive.
- Forms may be unclear and ambiguous when it comes to making vital decisions about a person's care.
- Forms may become out of date as a person's health status changes.
- There is usually no system for storing and retrieving forms easily and consistently.
- Health care providers often do not recognise the legitimacy of the directives.
- There can be problems if family members do not agree with what is in the directive and want to overturn it.

Recently, several authors (Ditto et al 2001; Martin et al 2000; Teno et al 1998) have de-emphasised the importance of the written document and put a stronger focus on the processes of communication that occur as part of ACP. This change in approach to ACDs signals an important shift from a legalistic paradigm to a more holistic, patient-centred one.

Martin et al (2000, p.1673) suggest that '...an AD form is not the central or defining feature of ACP. ACP is a process of communication, and AD forms are best viewed as an assisting device embedded in the ACP process'. AD forms may help people to articulate their values, goals and preferences and can provide a framework to facilitate discussions with others. They can give structure and clarity to discussions about death, illness, and end-of-life care.

ACDs remain important but are neither necessary nor sufficient for successful ACP. They are helpful as a guide and facilitative mechanism to help patients, family and health care staff communicate openly about the issues. They are particularly useful if a person does not have a significant other who understands their wishes and is able to strongly advocate for them, or if they have quite specific wishes they want honoured.

Proxy decision makers

A second legal mechanism associated with ACP involves proxy decision makers - a person(s) recognised as being able to make decisions on your behalf if you are no longer able. Other terms used in this context may be advocate, guardian, or surrogate. In most situations, the closest family member(s) will be asked to make decisions on your behalf if you are not able. In the majority of cases, this is an appropriate approach as close family are the people most likely to know and respect the wishes of the patient (Martin et al 2000; Meier 1997; Perrin 1997).

Problems arise if there is no close family member and no identified proxy, if the proxy is not clear about what you would want, if the person is not easily available, if the person is afraid of making clear decisions or is unassertive about them, or if there is conflict within the family about the best way to proceed. Complications may arise if there are several people who want to make decisions on your behalf eg de facto partner and family members.

A useful strategy is to ask a patient 'Do you have someone that the health care system will easily recognise and accept as your proxy ('advocate' or 'guardian' may be more easily understood by some patients) and whom you are fully confident will make decisions that are based on what you would want?' If the answer is 'No' the patient can be helped to identify an appropriate person and make sure that person is willing and able to act as a proxy. There are legal systems - discussed below - for nominating a person(s) as your legal proxy decision maker.

It is ideal if the identified proxy is involved with the health care team during the person's illness rather than appearing only in a time of crisis (Teno et al 1998). It is important to choose an effective and available proxy and to make your wishes and values known clearly to that person. The proxy's role is not to make decisions based on their own values but to answer the important question 'What would my loved one decide if she/he could speak to us?'

Power of attorney

This concept - the third legal mechanism associated with ACP - will be familiar to most readers. It is a legal document in which a person appoints another person to manage their financial and legal affairs such as signing contracts. It might be used if a person becomes immobile and cannot get around easily.

Unfortunately, there are two widely held misunderstandings about Power of Attorney. The first of these is that having a Power of Attorney enables you to make any decisions for the person - including health care decisions. This is not the case as decisions are restricted to business, property and financial affairs (NSW Committee on Ageing 1999).

The second misunderstanding is that a normal Power of Attorney automatically lasts till the person dies. In fact, the Power of Attorney becomes invalid if the person who has given it subsequently develops dementia or otherwise becomes incompetent to make their own decisions. There is a specific type of Power of Attorney - usually called an Enduring Power of Attorney - that remains valid even after the person giving it becomes incompetent (NSW Committee on Ageing 1999).

Current status of these legal mechanisms in Australia

The landscape of ACP within Australia is complicated by each State having different legislative and health systems. Furthermore, advance care directives and proxy decision making are concepts that are not widely understood in the community or by health care professionals.

Power of Attorney is covered by a different Act in each State but these are fairly consistent. Systems covering proxy decision makers or guardians are not so consistent, although they all allow a person to nominate one or more others to make health care decisions on their behalf. The legal mechanisms under different State Acts include:

- Enduring Guardian (New South Wales and Tasmania)
- Enduring Power of Attorney for Personal/Health Matters (Queensland)
- Enduring Power of Attorney - Medical Treatment (Victoria)
- Medical Power of Attorney and Enduring Power of Guardianship (South Australia)

(NSW Committee on Ageing 1999).

The legal status of ACDs is even less clear. ACDs in some form are specified in legislation in the ACT, Queensland, South Australia and the Northern Territory (NSW Committee on Ageing 1999). There is some indirect reference in Acts or government regulations in New South Wales (NSW Health 1993) and Victoria (Cartwright 2000).

A common concern about ACDs is that they are not 'legal' and therefore the health care staff do not need to - and should not - follow them. However, in several States they are clearly legally recognised documents. In other States their power comes from a person's right in common law to determine their own health care - including the right to refuse treatment (Cartwright 2000; Parker and Cartwright 1999).

Information about legal mechanisms underlying advance care planning in each State can be found in a booklet 'Taking Charge: Making Decisions for Later Life' (NSW Committee on Ageing 1999) and in Cartwright (2000). Readers should be aware that legislation will continue to change in this area and that they need to keep updated about current legislation in their own State.

Apart from legislation, readers should also be aware of guidelines and other resources published in their State. Within New South Wales (NSW), for example, much work has been put in during 2001 and 2002 to revise the 'Guidelines for Decisions Making at the End of Life' by NSW Health. This is a comprehensive and practical document that is in final draft form at the time of writing.

NURSES' ROLES IN ADVANCE CARE PLANNING

ACP can provide positive outcomes for both patients and their family carers. They can help people prepare for death by giving patients a sense of control, relieving burdens on loved ones, and strengthening or reaching closure in relationships with loved ones (Martin et al 2000). 'Research does show that advance planning catalyses important, memorable, and therapeutic discussions between patients, providers and family members about emotionally and conceptually difficult issues' (Miles et al 1996, p.1066).

The non-Australian nursing literature has put forward a number of roles that nurses can play in promoting and facilitating advance care planning (Jacobson 2000; Haynor 1998; Martin 1997; Parkman and Calfee 1997; Perrin 1997; Schlenk 1997; Johns 1996; Mezey et al 1996).

Johns (1996) suggests that nurses have roles in facilitating the initiation of advance directives, integrating family members as surrogates and advocating for patients to ensure their treatment choices are respected. According to Haynor (1998), nurses' roles in ACP include the giving of information and provision of emotional support to the patient and their family.

Perrin (1997) suggests that nurses have several roles in ACP. These include preparing people to think about end-of-life decision-making for themselves and their family members, providing public education about end-of-life decision-making, and facilitation of discussions about a person's end-of-life wishes within the health care team. Jacobson (2000) suggests that nurses are ideally placed to introduce the patient to the importance of ADs, to monitor how treatments comply with patients' preferences, to facilitate discussions amongst family members and to develop a dialogue about end-of-life care between those in the facility who make ethical recommendations and those who carry them out at the bedside.

As pointed out earlier in this paper, ACP is an area that has not been explicitly addressed in the Australian nursing literature. On the basis of the benefits of ACP and the range of suggestions from the broader nursing literature,

we believe that nurses in Australia need to take a greater role in promoting and facilitating ACP as an important aspect of nursing practice.

Two factors will assist nurses to move in this direction. The first is to become well versed in medico-legal concepts such as consent and decisional capacity (Darzins et al 2000; Molloy et al 1999) as well as the legal frameworks surrounding ACP in their State (Des Rosiers and Navin 1997; Schlenk 1997).

The second factor is to become aware of and work through their own issues and feelings about death and dying (Schlenk 1997). Discussing death and dying is difficult for most people. It will be made easier if the nurse feels comfortable to raise and discuss the issues. Nurses can help each other in this regard through peer support, education programs and clinical supervision.

We propose a number of roles that nurses can play in promoting and facilitating ACP. These proposed roles are based on an analysis of the literature and our own sense of sound nursing practice. The roles are as communication facilitator, risk identifier, emotional supporter, advocate, health care agenda setter, educator and researcher.

Communication facilitator

Of all health care workers, nurses spend the most amount of time with patients. Their relationships are more intimate and more holistic. Patients want to discuss end-of-life care but prefer health care workers to initiate discussion about this (Johns 1996; Mezey et al 1996). Nurses are ideally placed to initiate this discussion because of the openness and trust that often characterise their relationships with patients.

Nurses often also develop close relationships with the family of patients - especially if they are in a long-term caring situation. Because they can understand issues from the patients' and families' perspectives they can often facilitate discussion that the family may find difficult to initiate (Johns 1996). The nurse has a pivotal role in promoting communication about advance care planning amongst the patient, family, treating doctor and other members of the health care team.

Communication about end-of-life care should be a routine aspect of care for all patients - particularly those with chronic and late stage illnesses. It should not be left until just before the person dies.

Risk identifier

Nurses can be attuned to patients that are more likely to have problems in their end-of-life care. It may be helpful for nurses to ask all their patients the question mentioned earlier in this paper: 'Do you have someone that the health care system will easily recognise and accept as your proxy (or advocate) and whom you are fully confident will make decisions that are based on what you would want?'

In many cases, the person will have a supportive family whom they are confident will make wise decisions on their behalf (Martin et al 2000; Meier 1997; Perrin 1997). However, if the person answers 'No' to the question, the nurse can help in several ways. They can encourage the patient to write down issues that will be important to them in the way they are cared for toward the end of their life; they can suggest the patient discuss these issues fully with their treating doctor; and they can assist the patient to select and nominate an appropriate proxy decision-maker and then discuss these issues with that person as well.

Emotional supporter for patient and family

Problems can arise if family members have difficulty accepting the death of a loved one. They may find it hard to accept that more cannot be done to prolong life. On the other hand, they may be distressed that the person is suffering and want their death to come more quickly. This is made worse if the wishes of the family are at odds with what the patient has expressed or if there is conflict between family members about the best course of action.

The nurse can liaise with the treating doctor to ensure that the patient and family have sufficient medical information and support. The nurse can help by conducting private conferences, providing additional diagnostic information, encouraging open family discussions, providing time and emotional support to family members and arranging religious and counselling support as appropriate (Haynor 1998). Family members should be fully informed and actively involved in direct patient care as appropriate. When the patient is no longer able to make decisions, the nurse can support the family by helping them work through the care options and make decisions based on the best interests of the patient.

Advocate

Respect for personal autonomy is one of the core principles of both nursing philosophy and practice. For nurses to truly apply this principle they must be prepared to advocate for a patient whose wishes they think are not being respected.

'This conviction that the patient's autonomy should be respected brings with it, however, a particular requirement: that of exercising the role of advocacy. This role can take different forms: informing patients of their rights; ensuring that patients have all the information necessary to make enlightened choices; supporting patients in their decisions; and protecting patients' interests' (Blondeau et al 2000, p.407).

Johns (1996) suggests that nurses, because of their insights into patients' preferences and their role as patient advocates, have a legitimate role in ensuring that treatment complies with patients' preferences - as expressed in their advance directives. At times this may require the nurse to challenge the treatment proposed by other members of the health care team. The role of

advocate may also be to speak on behalf of family members who are not being given enough information or are not being fully consulted about treatment plans.

Health care agenda setter

While advance care planning is an important part of sound nursing care, it is not an issue confined to nursing, and nurses can play an important leadership role promoting the issues within the wider health system.

This might include raising the issues with those parts of their organisation that are responsible for ethical issues and quality improvement, with a view to incorporating ACP into the organisation's systems and procedures. Discussion of ACP can be included as a routine part of case conferences. It can be included in orientation, in-service and grand round presentations.

Nurses can also promote ACP within their profession. This might be through presenting papers at nursing conferences, providing case reports and articles for journals and incorporating issues into nursing curricula.

However, the promotion of ACP should not only depend on the personal enthusiasm and motivation of nurses. It is vital that it be taken up as an organisational responsibility. This will make it more likely that appropriate care practices will be adopted across the whole organisation on a longer-term basis.

Educator

The nurse has two types of educative roles. One is with patients, family members and the general community. The other role is in education of other nurses and health care providers.

In terms of the first of these roles, the best time for patient education is not in the emergency department in the middle of a crisis. It is more appropriate in a primary health care or community setting. Education about advance care planning should emphasise the benefits of communicating beliefs and values with family members and health care providers while the person is still healthy and competent.

A collaborative approach working through seniors' organisations, religious and volunteer groups is a useful way to go (Haynor 1998). Information could be provided through a range of media - including one to one interventions, seminars, print and audiovisual resources. Information could also be channeled through existing information services aimed at seniors and the general public (Sawchuk and Ross-Kerr 2000).

In terms of the second educative role, education of nurses and other health care staff will increase their understanding and comfort level when promoting ACP. Education programs need to go beyond simply imparting information. Nurses need to develop skills in raising and discussing these issues with patients and their family members. They need to be able to assess decisional capacity to execute an advance care directive and identify

methods to help patients and family work through the range of choices available to them (Darzins et al 2000; Mezey et al 2000; Molloy et al 1999).

For advance care planning to become a more explicit aspect of nursing practice, comprehensive education programs addressing the issue would need to be developed and fed into both workplace learning and academic curricula (Des Rossiers and Navin 1997). These authors suggest that educational programs should address the following issues: patient autonomy, cultural sensitivity, family support, legal implications, health and psychological effects and ethical considerations (Des Rossiers and Navin 1997).

Researcher

There are many issues that nurse researchers can focus on to gain a better understanding of, and further promote, the practice of advance care planning (Haynor 1998; Johns 1996). These include:

- nurses' knowledge and attitude to advance care planning;
- patients' preferences regarding the roles of nurses in advance care planning;
- best times and strategies for implementing advance care planning;
- the role of cultural and language background in advance care planning;
- effective ways to educate all the stakeholders about advance care planning;
- the relationship between a written directive and a well informed proxy;
- potential ethical conflicts between patient autonomy and some nurses' perceived responsibility to prolong life; and,
- nurses' roles in advance care planning in relation to the roles of doctors and other health professionals.

CONCLUSION

End-of-life care is an area of increasing clinical and ethical complexity. This is because of the ageing of the population and the technology that is available and promoted to prolong life even when the consequent quality of life is poor.

ACP is one effective response to this complexity. It allows people to openly discuss how they would want end-of-life decisions to be made on their behalf.

Discussions with close family members or loved ones, the treating doctor and other significant members of the person's healthcare team will provide a greater sense of autonomy and security for the person at the centre of the discussion. They will also mean that all parties will be

more clear and confident about implementing the person's wishes when the person can no longer express them.

ACDs are written statements of a person's values and wishes relevant to their end-of-life care. They are a tool to initiate and facilitate discussion between a patient, family members and health care staff. By promoting and respecting ACDs, health care staff contribute to autonomy in decision-making by their patients.

Family members can be supported to become effective advocates for their loved one. In situations where there is not a clear advocate in the picture, the person can be assisted to select and nominate a guardian within the local legal framework.

While nurses are intimately involved in providing end-of-life care, ACP has not been addressed as an issue in its own right within the Australian nursing literature. Because of their close connection with patients and family members, their advanced communication skills and their philosophical commitment to patient autonomy, nurses can take a more explicit and active role in promoting the importance of ACP. Specific roles they can play in this regard are as communication facilitator, risk identifier, emotional supporter, advocate, healthcare agenda setter, educator and researcher.

REFERENCES

- Blondeau, D., Lavoie, M., Valois, P., Keyserlingk, E.W., Hebert, M. and Martineau, I. 2000. The attitude of Canadian nurses towards advance directives. *Nursing Ethics*. 7(5):399-411.
- Cartwright, C. 2000. End-of-life decision making: practical and ethical issues for health professionals. *Australasian Journal on Ageing*. 19(2):57-62.
- Cartwright, C., Steinberg, M., Williams, G., Najman, J. and Williams, G. 1997. Issues of death and dying: The perspective of critical care nurses. *Australian Critical Care*. 10(3):81-87.
- Chiarella, M. 1994. Interim Guidelines on Dying with Dignity. *ACORN Journal*. 7(2):27-29.
- Danis, M., Southerland, L.L., Garrett, J.M., Smith, J.L., Hielema, F., Pickard, C.G., Egner, D.M. and Patrick, D.L. 1991. A prospective study of advance directives for life-sustaining care. *The New England Journal of Medicine*. 324:882-888.
- Darzins, P., Molloy, D.W. and Strang, D. 2000. *Who can decide? The six step capacity assessment process*. Adelaide: Memory Australia Press.
- Des Rosiers, M. and Navin, P. 1997. Implementing effective staff education about advance directives. *Journal of Nursing Staff Development*. 13(3):126-130.
- Ditto, P.H., Danks, J.H., Smucker, W.D., Bookwala, J., Coppola, K.M., Dresser, R., Fagerlin, A., Gready, M., Houts, R.M., Lockhart, L.K. and Zyzanski, S. 2001. Advance directives as acts of communication: A randomised controlled trial. *Archives of Internal Medicine*. 161:421-430.
- Ebell, M.H., Smith, M.A., Selfert, G. and Polsinelli, K. 1990. The do not resuscitate order: Outpatient experience and decision-making preferences. *Journal of Family Practice*. 31(6):630-635.
- Feldt, K.S. 2000. Rethinking advance directives. *Journal of Gerontological Nursing*. 26(10):5.
- Gamble, E.R., McDonald, P.J. and Lichstein, P.R. 1991. Knowledge, attitudes and behaviour of elderly persons regarding living wills. *Archives of Internal Medicine*. 151:277-280.
- Hawkins, H. and Cartwright, C. 2000. Advance health care planning and the GP: Is it time to move forward? *Australian Family Physician*. 29(7):704-707.
- Haynor, P.M. 1998. Meeting the challenge of advance directives. *American Journal of Nursing*. 98(3):26-32.
- High, D.M. 1993. Advance directives and the elderly: A study of intervention strategies to increase use. *The Gerontologist*. 33(3): 342-349.

- Jacobson, J. 2000. Advance medical directives. *Nursing Case Management*. 5(1):26-31.
- Johns, J.L. 1996. Advance directives and opportunities for nurses. *Image -The Journal of Nursing Scholarship*. 28(2):149-153.
- Mador, J. 2001. Advance care planning: Should we be discussing it with our patients? *Australasian Journal on Ageing*. 20(2):89-91.
- Martin, R.H. 1997. Advance directives: Legal implications for nurses. *Journal of Nursing Law*. 4(2):7-15.
- Martin, D.K., Emanuel, L.L. and Singer, P.A. 2000. Planning for the end of life. *Lancet*. 356:1672-1676.
- McLaughlin, K. 2000. Advance directives. In *Excellence in Nursing and Midwifery Practice 2000*. Royal North Shore Hospital.
- Meier, D.E. 1997. Voiceless and vulnerable: Dementia patients without surrogates in an era of capitation. *Journal of the American Geriatric Society*. 45(3):375-377.
- Mezey, M., Bottrell, M.M. and Ramsey, G. 1996. Advance Directives Protocol: Nurses helping to protect patient's rights. *Geriatric Nursing*. 17(5):204-210.
- Miles, S.H., Koeppe, R. and Weber, E.P. 1996. Advance end-of-life treatment planning: A research review. *Archives of Internal Medicine*. 156:1062-1068.
- Molloy, D.W., Darzins, P. and Strang, D. 1999. *Capacity to decide*. Canada: Newgrange Press.
- Moody, L.E., Small, B.J. and Jones, C.B. 2002. Advance directives preferences of functionally and cognitively impaired nursing home residents in the United States. *The Journal of Applied Gerontology*. 21(1):103-118.
- NSW Committee on Ageing. 1999. *Taking charge: Making decisions for later life*. Sydney: NSW Committee on Ageing.
- NSW Health. 1993. *Dying with dignity, interim guidelines on management*. Sydney: NSW Health.
- Parker, M. and Cartwright, C. 1999. Refusal of treatment: Ethics, law and medical practice. *Australian Medical Association Queensland News*. July:16-18.
- Parkman, C.A. and Calfee, B.E. 1997. Advance directives: Honoring your patient's end-of-life wishes. *Nursing* 97. April:48-53.
- Perrin, K.O. 1997. Giving voice to the wishes of elders for end-of-life care. *Journal of Gerontological Nursing*. 23(3):18-27.
- Prendergast, T.J. 2001. Advance care planning: Pitfalls, progress, promise. *Critical Care Medicine*. 29(2) Supplement: N34-N39.
- Sawchuk, P.J. and Ross-Kerr, J. 2000. Older adults and advance care directives. *Canadian Nurse*. 96(7):16-20.
- Schlenk, J.S. 1997. Advance directives: Role of nurse practitioners. *Journal of the American Academy of Nurse Practitioners*. 9(7):317-321.
- Steinberg, M.A., Najman, J.M., Cartwright, C.M., McDonald, S.M. and Williams, G.M. 1997. End-of-life decision-making: Community and medical practitioners' perspectives. *Medical Journal of Australia*. 166 (3 February):131-134.
- Taylor, D.McD. and Cameron, P.A. 2002. Advance care planning in Australia: Overdue for improvement. *Internal Medicine Journal*. 32:475-480.
- Teno, J.M., Licks, S., Lynn, J., Wenger, N., Connors, A.F., Phillips, R.S., O'Connor, M.A., Murphy, D.P., Fulkerson, W.J., Desbiens, N. and Knaus, W.A. 1997. Do advance directives provide instructions that direct care? *Journal of the American Geriatric Society*. 45(4):508-512.
- Teno, J.M., Stevens, M., Spornak, S. and Lynn, J. 1998. Role of written advance directives in decision making: Insights from qualitative and quantitative data. *Journal of General and Internal Medicine*. 13:439-446.
- Waddell, C., Clamette, R.M., Smith, M. and Oldham, L. 1997. Advance directives affecting medical treatment choices. *Journal of Palliative Care*. 13(2):5-8.
- Waddell, C., Clamette, R.M., Smith, M., Oldham, L. and Kellehear, A. 1996. Treatment decision-making at the end of life: A survey of Australian doctors' attitudes towards patients' wishes and euthanasia. *Medical Journal of Australia*. 165(10):540-544.