Chapter One

The Contexts of the Research
The following conversation is layered. It has been written and rewritten. Some work is very early, belonging to the first draft. By the time that the third draft was reached I had stopped referring to drafts and was predominantly reworking what I saw to be the eventual shape of the final document.

The study

The statement of the problem

The aim was to explore the practice of rural community nurses in the context of primary health care, their understandings of their practice, and their clients' perceptions of that practice. The potential significance of this research project is that it has direct relevance for the education of nurses in primary health care and students of nursing in undergraduate nursing programmes. It also has direct relevance for the shaping of primary health care nursing and the infrastructural support associated with the implementation of an effective primary health care service. In accordance with the nature of this study, there is no hypothesis to research. However, there is a primary question and a set of derived research questions to be answered. The primary question is:

- What shapes nurses' practice in community health care and what in turn does this practice shape?

From this general question flow several other questions. They are:

- What is the nature of the practice?
- What are the tensions within the practice?
- What are the effects of these tensions?
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- What are the effects of the practice?
  or
- How is the practice perceived by those people who participate in it?

And so began my early writing. Little did I suspect that everything would not proceed as I had anticipated. My next decision was, however, to explore the general terrain of the study.

The vision and ideological debates: Policy

Background

The monolithic modernist health vision (with its ideological framework of liberal humanism, which has preoccupied various governments of the world for several decades) is Primary Health Care (PHC). The major concepts of the liberal humanist approach underpinning PHC are social justice and equity (Ibell 1992). This framework is demonstrated firstly by its redefinition of 'health'. This redefinition implied a deliberate move away from the medical model concept of health as the absence of disease, and included the consideration of social and environmental factors. It has been referred to as a social definition of health.

Furthermore, and importantly, it was also a challenge by the WHO to governments of the world to respond appropriately to this redefinition of health.
These ideas were formulated more thoroughly by the WHO during the course of
two major events they sponsored: the Alma-Ata conference in 1978 and, eight
years later the Ottawa Charter (1986) on health promotion.
An outcome of the Alma-Ata conference was a declaration which contained the
principles of PHC. Related identifiable concepts included equity, community
development and participation, health personnel intersectorial participation and
co-operation, international co-operation, disarmament and world peace, and the
development of appropriate technology. Also contained within this document
was a stated goal which was globalised to form the basis of health policy for most
countries of the world. This globalised health goal aimed to achieve 'an acceptable
level of health for all the people of the world by the year 2000' (WHO 1979).

Having set the scene, I then decided to
explore closer to home. I asked myself two
general questions. What was the national
context and what were the implications for
nursing?

The Australian context
In Australia the WHO policy was reflected in a document which provided for a
measurable outcome of the Health for All by the Year 2000 health policy (Percival
1989). This was the beginning of the New Public Health. Primary Health Care,
therefore, was to be a globalised monolithic philosophy underpinning the social
system as well as the health care system of particular countries. The implications
of this were enormous and basically demanded the dismantling of the medical
model approach to health care and disease-oriented definitions of health, a
wresting of power away from the medical profession and its ability to determine
the nature of health care, a redistribution of spending away from destructive activities of war, and a redirection by governments towards activities to rectify poverty, unemployment, homelessness, racism, and sexism. The emphasis was on health promotion and illness prevention with communities deciding their own health needs and how to address them.

Inherent within this modernist health policy was the element of critical social science with leanings towards Marxist and Freirean critical theory. People were to be empowered to take control of their own health, and with the decision making concerning this matter. Moreover there was to be a redistribution of the wealth of society to eliminate poverty and homelessness. There was also a hint of anarchist thinking in the small, localised approaches to health.

Education was one of the key concepts, where enlightenment concerning one's health was to form the basis of changes in health behaviour, which would now be directed towards a more positive states.

**Who is to carry out the great task of enlightenment, and undertake the huge tasks of health promotion, health education, illness prevention, and tertiary prevention?**

The rhetoric of PHC articulated intersectorial support, multidisciplinary teams and local community health centres which served the needs of the community. There is no doubt that this approach to health care validated and welcomed the involvement of many different health care workers (HCWs). Nurses, however, were provided with perhaps an unrealistic challenge in the WHO's articulation that if nurses, who form the bulk of HCWs in most countries, were to put their weight behind the PHC movement then the vision would be achievable. Moreover, nurses were also challenged to lead the movement (Coxhead 1992).
This involved, however, not just tinkering with the Health Care System (HCS); rather, it demanded a revolutionary change in social organisation and social structures, especially as they concern power relationships in health decision making.

Further to this, the International Council of Nurses in 1985 (ICN 1988) called for a review of nursing’s role in primary health care and the effectiveness of nursing’s contribution to Health for All by the Year 2000. As part of that review the ICN specifically called for the clarification of nursing’s role in terms of developing, nursing care delivery systems, action plans to meet health needs, and curricula in which primary health care is a fundamental part.

A brief review of the literature (ICN 1988, Health for All Australians 1988, ANF 1990, Ibell 1992) indicates that if a philosophy of primary health care nursing exists at all, then it is mainly that related to social justice and reflects the WHO philosophy.

On the other hand, although concepts such as holism and interrelationships (ICN 1988) are spoken of, there is no clear articulation of the philosophical framework which will guide nursing practice.

It has been said by some that primary health care is a natural extension of nursing, and by others that it is an ‘integral aspect of nursing practice‘ (Miller Dolan and Boswarve 1995:252); but vision and action are necessary to enhance nursing’s pivotal role in PHC.

Further to this, the ICN (1988) believed that the quality of primary health care would be determined by the philosophy which underpins nursing practice. Such ‘motherhood’ statements, unfortunately, have been appropriated and form the
basis of nursing curricula (Clark 1996, Clare 1997), nursing practice and health policy. And, in Australia, community nurses were seen as the group who could most effectively implement the vision.

Influences on national health policy
In terms of health policy, Australia partially took on the vision of the WHO's New Public Health with the setting up of community health centres in 1973 based on the implementation of the Community Health Program for Australia. This was an initiative which commenced at a time which is often referred to as the 'Whitlam era' in Australian politics.

After the demise of Whitlam and the Australian Labor Party government of the day, however, the 'Fraser era' followed and the situation went into decline. There was lack of funding, lack of jobs and constant administrative change.

A change of government from the Australian Liberal/National Party to the Hawke-led Labor party in 1984 heralded a review of health services and the establishment of Medicare to replace the older Medibank. Although Australia had become a signatory to the WHO Health for All campaign in 1981, it was not until 1986 that the Health for All goals were articulated in the policy, Looking forward to better health. A further refinement occurred in 1988 with the establishment of the Health Targets and Implementation Committee which produced the report Health for all Australians which was to be the framework for achieving the goal of health for all by the year 2000.

One is reminded here of Bob Hawke's statement that no child will live in poverty by the year 2000.
In the postscript to his book *Illness and Social Relations*, Willis (1994:188) clearly indicated the role of politics in the formulation of health policy when he stated:

> The outcome of the policy-setting process, the recommendations, can be understood as a meeting of the two considerations (technical and political) ... At times though, political decisions were dressed up as technical considerations; that a basically political decision having been made, a technical rationale was developed to justify that decision.

Over the last ten years, perhaps in recognition of the possible failure of such a vision of empowering communities, or perhaps because the medical model and the power of the medical profession is so extensive, this comprehensive approach which has just been described has given way to the more moderate, economic rationalist, selective primary health care approach.

> At first glance it may seem that it is easy to distinguish the two approaches. However, this may not be possible until the values underpinning the activities are examined.

In selective PHC there is a return to the medical model definition of health, with a neglect of the social context of disease and people's own knowledge of and role in regard to their own health. Instead, the agenda for community development is to convince people that medically-oriented solutions to health problems are the most appropriate (Wass 1994).

> Moving to narrow the gaze further meant an early exploration of state health policy implementation. In 1995 I wrote the following in an early draft.
The New South Wales context

In a recent discussion document, *Future Roles and Direction of Community health in NSW* (1994), the NSW Health Department examines the case concerning the restructuring of health care in NSW. A brief examination of the document indicated it was concerned with 'so-called' value for money as measured in terms of health outcomes particularly as it concerns community health. However, it also drew primary health care into the context of the discussion and attempted to identify and discuss the boundaries and grey areas concerning definitions, approaches and responsibilities.

In terms of definitions of community health in Australia, the document suggested that the definition in this country was so wide that there was a tendency for confusion and lack of coherence. The view that community health services could be equated with a 'specific organisational form in the public sector' was said to be the most limiting approach to defining the area (NSW Health Dept 1994:6).

The scope of community health services was outlined in the above document as including 'general practitioners, publicly-funded community health services operated by Area/District Health Services, community support services funded from a variety of government programs and non-government organisations' (NSW Health Dept 1994:33). In this research, community-based nursing services were accepted as part of the publicly funded community health services operated by Area/District Health Services as noted above.

The relationship between community care and primary health has been described in the National Health Strategy (1991 in NSW Health Dept 1994:6). Here, it is suggested that there are two distinct but related activities within community-based health services. First-level primary health care is one activity, and includes health promotion, early detection, assessment, referral, and primary levels of treatment.
The second activity is community/continuity of care for members of the community with short- or long-term dependency, and is aimed at maximising independence, thereby assisting them to stay in a community setting and thus avoiding institutional care (NSW Health Dept 1994:A2).

The NSW Health Department discussion paper also considered the future roles and directions of community health in the framework of the types of key decisions necessary to refocus community health toward the major trends in health service delivery which emphasise customer focus, health outcomes and value for money (McEwin 1992). The major issues highlighted included the need for an expansion of community-based services. This is particularly relevant to community nursing services as the paper called for, among other things, an increase in post-acute medical care and continuing care services (NSW Health Dept 1994:35).

Keyzer (1995:32) referred to this as 'the colonisation of the community by the hospital services'.

Further to this there was an emphasis on balancing competing service priorities; establishing minimum service standards; and related to outcome standards; a move towards horizontal integration of services to increase the efficient use of funds. The discussion paper saw as a high priority the need to establish and fund process and outcomes evaluations of this integration. There was an emphasis on integrated management structures which balance service provision needs within a primary health care orientation. There was some discussion of the need to provide appropriate career structures for community health staff, with an
Moreover, it was suggested that the three major areas underpinning the restructuring (customer focus; health outcomes and value for money) need to be supported by adequate computer and information systems infrastructure to ensure integration of services. The need for an appropriate level of capital investment linked to priority setting was identified. It was therefore suggested that 'multipurpose services in rural areas may provide a useful model' (NSW Health Dept 1994:39).
Further to this, the need for a reorientation of community thinking was identified, with the setting up of processes to ensure community participation in and responsibility for decision making.

The Northern NSW context
The reorganisation of the structure of health services in the Northern Rivers region of NSW saw the establishment of regional health boards and a Primary Health Care Service. At that time, the administrative control of community nursing was shifted from the Director of Nursing at the Base Hospital to the Director of PHC (March 1995). The community nursing service for the region was divided into three areas, each with a district manager.

This ethnographic study was located in only one section of one of these areas. However, this one part of the service was further subdivided into six areas of responsibility.

Two of these areas could be classified as rural, one as semi-rural and the other three as urban.
"The community nursing service is therefore in the process of evolving and in a constant state of change. Concern is expressed by the nurses in this section of the service that another reorganisation may occur in March 1996. This, they say, is due to the new NSW Labor government reviewing the present system with consultants due to arrive at this service November/December 1995."

"There has been talk, although unofficial, that another reorganisation to form 3 large regional boards for the state will be undertaken. Therefore there will be a smaller number of larger services."

'So clarity was gained on this issue when I attended the District meeting. The notes I took during that meeting revealed the situation."

'The change in the structure of the service is due to come into effect in July 1996. The emphasis, however, will continue to be
equity of access, continuity of care, with the addition of the
'hospital in the home' plan being implemented'.

At the time I made the following summary:

'The service therefore is changing rapidly, seems fragmented and
unsure of its own identity in terms of directions and
responsibilities as individuals are receiving multiple messages
from senior management'.

I realised quite early that the terms 'PHC,
'rural', and 'community' were problematic.
Therefore I felt the need to establish at least
at this point some notion concerning the
group whose working life I intended to
explore.

The focus of the study
In terms of this research, a rural community nurse is one who practises
predominantly as a generalist community nurse in a non-metropolitan area.
Whilst acknowledging the problematic nature of a definition of 'rural', a rural
area is any location in which the community or town has only one permanent
medical practitioner (Kreger 1991a).
The location of this study, however, was within a defined rural area health service where there are several areas in which there was more than one permanent medical officer.

The problematic nature of these definitions will be discussed later in chapter 3.

Relationship to the identified gaps
In 1983, Dowling Rotem and White conducted an exploratory study of nurses in NSW to determine their perceptions of the role of the nurse in the provision of PHC. They interviewed 58 nurses, 47 by personal interview and 11 via telephone interviews. These nurses were drawn from several different organisational levels and included administrators, nurse educators, clinicians and student nurses. Of the group interviewed, 30 percent were said to be non-hospital-based. Of that 30 percent, 17 percent were clinicians.

The researchers in this study did not, however, differentiate between non-hospital-based metropolitan, and non-metropolitan participants. It is therefore difficult to determine the exact perceptions of PHC provision held by community nurses 'in the country' in the early eighties.

As far as I can ascertain, at the time of commencement of the fieldwork, no research had examined primary health care in the
Hegney (1996) indicated in her research that the rural nurses she interviewed did not identify primary health care as an issue. The only work which mentions this topic is that of Kreger (1991a; 1991b). In her reports on rural and remote area nursing practice, Kreger found that remote community nursing with a population focus was limited by knowledge, education and employer demands. Furthermore, only a small number of programs in public health were carried out by nurses in her study (Kreger 1991b). Based on this she made the recommendation 'that funding for education in ... primary health care be made available to management personnel from remote area health services' (1991a:ii). Further to this she outlined the PHC content material that should be included in a remote area nursing course. In another study which reported on the role of both rural and remote area nurses, Kreger (1991a) examined rural nurses’ scope of practice, which included their involvement in PHC. She suggested that the literature indicated that rural nurses provide a 'wide range of primary health care' and that between 40 and 50 percent of South Australian and 41 percent of Queensland rural nurses in 1991 carried out health education and promotion programs (Kreger 1991a:30). Further, Kreger (1991a) found that rural nurses conducted higher levels of individual- focussed rather than population focussed programs. The limitations experienced by rural nurses in her study concerned the inability to collect data related to the effectiveness of their programs.

Again, however, there is a failure to differentiate rural hospital- based and rural community nurses' practice.
Percival (1994) suggested that little has been done on PHC in the context of community nursing in Australia. Further, the studies that have been conducted have explored educational needs or PHC practice.

I concluded by writing:

Therefore, no studies have examined the principles of primary health care philosophy and its implementation by rural community nurses in the context of their work culture.

In order to frame the types of questions and focus the gaze I explored a selection of literature on PHC. This was mainly because I had been nursing and teaching for most of my career in the acute context and was unfamiliar with the territory and the writing in PHC. To begin with I wrote:

The literature on primary health care and nursing

The following is a brief overview of the Australian, British and North American discourses on primary health care. Some work/s are based on scholarship, while others are researched-based. The review is deliberately brief and is not intended to be comprehensive. This decision is based on the nature of the methodology and is in keeping with the thoughts of Lather (1988) and Harvey (1990).
On returning to review this section I later wrote:

I am in agreement with Lather (1988:572) when she claimed:

In sum, my first basic assumption is that a definitive critique of positivism has been established and that our challenge is to pursue the possibilities offered by a post positivist/postmodern era.

Appropriating the ideas of Harvey (1990:208) concerning critical social science research, the implication of the above statement is that, in the postmodern era, there is no 'idealised research report format'. The linear format so typical of positivist research is not consistent nor coherent with the present type of research (Denzin 1994; Fontana 1994). Postmodern feminist ethnographic methodology does not provide the certainty of prediction that hypothetico-deductive approaches require. Rather, the methodology provides multiple sites for exploration with no guarantees or controls related to the findings. The review of the predominant discourses was therefore carried out in order to frame the questions (Denzin 1989) and observations fundamental to the field work.

What would be discovered was unknown and unpredictable.

Definitions of primary health care
One of the major problems discovered when examining the written discourses was an entrenched failure to differentiate the terms 'primary care'; 'primary nursing'; and 'primary health care'. The tendency for author's of reports and research to use the terms synonymously has added to the confusion concerning
these types of services and the philosophy that underpins each (Dowling et al. 1983, Rural and Remote Nursing Summit 1998).

Primary nursing is a method of organising the delivery of care to a client where one particular nurse has the responsibility for the care of that client during the entire time of contact with the health service (Dowling et al. 1983). Primary care refers to the first level of contact that is experienced by a person seeking assistance for a health related-problem (Australian Health Ministers' Advisory Council 1988). In the study by Dowling et al. (1983:3), close to half of the respondents (n=58) referred to PHC in terms of 'point of first contact'. Without providing exact figures, Dowling et al. (1983) indicated that the respondents in their study included domiciliary and community nurses.

Primary health care, while it may involve primary care or primary nursing, is a particular philosophical approach of a total health service which takes account of the health as a human, social and economic phenomenon (Dowling et al. 1983).

On the other hand Kreger (1991a) claimed that the WHO viewed the concept of PHC as composed of three different levels of understanding. Firstly, PHC is viewed as 'the primary level of service' (Kreger 1991a:xv) within a particular health care system. Secondly, as a service delivery that was based on six major principles. Thirdly, as a strategy aimed at developing a health care system based on these principles (Kreger 1991a).

Writing in the Australian literature, Lamont and Lees (1994) differentiated terms such as 'primary care' and 'primary nursing' but favoured the term 'primary health care'.

The confusion discussed above has been linked to a lack of universal understandings of the above terms (Dunlop & Jacobs 1995), with a continuum
model postulated as explaining most conceptualisations (St John 1991; Wass 1994). Furthermore, a blurring of conceptual boundaries due to a lack of coherent practice (Lamont & Lees 1994), or an 'unarticulated conceptualisation of nursing' (Schoenofer 1995:15); PHC's trans-disciplinary origins (Lamont & Lees 1994) and, therefore, varying values and attitudes of the practitioners; lack of appropriate job description; varying professional training and education; and different personal political philosophies has also contributed to the confusion (Kendall 1993; Bradford & Winn 1993; Dunlop & Jacobs 1995).

While those writing in both the UK and Australia have largely ignored the problematic nature of the conceptual fuzziness created by the failure to clearly define relevant terms, Chinn (1995), in an editorial, has made a fine contribution to clarity within the North American literature. She has clearly discussed the terms 'primary care' and 'primary health care'. Further, she noted the trend towards reacting to these terms in the context of policy formation and the reorganisation of health care structures. Within these structures there was an attempt to realise concepts of primary care which are often unclear, with conflicting definitions, concerns regarding cost, and the extent of changes that need to be made. Moreover, Chinn (1995) stated that she chose the term 'primary care' over 'primary health care' because it was the more generally used term and therefore placed nurses in the centre of the debate rather than marginalising their contribution. She also noted however, that it was up to nurses to define what this context was, especially in the arena where primary care is actioned and where nurses have a vision of its implementation.

In Australia, however, St John's (1991) approach has added further confusion. She differentiated between Community Health nurses and primary health nursing, implying that these were two different categories.

The implied ambiguity, therefore, has raised several questions. Does she refer to the differentiation between
domiciliary and community nurses? Or community nurses and nurse practitioners at first level of contact?

It is important to note that Dowling et al's (1983) study in the early 'eighties identified the problems raised by the lack of conceptual clarity.

It is somewhat surprising then that it is still evident in work in the early (St John 1991) and late 'nineties (Rural and Remote Nursing Summit 1998).

In a later review of this chapter I realised that two concepts I struggled with were 'discursive' and 'discourse'. The label for this section changed many times as I sought to understand each. I finally differentiated both terms and chose 'discourse' as defined by Rosenau. She stated that discourse is 'all that is written and spoken and all that invites dialogue or conversation' (Rosenau 1992:xi). It came to my mind then that what I would do at the end of each chapter was to invite a conversation with the reader. By putting aside a page at the end of the chapter
a space would be created for dialogue with the reader.

The discourses

Health promotion as primary health care

The writing on the topic of primary health care in Great Britain is characterised by a lack of differentiation between 'health promotion' and 'health education' which has tended to created some conceptual confusion (Wilson-Barnett & Clark 1993). While some authors such as Tones (1993), Campbell (1993) and Cribb (1993) situate the discussion within an ideological framework, the notion of primary health care remains within an education framework. Furthermore, Cribb (1993) discussed the difficulties concerning the idea of health promotion and stated 'health promotion denotes a conceptual space rather than a clear professional policy or institutional domain; and it is a space of debate, uncertainty and ambiguity' (1993:29).

The depth and breadth of primary health care in nursing seemed underdeveloped, lacking both an ideological framework and a body of practice from which to draw researched-based theory. The perspective also lacked reference to the major conceptual work derived from the Ottawa Charter and WHO health policy.

In the first and second drafts, the exploration of the literature was structured by country: Australia, United Kingdom and USA. I chose this mainly because it has
always been of great annoyance to me when conclusions about nursing have been drawn without due consideration given to the differences between health systems and health cultures. By the third draft, however, I realised that more sense could be made if the discussion was restructured into major themes related to the concepts inherent in the PHC discourse.

The Ottawa Charter
 Unlike the British, the Australian nursing literature has taken an approach based on the Ottawa Charter. Lamont and Lees (1994) stated that the principles of primary health care are important for community nurses for several reasons. Firstly, because the principles would help the achievement of health for all by the year 2000. Secondly, they would provide the framework for decision making, autonomous practice and being a primary health care provider.

What has been put foreword here is the idea that this framework will increase professionalisation.

St John (1991) in her research also referred heavily to the WHO's (1977) adaptation of the goal of Health for All by the Year 2000, and the WHO (1981:11) document which outlined the vision of the social context of health. She noted the obvious move from the old public health to the new public health; the recognition of the contribution social and environmental factors make to ill
health; and, therefore, the move away from the medical model. She cited the WHO (Europe) Regional Strategy in support of Health for All (1985) and identified such concepts as ' (a) adding life to years (health promotion), (b) adding health to life (reducing morbidity) and (c) adding years to life (reducing premature mortality)' (St John 1991:2).

Keith Tones (1993) is one of the few writing in the UK who has articulated an ideological basis for PHC, although situating the discussion within the narrow concept of health promotion. For Tones (1993) 'Health Promotion = Health education x Healthy Public Policy' (in original). He placed the ideology within a moral and ethical perspective. Further, health is conceptualised as: holistic; a positive essential to living a productive life free of inequalities, with social change embedded in the community which has the power and resources necessary to bring about structural and attitudinal change; directed towards providing health for everyone; and utilising enabling and cooperative strategies to alter inhibiting social, economic and environmental barriers to health. From a North American perspective, Schoenhofer (1995) has drawn on the 1960s conceptualisation, and referred to the WHO definition and the 1978 Alma-Ata conference as well as the ANA definition of primary care to fully conceptualise the broad concepts of primary care.

Socio-political activism and social change

Scholarly work within Australian nursing has identified the embryonic strands of PHC within Australian health policy. In particular Watts (1990) has influenced the discourse of socio-political activism both nationally and internationally (Schoenhofer 1995). She clearly identified the potential leadership role of nursing, and community involvement (development) as a form of democracy informed by ethical principles (thus linking the substantive nature of nursing with that of democracy); and the need for a politicised, proactive advocacy-based nursing profession (Watts 1990).
Her argument is balanced. Furthermore, she questioned the reality of social activism by nurses in the context of the present health care system.

Critical social activism directed towards empowerment of individuals and communities, and radical social change aimed at reducing social inequalities, (in keeping with the Ottawa Charter) is also a major theme in some of the scholarly discourses in the United Kingdom (Campbell 1993, Cribb 1993, Igoe 1993, Tones 1993). Nurses have been challenged, both as a professional group and as individuals, to publicly support the radical nature of the social changes required to dismantle structural inequalities (Campbell 1993). Campbell (1993) and Cribb (1993) have also recognised the difficulty for nurses in achieving this while still being part of the systems of control which underpin nursing. Furthermore, Tones (1993) linked empowerment, health education and critical theory and drew on critical consciousness raising to challenge nurses to be involved in political activism.

This theme is further articulated by Hagedorn (1995) who has drawn on Freirean critical social theory. From a North American research context with adolescents, she stated: 'a political perspective on primary caring energises and gives meaning to primary care practices' (1995:1). Political activism, she contended, is based in the primary nurse’s conscious action within and on the social world in which the health of clients is situated. The 'primary caring experience' (Hagedorn 1995:1) was capable of social and personal transformation. The development of the political perspective provided the basis for transformation of the system of health care. She defined health from a critical social perspective, locating it with social transformation. She stated:

Health is the power to critically understand, resist, and transform the personal, social, political, environmental, and ideological contradictions that
affect individual and collective well-being (Hagedorn 1995:3).

Her discussion articulated social justice and the processes of activism that enabled social transformation, and referred to Freire's (1993) idea of the relationship between action and meaningful thought. She challenged nursing 'to more explicitly express its connectedness and social relevance' (Hagedorn 1995:3).

In support of these ideas and writing in the USA, SmithBattle (1995) discussed the findings of her research on teenage mothers in terms of primary care concepts related to social justice.

From an Australian perspective, Dunlop and Jacobs (1995) have noted the contradiction between the above and the discourse of primary health care policy. While they clearly identified from Jacobs' research that health promotion was a major tenet of primary health care, they also suggested that this necessitated an active involvement in 'a political process to achieve social justice' (Dunlop & Jacobs 1995:282). Moreover, they believed health promotion necessitated an attitude embedded in the nurse as change agent.

While there are those as outlined above who speak of the critical context of the nurse, Cribb (1993) provided the example of the 'self-empowerment model' for individuals and the community.

Cribb (1993) questioned however, the contradiction of utilising this model together with an emphasis on process or outcomes. He further differentiated between health promotion as behavioural science and as care, and suggested there
is a tension between the two conceptualisations in terms of how individuals are viewed.

This theme is also encountered in the views of Dunlop and Jacobs (1995), who question the political stance of Australian nurses.

Dunlop and Jacobs (1995) suggested that nurses have failed to empower those of their client base by an adherence to the rhetoric of and no challenge to the dominant discourses. Furthermore, the apolitical nature of nursing has maintained the status quo, where dominant discourses maintain the power to define the individualised, treatment-orientated approaches to primary care.

In answer to the concerns raised above, White's (1995) research discussed the concept of the sociopolitical knowing context of nursing.

White suggested that unlike other patterns of knowing, sociopolitical knowing addressed the 'wherein' (White 1995:83). It changed the gaze of the nurse from the narrow interpersonal relationships to the structural context of ill health and nursing practice.

White concluded that nurses' lack of sociopolitical knowledge had resulted in an invisibility of nurses in health planning, policy and decision making. Further, she referred to 'gatekeeping mechanisms' (White 1995:85) and the role of public conceptions of nursing in terms of nurturing which seem contradictory to nurses' political involvement in health planning and policy formation.

Schoenhofer (1995), in her research, also articulated the need for a reconceptualisation of primary nursing. As suggested earlier, she draws heavily on the work of Watts (1990) whose central ideas were community involvement
and the democratisation of health care, redistribution of power, and a clear understanding of health care as a political process.

The marginalised and social change

Pursey and Luker's (1993) British research identified the marginalisation of the aged. This was exemplified by the fact that none of the participants in the study they undertook believed they had a role in health promotion with the aged (Pursey & Luker 1993).

Their study was limited, however, in that it did not allow the researchers to know exactly why this was so, although there was some indication that this was related to viewing old age as an end of life period with deterioration and disability to be expected. Health promotion, therefore, was seen to be inappropriate.

Although writing from a North American perspective, Burke Wieser and Keegan (1995) were some of the few researchers who spoke in terms of culturally sensitive primary care.

Their approach, however, was apolitical.

They placed the discourse within in the context of holistic care and spoke about the need for primary care providers to be aware of 'culturally based health beliefs and behaviours' (Burke et al. 1995:51).

Further, St John (1991) was one of the few writing in the early 1990's in Australia who examined PHC in the context of Indigenous health.
St John identified the concept of 'diseases of affluence' (St John 1991:1) and the health status of Kooris, and the problems of inequality based on 'socioeconomic status' (St John 1991:2). St John argued that the health of Indigenous Australians was related to poor socioeconomic status; however, issues related to marginalisation based on discriminatory practices were given scant attention.

On the other hand, the importance of the sociopolitical knowledge of the nurse and the patient was linked by White (1995) to the cultural identity of the marginalised.

This form of knowledge was concerned with understanding cultural identity which influenced health beliefs, 'language', 'identity, and connection to the land' (White 1995:84).

Tokenism, colonialism and paternalism
While the marginalised have largely been ignored in the primary health care literature, discussion concerning tokenism, colonialism and paternalism has been more forthcoming. In the UK, both Wilson-Barnett (1993) and Tones (1993) warn against tokenism and the possibility that things may appear progressive in theory but in actuality may be very different. Schoenhofer (1995) in the USA and Watts (1990) in Australia echoed these thoughts. SmithBattle (1995) reflects the North American view that nursing needs to be careful to avoid tokenism and hidden power plays (justified in the concept of increasing the professional status of nursing) which are contradictory to the accepted ideology of primary care.

Extending this idea further and from an Australian perspective, Keyzer (1995) noted that community-based
care under the banner of PHC was at risk of colonisation of the community by the hospital services (Keyzer 1995).

Dunlop also mentioned the need to recognise the values underpinning primary health and where it existed as an example of 'post-colonial imperialism' (in Dunlop & Jacobs 1995:285). Further, Jacobs contended that the disenfranchisement of some groups in the health care system is contrary to primary health philosophy. Jacobs drew on her own research on Australian mothers of children with disabilities. She warned about community development and healthy public policy as oppressive paternalism and 'social engineering' which hid the problems of the disadvantaged (in Dunlop and Jacobs 1995:289).

Dunlop and Jacobs (1995:290) espoused the view of nursing as 'the individualised arm of the primary health movement', with nursing's importance being seen in terms of numbers. This they believed arose through embracing PHC out of a discontent with the previous system. They further believed, that nursing lacked an appropriate model to guide practice and a strong voice in policy formation.

St John (1991) has also added to the knowledge on why there has been limited success in the implementation of PHC in Australia.

St John identified 'political, economic, structural and social factors' (St John 1991:6), but also believed that appropriate 'knowledge, skills and understanding of primary health care' (St John 1991:6) was important for health care workers in PHC.

Surveillance and the language of control

Control in the context of the necessity to control circumstances to bring about desired change was articulated in the British literature (Tones 1993). A recurring theme, however, was the need to prevent the language of health promotion
becoming the screen which hides what is going on in practice and, at the same time, legitimising other activities.

**Language can be a mechanism to express care and also to control.**

The elements of control are sited within ‘the existing institutions and cultures of health care or public policy’ (Cribb 1993:32) and nursing activities (Kendall 1993). Foucault and Grace feature in much of the analysis of those reviewed. This was characteristic of both research and scholarly work in Britain (Cribb 1993, Campbell 1993), USA (Smith-Battle 1995) and Australia (Dunlop & Jacobs 1995). Reference was made to ‘patterns of social knowledge’ and the connections to ‘patterns of power’, ‘technolog[ies] of control’ by the controllers of knowledge (Cribb 1993:33), and the ‘language of control’ and a ‘logic of consumerism’ (Campbell 1993:23).

**Furthermore, the move to envelop all care within a health promotion perspective, especially the discourse of holism, has provided ‘multiple sites for surveillance … [and]… social control’ (Cribb 1993:33-34).**

In Australia, Jacobs (in Dunlop and Jacobs 1995) drew on her own research and identified the role of quality assurance and accountability discourses as reflecting the pivotal role of government in controlling the agenda. Dunlop referred to Foucault’s (1977 in Dunlop & Jacobs 1995) idea of surveillance of the self, and suggested that this is what is being demanded by governments in the quality discourses. She stated:

*The intention is to convert accountability measures into shopfloor ideology, in much the same way as primary health philosophy seeks to convert health*
care decisions into 'community decisions'. Both moves effectively conceal who is running the show (Dunlop and Jacobs 1995:284).

Talking about language, Schoenhofer (1995:13) questioned what can be learnt about primary nursing care from the 'person who experienced it'. Furthermore, she questioned the need to reinvent a nursing language of primary care, which reorientates the focus towards social relations and interpersonal connections.

Medical dominance
The power of a reductionist, mechanistic illness-orientated model and the people that espouse that model for health is discussed from several viewpoints within the literature. The debate concerning biomedical and social models of health, and the influence this has had on the emergence of selective and comprehensive PHC, is clearly articulated. Also, the extent to which the medical model has influenced nursing curricula, health versus sickness models of nursing, and individual-versus community-focus implementation of programs are discussed in the context of powerful discourses of health policy.

Biomedical versus social models of health
The major powerful discourse in health was seen by many writers in the three countries reviewed to be a medically-orientated illness model. In a discussion of their research, Bradford and Winn (1993) indicated that even with the 1990 policy changes in Britain (Community Health Care Act) related to health promotion practice, nurses were carrying out illness prevention in the areas of diabetes and asthma. They suggested, however, that this would be difficult to accept as primary health care. Furthermore they noted that the prominent use of the medical model indicated that health promotion services were largely prescriptive and centred upon the individual rather than the community.
Interestingly, they also found that more radical models of health promotion were held by younger members of the group they studied (Bradford & Winn 1993).

Although having written from a North American perspective, Schoenhofer (1995) noted that nurses' activist strategies in dismantling the biomedical model was hindered by a lack of clearly articulated nursing primary health care models.

In Australia, Dunlop and Jacobs (1995) echoed this idea.

Dunlop and Jacobs noted that nurses naivety regarding the power of the dominant discourse to influence the type of health care system was conceptualised in 'the myth of the neutered systems' (Dunlop & Jacobs 1995:284). Further, they stated that a belief in the harmlessness of these systems of control in the context of community development resulted in a shift in responsibilities with: lack of funding for infrastructural support for individuals or communities; the creation of new inequalities; a de-politising of PHC; and little authority for nurses to control the agenda (Dunlop & Jacobs 1995).

Writing in 1991, St John questioned the relevance of PHC in an affluent country like Australia, but noted that the philosophy seemed appropriate for third world countries.

While PHC had been picked up by Australia, St John also considered this problematic.

St John (1991:4) suggested that the goals of PHC had not been reached at that time, that there was a still an illness focus; and that the attempt to reach this goals had extensive implications related to a 'change in thinking'. Further, she challenged nurses' total allegiance to an illness model. She questioned the appropriateness of
this model and challenged the profession to be prepared to alter education, practice and management in order to take up a role in PHC (St John 1991).

Health versus sick nursing

McLeod Clark (1993) suggested that, in the British nursing context, health education and promotion were seen as the domain of health visitors. When these concepts had been taken on by other nurses, the approach had been to just add them on as something else to be incorporated into the 'traditional role' (McLeod Clark 1993:257).

While there has been some change in the emphasis of nursing curricula in the UK based on the ideas in Project 2000, there continues to be an emphasis on what the author terms 'sick nursing' rather than 'health nursing' (McLeod Clark 1993:257).

Selective versus comprehensive primary health care

In Australia, Wass (1994) has raised the idea of selective and comprehensive Primary Health Care. Selective PHC has been viewed as a biomedical model implementation of PHC. Comprehensive PHC has been seen as the implementation of PHC in keeping with the Ottawa Charter.

This differentiation was further explored by Dunlop, who suggested that when the government supported primary health there was a tendency for it to slide towards the selective type (in Dunlop and Jacobs 1995).

Jacobs talked about the apparent contradiction in the espoused holistic approach of primary care and the need to consider the socio-economic context and the quality
assurance and accountability discourses that hid the politically driven discourse in relation to tight economic times. Dunlop and Jacobs referred to the difficulties as posing a type of victim-blaming. In the context of this debate, Jacobs concluded that the comprehensive approach may be quite idealistic (in Dunlop and Jacobs 1995).

MacDonald (1993), an educationalist writing on PHC while at the University of Bristol in the UK, has taken a sufficiently broad approach in keeping with the original notions of primary health care. Framing his discussion ideologically, he suggested that PHC is needed because of a failure of the present medically orientated system to meet health needs in most countries. He also discussed the nature of the medical model and the broad concepts of PHC, and raised the idea of 'selective PHC' (MacDonald 1993:11). He was critical of medical dominance, and sited the failure of governments to fully incorporate comprehensive PHC within the realm of medical dominance.

Further to this, MacDonald challenged members of the health professions to ask critical fundamental questions about the health care system in which they work.

Finally, Lamont and Lees (1994) discussed PHC in Australia, including such concepts as community, health in the context of the environment, economics, and the social and political arenas. In keeping with the Ottawa Charter, they stressed intersectorial approaches, inequalities in service provision and the implications of the medical model, and stressed the value of the social model of health.

Education and professional development
Many nurses, including those in Australia, have called for increased education for nurses in the areas of PHC and community nursing (Mahler 1985; WHO 1986;
Bradford and Winn (1993), in the UK, noted the development of the extended role of the nurse and stressed the importance of health promotion training.
In a research context, Schoenhofer (1995), in the USA, identified that the social model of health does not emphasise medicine or medical knowledge as the cornerstone of primary care.

While this is so, Schoenhofer also questioned why nursing curricula continued to utilise a biomedical model.

Economic rationalism
Relating the experience in the USA, Schoenhofer (1995) firstly discussed the co-option of primary care nurses into the medical discourse as ‘advanced practitioners’, usually in a medical subspeciality, with nursing following ‘medicine down the related trail of consumerism in the 1960s and 1970s’ (Schoenhofer 1995:13). Furthermore, she stated that the rhetoric was such that the move was articulated as socially relevant and just.

As a consequence nursing was constructed within a market economy as consumable, like any other product where profit rather than empowerment was the goal (Schoenhofer 1995).

On the other hand, Lamont and Lees (1994:318), from what is an economic rationalist approach, accepted that ‘[c]ommunity health nursing [in Australia] is affordable, accessible, acceptable and appropriate health care'.
Nursing in the community or nursing the community

In Australia, in the past, community nursing has been defined by the practice setting (Lamont & Lees 1994). Community nursing historically was viewed as an extension of the hospital setting. Lamont and Lees (1994:318) stated:

*The characteristic of community nursing which distinguishes it from all other nursing practice is its emphasis on primary health care and its focus on community as the client, not its community practice setting.*

Moreover, they placed the setting of PHC in the total health system, based on holistic practices with information and assistance as resources. The aim, they suggested, was to support and create a self-care climate and community participation.

Furthermore, Lamont and Lees articulated the role of the PHC practitioner as one of facilitation and empowerment of both individuals and the community.

A reorientation in nursing education was stated to be necessary in order to develop more appropriate skills for practice which emphasised population needs. Lamont and Lees (1994) correlated the focus on individual programs within nursing curricular with a biomedical model of health. They suggested that the principles of community nursing practice are health promotion and education and the prevention of disease, and they spoke in terms of primary, secondary and tertiary prevention. Moreover, they linked community nursing processes and the nursing process as applied to individuals, family and the community to PHC. They stated:
Primary health care is the philosophy on which nursing practice is based, and the principles and process of community nursing provide the directives for nursing care delivery, which remains constant regardless of the practice setting (Lamont and Lees 1994:320).

Primary health care and remote area nursing
While it is acknowledged that the sameness/difference debate concerning rural/remote area nursing continues, the point made by Lamont and Lees (1994) concerning this issue is relevant. They described PHC in the context of child health practice in the school setting and remote areas as primary, secondary and tertiary prevention framed by the nursing process. They commented regarding remote area nursing:

In many remote areas community nurses are the main providers of health care and in order to meet the health care needs of the isolated community must perform an extended primary health care role (Lamont and Lees 1994:325).

It is difficult to know exactly what the authors meant by this extended role.

Some light, however, was shed on the topic by describing the context of remote area nursing as one where nurses often functioned without resources and intersectorial support. There was value, they believed, in a community development model for remote area nursing.
Policy rhetoric
Little has been written concerning the nature of PHC policy in relation to nursing in Australia. Rather, PHC policy has been situated in the broader context of health policy. Martins (1994) is one of the few who have written on this topic. She is mainly concerned with policy formulation, evaluation and the professional's role.

This is only briefly discussed, however, in relation to the context of community health.

Martins (1994) suggested that policy in this area was concerned with services, consumers, agencies and providers. The benefits gained from considering PHC as a special category of health policy were mainly couched in the ideas of preventing hospitalisation and increasing, self-management; independence and continuity of care.

Further, Martins (1994) suggested that the basis for having a separate policy was due to past fragmentation of services and the complexities in accessing services especially for the aged; however, she stressed the need for policies to be flexible and integrated. This, she claimed, was aimed at reducing or preventing over-servicing as well as enhancing the other points raised above (Martins 1994).

In this case there is a hint of economic rationalism, a lack of analysis of the political discourses which form much of health policy, and a lack of critical discussion concerning the difference between policy intent and implementation.

Individual versus population (community) focus
Dunlop and Jacobs (1995) have asked a major question: If nurses have such a central role in primary health, why is it that they have not been advocating on
behalf of clients? They suggested that, while this role is obvious in policy documents, it was not identified in the actions of primary health nurses that Jacobs studied. Dunlop and Jacobs (1995:277) sited the 'individualised care' of nursing today within the historical roots of the British public health movement of the 19th century.

Furthermore Dunlop and Jacobs (1995) suggested that involvement with family or community happened as an extension of this individual approach.

Dunlop and Jacobs (1995) placed the evolution of district nurses in Britain within the work of Nightingale in relation to the importance of a healthy environment. Moreover, they saw the move in Britain to health visitors as the splitting of nursing care from 'nursing advice' (Dunlop and Jacobs 1995:281) and drew a parallel in Australia with the trend to differentiate between 'domiciliary and community nursing' (Dunlop & Jacobs 1995:281). As evidence, they cited Symmonds' (1991) study where '[B]ritish respondents tagged the two groups "angels" [district nurses] and "interfering bodies" [health visitors]' (Dunlop & Jacobs 1995:281). Further, they postulated that the reasons for this included: a framing discourse of the nurse as the saviour; 'victim-blaming' (Dunlop and Jacobs 1995:282) by nurses; individual responsibility and 'his/her family'; and, sometimes, friendship networks to account for this categorisation. Following this, Dunlop commented:

What disappears from view in this individual focus is the wider socio-political and economic framework in which the nurse-patient dyad and its micro-environment is situated increasingly a world order (Dunlop & Jacobs 1995:282).
In the USA, Schoenofer (1995) discussed the need to connect the individual, family and community. Further to this, she suggested that the similarity in the basic concepts of nursing and PHC is the basis for the move to rename 'public health nursing "community health nursing "' (Schoenofer, 1995:17). Schoenofer (1995) stated '[t]he "what" of primary care and of nursing is caring, an active expression of personal knowing, respecting, and valuing created and communicated moment to moment' (Schoenofer, 1995: 17-18). Schoenofer (1995) drew on her experience of observing primary care in the Philippines and concluded 'when primary care is the mode of nursing practice, it is nursing care' (Schoenofer 1995:20).

Writing the conclusion to this section occurred in the final days of writing and reflects the position I had arrived at several years after beginning the research.

Concluding thoughts

Primary health care philosophy has embedded within it certain principles, which are suggested by McMurray (1999:24) to be 'equity, access, empowerment, community self-determination and intersectorial collaboration'. In 1997 the Jakarta Declaration incorporated these principles to guide health promotion strategies (McMurray 1999). One year before the Jakarta Declaration, however, Hegney (1996), in a discourse analysis of policy documents, found that a wellness rhetoric of the health service was still dominated by the medical model and illness-orientated services. Hegney (1996) identified the importance these documents placed on the delivery of primary health care in rural areas, especially the importance of community involvement, responsiveness to community
needs, and mechanisms for local residents' input into services. While it may be relatively easy to form and adopt policy, full implementation is proving to be more difficult.

The work previously discussed has identified the discursive practices which have shaped the PHC literature. These texts either articulated or critiqued the principles of PHC to a greater or lesser degree. A reading of these texts informed the broad ethnographic questions utilised in the interviews of nurses and clients, and served to frame the gaze by which I read the cultural context.
Chapter Two

World Views and Paradigms
The decision to situate this research within postmodern feminism was based on both a personal world view and research design considerations. Firstly, I was personally challenged by a world view that validated difference and diversity and questioned positivist notions of authorities, knowledge and absolute truth. I had also, in earlier work, stated that I had some difficulty with the modern conception of self (Davis 1993b). By the end of my Masters work I had come to view the partiality and multiplicity of knowledge and truth as notions that I wished to pursue in a research context. And, as I had concluded earlier, the notion of separating the personal and professional, or my knowing and being, was something I no longer accepted as valid (Davis 1993b). As a self-identified feminist, I wished to explore the value of a world view which incorporated my belief
that the personal was political and vice versa within a framework for those who had essentially been left out by feminism's centralist form of analysis. Furthermore, I desired to explore contemporary philosophical and political thought in order to understand the contribution they could make to my understudying of nursing. I was of the view that it is important to explore that which challenged some of the assumptions underpinning contemporary nursing in this country.

Secondly, from a research design perspective, my original intention was an ethnography which included both women's health nurses and rural community nurses. The notion was not comparativist. Rather, it was to do as Grosz (1994); Game and Metcalfe (1996) and Fox (1993) had done: that is create a context of intertextuality. That is, to put the women's health nurses' texts and the rural
community nurses' texts alongside each other and create a conversation. To do this required an appropriate methodology – hence the choice was postmodern feminism. The following is my exploration of postmodern feminism and the contribution this world view makes to our understanding of the lifeworld of rural community nurses in the context of implementing primary health care policy. Why it is just rural community nurses will become evident in the proceeding chapters.

While the discussion of the methodology was lengthy, it was also a necessary part of understanding a way of thinking about the world of nursing which was new, challenging and risky. Further, it was a paradigm that was well outside the scientific paradigm that had contextualised my own experience of knowledge production. I had a Bachelors and a
Masters degree in science, and I was aware of the degree to which postmodernism challenged the elitist position of science. I was interested, however, in nursing and sociological or cultural knowledge production within an interdisciplinary context.

Introduction
Postmodern feminism is a concept which was referred to by Benhabib (1995), as the unhappy marriage between feminism and postmodernism. It is also a play on a similar concept from the title of a book _The unhappy marriage of Marxism and feminism_, edited by Lydia Sargent (1981). The following discussion represents an exploration of the terrain created by a merging of these two theoretical positions.

Postmodernism has been referred to as a way of life, in that it is what exists in this post-Fordian (what comes after the capitalist economics of the assembly line) world; the postmodern contestation within feminist discourse is a way of coming to terms with this lived experience (Lather 1991; Wicke & Ferguson 1992). How they will both affect each other is difficult to envision. However, both feminism and postmodernism are discourses which are changing.

Rather than the meeting of binary opposites I would argue that there is a degree of shared ground where the boundaries are blurred and overlap. It is a place where a new intellectual and political terrain has the possibility to come into being.
It is this possibility I wish to explore. Before I do, however, it is worthwhile explaining several aspects related to the structure of the text. The writing strategy employed is similar to that utilised by Grosz (1994), Game and Metcalfe (1996) and Lather (1991). In their works, these scholars abut the idea of others up against each other, staying as close to the original text as possible. My need to explain is based on comments received in relation to an earlier rejection for publication of parts of this chapter. The rejection of the material was based on an interpretation of the work as clumsy in style and non-reflective of the author’s own work. There was, I believe, a misunderstanding of the writing strategy. The originality of the work, however, exists within the way the text is structured. It is a deliberate writing strategy which attempts to stay close and not appropriate
the 'other' voice as my own (Opie 1992). The methodological consistency of this ironic writing strategy is discussed in greater detail later in the chapter. A second structuring tactic I have chosen, is similar to Lather's (1992b): that is, to present three layers to the story, these being realist, oppositional (deconstructive) and reconstructive analysis.

Finally, the text is layered. The major writing occurred in 1996 with several revisions in 1997 and 1998. What is heard by the reader, then, is a reflexive movement through time.

The debates

Postmodernism

The debate about postmodern epistemology has led, I suspect, to an incredible proliferation of diverse discussions and critiques situated in several diverse contexts.

On this point, Wicke (1992:13) notes that '[t]here are more than thirty-one flavours of postmodernism, and sorting out the indica and differentia of these critical brands entails opening a theoretical Pandora's box, especially apt for
feminism'. Natoli (1997) postulates over a hundred different brands of postmodernism.

On the other hand, Thomas Skrtic (1990) stated that there are two versions of postmodernism. One is the more 'radical or continental form ... [after] ... Lyotard (1984)' which rejects modernism (Skrtic 1990:127). And the other is the progressive liberal or American form after Bernstein (1983) 'which reappropriated American pragmatism and thus conditionally accepts modernism as a starting point for an emancipatory critical discourse' (Skrtic 1990:127).

Postmodernism can be viewed as a point in the history of late capitalism, a period after modernity, or a somewhat contradictory collection of theorising on the 'nature of language, texts, and human subjects within the lens of the social' (Wicke 1992:13).

While this may be so, there are those like Antonio and Kellner (1995) who have argued that the attempted rupturing of the rationalism of western philosophy by postmodernists such as Lyotard, Foucault and Baudrillard is in itself a rejection of the possibility of a postmodern social theory.

On the other hand, Lemert (1992:23) does not agree, and refers to postmodernism as an 'ironic general social theory'. Scholars often debate postmodernism based on a selected postmodernist theorist such as Foucault (McNay 1992), or speak of postmodernism in terms of its relationship to modernism (Nicholson 1992a and b, Lather 1991). For example, they speak of postmodernism as a critique of enlightenment, or in
terms of its major tenets (in much the same way that feminism has been discussed).

Hassan (1987:168) speaks conceptually, referring to his 'catena' of 11 concepts of postmodernism. These are: 'Indeterminacy'; 'Fragmentation'; 'Decanonization'; 'Self-less-ness, Depth-less-ness'; 'The Unpresentable, Unrepresentable'; 'Ironic'; 'Hybridisation'; 'Carnivalization'; 'Performance, Participation'; 'Constructionism'; and 'Immanence' (Hassan 1987:168-172). Furthermore, most of the critique is discipline-based (Yeatmen 1994) and situated within the world view of the writer. For example, Rosenau (1992:x) views herself as 'a "modern" author'.

The modern author writing about postmodernism is a different author to the postmodernist writing about postmodernism.

Another matter is whether or not the writer differentiates between post-structuralism and postmodernism or basically sees them as the same. For example, Rosenau (1992:3) noted:

Most of what is written here with reference to postmodernism also applies to post-structuralism. Although the two are not identical, they overlap considerably and are sometimes considered synonymous. Few efforts have been made to distinguish between the two, probably because the differences appear to be of little consequence.

On the other hand, Nicholson (1992b) views this lack of differentiation as problematic.

Nicholson (1992b) located her discussion within postmodernism as she saw her context as philosophy and social theory. Post-structuralism, she viewed as
belonging to the realm of literary criticism and theory. Further to this she viewed post-structuralism as having a problematic 'historical legacy ... [which has] ... contributed to skewing the discussion among feminists in non helpful ways' (Nicholson 1992b:53).

Hyssen (1990) is in agreement, seeing the merging of the two together as incompatible, since he viewed poststructuralism as reproducing the oppressive element of modernity.

Others include poststructuralism and de-constructionalism within postmodern theorising (Stanley 1994), especially that concerned with representation (Denzin 1991).

Given the preceding discussion, it is obvious that there is substantial debate both within and across disciplines.

What is clearly relevant is that the author should state their position concerning their approach. The reader can then take this into account in their understanding of the context of what is represented as postmodernism, as this will vary according to the standpoint taken (Yeatman 1994). Lather (1991:4) indicated her position, although somewhat ambivalently; when she stated:

I sometimes use postmodern to mean the larger cultural shifts of a post-industrial, post-colonial era and post-structural to mean the working out of these shifts within the areas of academic theory. I also, however, use the terms interchangeably. This conflation of postmodern with poststructural is not popular with some cultural critics.
In her later writing, Lather (1992b) had not moved from this position.

Adding to the confusion, Foster (1988:257) has referred to 'neoconservative postmodernism' and 'poststructural postmodernism'. For Drucilla Cornell (1995:145), however, there is real doubt about even the terms 'postmodernism' and 'postmodernity'. She commented:

[I] even question "postmodernity's" adequacy as a description of either a set of hypotheses that can be associated with a specific group of thinkers or with a series of normative and political rejections that could successfully indicate a unique historical period (Cornell 1995:145).

Bring this all together, and there is no wonder there is some confusion.

However, let me at this point identify some terms I have discovered in the literature to conceptualise the relationship between modernism and postmodernism.

These include; the post-modern turn, after Hassan's (1987) book entitled The Postmodern Turn. This is a term which has also been selected by many feminists critiquing feminism's relationship to postmodernism (Frazer & Nicholson 1990, Lather 1991, Nicholson 1992a and b). Others are: 'the post-modern condition', after Lyotard's (1984) book entitled The Post-modern Condition: A report on Knowledge (Denzin 1991); 'the post-modern terrain'
(Denzin 1991); 'encounter'; 'scene' (Kroker & Cook 1986 in Lather 1991); 'position' and 'moment' (Benhabib 1995, Nicholson 1992b:68).

Each of the above expressions reflects a metaphoric stance in the authors thinking about postmodernism.

The question that I begged at the beginning of this discussion is do we want a marriage of feminism and post modernism, or, in fact, has the intellectual space already been created?

There is no doubt that there is much debate in feminist and nursing academic circles concerning the need to make the turn, walk the terrain, or welcome the condition. Feminists have been critiquing the grand narrative of enlightenment (Farganis 1994) for many years and feel that feminism does not need postmodernism to help it along. And some see postmodernism as denying the very need for the emancipation of women and, therefore, the very ground upon which feminism stands (Benhabib 1995).

Before coming back to discuss these issues I want first to examine the epistemological heritage and connections of postmodernism that may contribute to a feminist alliance.

This discussion is based extensively within the work of Rosenau (1992). She stated:
[P]ostmodernism represents the coming together of elements from a number of different, often conflicting orientations. It appropriates, transforms and transcends French structuralism, romanticism, phenomenology, nihilism, populism, existentialism, hermeneutics, Western Marxism, Critical Theory, and Anarchism. Although postmodernism shares important elements with each, it has important quarrels with every approach (Rosenau 1992:13).

The philosophical roots of postmodernism
Table one demonstrates some of the elements of epistemology that postmodernism has appropriated from the major political or social theories/theorists.

On the other hand they do not accept all of the thinking in the above outline and would reject the elements listed in Table two.
**Table one: Postmodern Appropriations**

<table>
<thead>
<tr>
<th>Theories/Theorist</th>
<th>Element Appropriated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Marxists</td>
<td>The critiquing of modern science and enlightenment</td>
</tr>
<tr>
<td>Critical theorists</td>
<td>Doubting of instrumental reasoning, 'modern technology, and the role of the media in a modern 'consumer society'</td>
</tr>
<tr>
<td>French Structuralists</td>
<td>Critique of humanist conceptualisation of the author and subject, 'understanding' situated in the subjective and conflicting interpretations, and a doubting of such concepts as truth, reason, moral universalism and good/bad.</td>
</tr>
<tr>
<td>Ethnomethodology</td>
<td>The concept of variation in meaning in different contexts</td>
</tr>
<tr>
<td>Symbolic interactionism</td>
<td>The deconstruction of objective reality and the situating of the meaning of social relations as a human construction.</td>
</tr>
<tr>
<td>Husserlian phenomenology</td>
<td>There is an emphasis on personal knowledge, a rejection of logocentrism and a doubting of historical lessons.</td>
</tr>
<tr>
<td>Populism</td>
<td>It shares a love of spontaneity, a degree of anti-intellectualism and an idealisation of mass culture.</td>
</tr>
<tr>
<td>Anarchism</td>
<td>A rejection of authority, single viewpoints and a toleration of contradiction.</td>
</tr>
<tr>
<td>Sartrian existentialism</td>
<td>Anti-humanism.</td>
</tr>
<tr>
<td>Hermeneutics</td>
<td>Critique of direct causal relationships and universal science.</td>
</tr>
<tr>
<td>Romantics</td>
<td>Emphasis on the metaphysical, emotional, sacred, and primitive</td>
</tr>
</tbody>
</table>

Adapted from Rosenau (1992).
Table two: Elements Rejected by Postmodernism

<table>
<thead>
<tr>
<th>Theories/theorist</th>
<th>Element rejected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hermeneutics</td>
<td>If the search for meaning results in one answer.</td>
</tr>
<tr>
<td>Structuralism</td>
<td>Emphasis on a logical, rational science.</td>
</tr>
<tr>
<td>Critical theories</td>
<td>Tendency to explain social phenomena in extratextual form and in terms of their search for truth.</td>
</tr>
<tr>
<td>Western Marxism</td>
<td>Humanism.</td>
</tr>
<tr>
<td>Anarchism</td>
<td>Emphasis on decentralised grassroots democracy and rational societies.</td>
</tr>
</tbody>
</table>

Adapted from Rosenau (1992).

It seems, in discussing emerging epistemologies, there is the tendency to view them as monolithic, having no internal differences, or being homogeneous.

_This I believe was the common way to think about feminism; it was only later, as women's studies programmes developed, that we began to speak in terms of feminisms. Here I am referring to the categories of liberal, Marxist, and radical feminisms which, although they share the common premise that women are oppressed, provide different explanations as to the cause of that oppression and the types of strategies that should be implemented to deal with that_
oppression. In the same way, I believe, due to the proliferation of scholarly work concerning postmodernism, it is also time to speak of postmodernisms. To some extent this has begun to occur—however, at a less theoretically tight level. For example, major approaches I have discovered tend to classify postmodern thinking into what appears at first glance to be a somewhat dualistically constructed conceptualisation.

Rosenau (1992), however, does suggest that there is overlap, and that the distinctions are not as clear as we would like them to be. The following distinctions have been mentioned by Rosenau (1992) and others (Benhabib 1995, Dickens & Fontana 1994), and are outlined in Table three.
### Table three: Dualistic Conceptions of Postmodernism

<table>
<thead>
<tr>
<th>Scholar</th>
<th>Dualisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graff (1979)</td>
<td>'Apocalyptic, desperate'/ 'visionary and celebratory'.</td>
</tr>
<tr>
<td>Foster (1983)</td>
<td>'Post-structural' / 'neo-conservative'.</td>
</tr>
<tr>
<td>Griffin (1988)</td>
<td>'Deconstructive or eliminative' /'constructive or visionary'.</td>
</tr>
<tr>
<td>Gitlin (1989)</td>
<td>'Cool' / 'hot'.</td>
</tr>
<tr>
<td>Agger (1990)</td>
<td>'Establishment' / 'radical, critical'.</td>
</tr>
<tr>
<td>Rosenau (1992)</td>
<td>'Sceptical' (cynical) / 'affirmative' (optimistic).</td>
</tr>
<tr>
<td>Dickens &amp; Fontana (1994)</td>
<td>'Chaos'/ 'liberation'.</td>
</tr>
<tr>
<td>Benhabib (1995)</td>
<td>'Weak' / 'strong'.</td>
</tr>
</tbody>
</table>


As you can see the authors are structured chronologically in sets of negative approaches and positive approaches. The view of scholars is that feminism will find an easier allegiance with the more positive and less negative postmodernists. To summarise the thinking of the two groups, I have again drawn on Rosenau (1992).
Table four: The Sceptical Postmodernist's Orientation or the 'Post-modern Despair' (Rosenau 1992:15)

<table>
<thead>
<tr>
<th>Scholar</th>
<th>Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scherpe (1986-7) &amp;</td>
<td>'Fragmentation, disintegration, malaise,</td>
</tr>
<tr>
<td>Baudrillard (1983)</td>
<td>meaningfulness, ... absence of moral parameters and</td>
</tr>
<tr>
<td></td>
<td>social chaos'.</td>
</tr>
<tr>
<td>Gitlin (1989), Foucault</td>
<td>Immediacy of death, death of the subject and author,</td>
</tr>
<tr>
<td>&amp; Derrida (1978)</td>
<td>the impossibility of truth, all that is left is a play of</td>
</tr>
<tr>
<td></td>
<td>meanings and words, and of the Order of</td>
</tr>
<tr>
<td></td>
<td>Representation'.</td>
</tr>
<tr>
<td>Scherpe (1986-7)</td>
<td>Catastrophe.</td>
</tr>
<tr>
<td>Latour (1988)</td>
<td>'The dis-illusion of space ... as a distorted de-centred</td>
</tr>
<tr>
<td>Jameson (1984)</td>
<td>global network'.</td>
</tr>
</tbody>
</table>


While the affirmatives are in agreement with the sceptic's critique of modernity, they are generally more optimistic than the sceptics about the age of the postmodern. They have tended to adopt a process oriented approach situated predominantly in Anglo-American thinking. This is outlined below in Table five.
Table five: The Postmodern Celebration

<table>
<thead>
<tr>
<th>Scholar</th>
<th>Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Derrida (1978)</td>
<td>'Happiness, farce, parody, pleasure &quot;joyous affirmation&quot;'.</td>
</tr>
<tr>
<td>Kristeva (1986)</td>
<td>'The &quot;subject-in-process&quot;'.</td>
</tr>
<tr>
<td>Bordewich (1988)</td>
<td>'Struggle and resistance'.</td>
</tr>
<tr>
<td>Frank (1983) &amp;</td>
<td>'Visionary, celebratory nondogmatic... tentative,</td>
</tr>
<tr>
<td>Hirschman (1987)</td>
<td>Non-ideological'.</td>
</tr>
<tr>
<td>Corlett (1989)</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from Rosenau (1992:16).

As Rosenau (1992:21) so aptly stated, the difference between the sceptics and the affirmative is that '[i]n the end, it is not the death of the subject that is of greatest interest in the social sciences so much as the birth of the postmodern individual and the "return of the new subject"'.

Further to this, Rosenau (1992) has noted that there is a lack of unity in postmodernist thinking and not all postmodernists would accept the above.

However, the implications of this are, given the historical roots of postmodernism, some people will find something in postmodernism with which to feel comfortable. And, as one can see, this has been so for those feminists who would see the postmodern terrain as a comfortable space.

Others, identifying the more negative aspects, will lay charges that this post-enlightenment perspective is relativistic, nihilistic, bent on world chaos and disruption and useless for theorising the everyday and the practical. As
Goldman and Papson (1994:224) succinctly noted in their discussion of the *Postmodernism that Failed*:

> There is also the shallow consensus that the postmodern encompasses a loss of unified meaning, a loss of certainty - the price of too much individuation, too much social construction of reality, and too much commodity hyperbole. In this conception of the postmodern sensibility, the loss of faith in the possibility of meaningful certainty elicits a cynical, jaded, blank, and blase attitude.

**Given the above, what then can be born out of the marriage of postmodernism and feminism?**

**Postmodern feminism**

The term 'feminist postmodernism', which is used by such scholars as Laurel Richardson (1991) is seen by Wicke and Ferguson (1992) to be an oxymoron. Therefore the preferred term used in this discussion will be 'postmodern feminism/st'. There are two approaches to the notion of postmodern feminism. It can be approached by considering what feminism brings to postmodernism or what postmodernism has to offer feminism.

**A major question is, however: Can feminism appropriate, transform and transcend postmodernism and avoid the death struggles that Benhabib (1995), Farganis (1994) and Wicke (1992) warn about? Adding to this question is the personal and professional cost that this move may incur.**
In academic circles the debate around the relevance of postmodernism for feminism is extensive and in places bitter and divisive. On just this point Benhabib (1995:31) noted:

This exchange brought four of us [Seyla Benhabib, Judith Butler, Drucilla Cornell and Nancy Frazer] who share profound ties of personal friendship into open public disagreement about our theoretical and political commitments. This process has not always been easy: public disagreements have strained personal loyalties and friendships.

And I was convinced that this, too, could be my story.

Yeatman (1994) refused to take a simplistic position in relation to this issue, stating that the relationship of feminism to postmodernism is filled with complexity. As Liz Stanley (1994:134) has noted, [t]here are different ways feminists can read postmodern theory.' Consequent to this, different feminist writers have discussed feminism's relationship to the major postmodern concepts identified by Rosenau (1992) in terms of both theory and politics (action). These concepts are: the author, text and reader; the subject; history, time and space; theory and truth; and representation.

It would seem that on a theoretical level postmodernism may offer a new perspective for feminism, especially in the area of accounting for difference.

Farganis (1994:109) suggested that the shared aspects feminists see in postmodernism is a context which validates and celebrates difference and
variety and is inclusive of 'marginalised voices'. It is a critique of essentialism, foundational and universal knowledge, science, truth; and the subject/object. Postmodernists validate the socially constructive nature of existence, the blurring of boundaries, and the need for dialogue or conversation rather than an authoritative voice (Glass 1994). Women's voices are therefore given new scripts, texts and discourses (Faganis 1994).

Ironically, it is not coincidental that women are being asked to give up their authoritative voice when either they don't yet have it or have just found it.

Postmodernism has been described as a 'theory of limits' by Faganis (1994:112) in that it is local and contextual. Truth is viewed pragmatically and is contextualised rather than universalistic. Postmodernism also sees people as political actors capable of rewriting history as we are each considered both victims and agents within a system of domination, so there is an emancipatory implication (Faganis 1994). This is further articulated in Jameson's idea of a postmodern resistance historically situated within the logic of the culture of late capitalism (1984; 1991) and Huysen's (1990) view that postmodernism is liberatory in that it rejects modernism's oppressive tenets such as false consciousness.

Postmodernism's emphasis on language or text continues feminism's critique of who writes/speaks and what is written/spoken. Values and norms are situated and contextual. Faganis (1994:113) summarises the above when she states:

With the shift to a postmodern feminism, attention was directed to the variety of discourses, to the many ways of being women, to the multiplicity of sites at which we engage power.
On the other hand Farganis (1994) has some problems with the political implications of this for feminism in terms of theory, and for the women's movement in terms of action. The questions which arise from the above include:
What type of emancipatory strategies are possible?
How can feminists claim a voice without being authoritative?
Who are feminists speaking for?
On what basis can feminism claim an epistemic advantage?
And Lather (1991) asked: What's at stake?

The ruptures of feminism and postmodernism
Craig Owens (1983) complained about the absence of feminist theory rather than feminist politics in postmodernism. And he finds this somewhat contradictory given feminism's increasing concern with difference and increasingly loud protestations on the master narratives within postmodernism. Denzin (1991); Morris (1988); Wicke and Ferguson (1992); and Richardson (1991) strongly refute this argument.

Denzin (1992) who is a notable exception amongst men writing in cultural theory, commented on this omission or sidelining of feminist theory within postmodernism. Furthermore, he also challenged Arac's assertion that women are absent from the debates (Denzin 1992).

Morris (1988) responded to this in the writing of The Pirate's Fiancée: Feminism, Reading, Postmodernism where, at the end of the 'Introduction', she provided seven pages of bibliography listing women who have written on feminism and postmodern cultural theory. And Laurel Richardson (1991:31)
takes Manning (1989) to task concerning the position he has taken in terms of the absence of women’s voices in his account of postmodernism and ethnography, (where feminism is cited 'in parentheses, after "deconstructive"'). Richardson (1991) made the point that this is an extremely inaccurate and simplistic representation of feminist writing in the postmodern. Making a stronger statement, she stated Manning’s ‘egregious subsuming of feminism under deconstructionism is neither intellectually aware nor politically benign’ (Richardson 1991:32).

However, for the purpose of simplicity, it can be said that there are two groups of scholars who have read the issues differently and clearly spoken about the relationship of feminism and postmodernism from their own personal experience and thinking. It is similar to what Wicke and Ferguson (1992:3-4) call 'reading each discourse through the lens of the other'.

The following discussion seeks to explore this fertile intellectual area and has drawn predominantly on scholars such as Fraser (1992); Fraser and Nicholson (1990); Lather (1991); and Nicholson (1990, 1992a, 1992b).

The feminist rupture of postmodernism
While Lather (1991) saw within the postmodern turn the vantage point from which modernism's failures could be critiqued, she also viewed her position on postmodernism's value for emancipatory movements as one of ambivalence. This position is also echoed by Farganis (1994) and Flax (1990), and what they
have in common is to view this marriage as a position which is always in relation to a critique of the Enlightenment's failure to deliver the 'goods' of emancipation as promised.

Reflective of her ambivalent stance, Lather (1991) also concluded that it was this very critique of enlightenment, especially that which examined the link between power and knowledge, that provided postmodernism with its emancipatory socially transformative framework.

Furthermore, Lather (1991:21) discussed the concept of postmodernism on the basis of a disciplinary response to the 'crisis of representation'. Like Nicholson (1992b), Lather's political roots were in Marxism and she, too, was unhappy with its failure. She saw in postmodernism the possibility of speaking in terms of post-Marxism. Moreover, in the same way that quantum theory has questioned the linearity, subject/object and universal laws of Newtonian physics, she saw that feminism could question similar concepts within postmodernism.

Therefore feminism is seen to be pushing the boundaries and widening the frames of a patriarchal postmodernism.

Perhaps Bauman's (1992:133) discussion of a postmodern sociology was descriptively apt when he stated: 'It aims not so much at the fusion of horizons, as the widening of horizons through exposition of their inherent plurality and their mutually supplementary, rather than mutually exclusive, character' (emphasis in the original).

Lather (1991) agreed with Kipnis (1992:207), who viewed this as a position where feminism has become the 'paradigmatic political discourse of
postmodernism', displacing the authority of the fathers in postmodern discourse. Lather (1991) explained that, in the same way that feminism had at times had conflicting theories sited within it and yet has been able to provide a platform for political action, so feminism could provide this for postmodernism. Further to this, she believed feminist theory had already been moving towards an emphasis on praxis and self-reflexivity, had recognised the importance of subject and agency in the effort towards transforming society, and had begun the move from essentialism towards social construction of the subject and the questioning of difference (Lather 1991). Grand theories that sought to speak for all women have been challenged by those left out or marginalised — or what Lather (1991:31) referred to as the 'ex-centrics' or 'colonised' (Kipnis 1992; Seidman 1992). Lather (1991) believed that resistance to the universalising of feminist theory grew out of the need for such groups to survive.

This view is supported by Steven Seidman (1992), who spoke about the link between the new social movements and postmodernism.

Seidman (1992) argued against postmodernism as an academic creation, and traced the relationship historically, especially those in France such as Foucault, Lyotard, and Baudrillard. He believed that the main carriers of postmodernism have been those in the marginalised groups involved in social movements (1992). Moreover, he demonstrated the influence feminism and the gay movements had on the development of 'postmodern social criticism' (Seidman 1992:50). The discontent of marginalised leftist groups and the resultant decentralising of Marxist theory and the questioning of science resulted in the marginalised communities developing a 'postmodern criticism of science' (Seidman 1992:51).
In other words postmodernism arose as an active or emancipatory stance situated with the lived experience of 'ex-centrics' rather than within the realms of academic theorising by, say, the French post-structuralists.

Kipnis (1992:207), however, gives centrality to the French (continental, poststructural) feminists as theorising the political subject as situated in a structural position 'variously occupied by the feminine, the body, the Other'. By categorising feminism into 'Anglo-American' and 'continental', Kipnis (1992:206) was able to show the different trends in feminist thinking about the marginalised. On one hand, Anglo-American feminism needed the marginalised social movements to force it into incorporating their theoretical and political needs, and on the other hand the French feminists had already given them a central theoretical position; however, it lacked 'political praxis' (Kipnis 1992:209). The result of the above, for Anglo-American feminism, was a practice-based theorising that moved feminism towards a postmodern praxis as a result of listening to those marginalised within feminism.

In other words, the rupture was from within.

And Lather's (1992a) argument against postmodernism's rupture of feminism is that the marginalised had already begun the process. This was demonstrated by feminism's increasing emphasis on the power of agency and subjectivity in social transformation, which meant that feminists questioned the notion of the dead, fragmented or fractured subject. As there was a need for specificity of gender without recourse to essentialism, there was a move to the viewing of gender as a social construct, which meant that feminism was led by marginalised groups to deal with questions of difference.

Alcoff (1987) also argued that a rejection of essentialism was not necessarily influenced by French post-structuralism. For example, women of colour
writing fiction and poetry were also moving in the direction of postmodernism and post-structural writing strategies (Lorde 1984; Morrison 1988; hooks 1986, 1990).

Further to this, Lather (1991:28) believed that people like Alice Walker anticipated a move towards a 'postmodern theory and textual practice'.

Lather saw the category 'women' as being 'theorised in ways that offer hope for a sustained contestation and resistance' (Lather 1991:29) in which she (women) can move amongst the various constructions and at the same time question such notions as biological determinism, linguistic determination and post-structural fragmentation. Further to this, feminism had begun to develop a self reflexivity which enabled 'a contradictory double strategy ... [which] ... both assumes and then immediately problematises its subjected positions' (Lather 1991:29). Furthermore, she put forward the idea of questioning the unambiguous category 'women', and suggested that there was an indeterminacy about the category and that feminism is the site for arguing this instability (Lather 1991).

Lather warned about anti-essentialism, however, referring to the Irigaragian notion of 'undoing by overdoing', and using deconstruction to 'avoid dogmatism' and competition in feminist theory (1991:30).}

Both Lather (1991) and Hutcheon (1988;1989) have agreed that feminism has provided the impetus for post-structural political activity.
On the other hand, Lather warned about the urge to see post-structuralism as the theory and feminism as the practice (1991).

Her effort, she says, in putting forward feminist theory and practice is aimed at inscribing the postmodern and displacing the power of Marxism in a type of rupture of all three (postmodernism, Marxism and feminism).

Therefore, Lather, like others such as Megan Morris (1988) and Laurel Richardson (1991), sees feminism as having a central and key role in postmodernism.

As suggested earlier, however, both Richardson (1991) and Morris (1988) raised the problem of the marginalisation of women's voices in postmodernism. And Lather echoes Nicholson's (1990) and others' (Brodribb 1992; Lovibond 1993) question of whether postmodernism is a theory whose time has come for men but not for women.

Furthermore, Lather (1991) clearly asked two important questions: Can the category 'gender' survive a postmodern critique and is a coherent theory and politics possible within a postmodern position?

In a partial answer to this Lather (1991) spoke in terms of the positives and negatives for the marginalised in appropriating postmodernism. From a positive perspective she viewed postmodernism as offering a less fixed way of viewing the world, a way of dismantling the 'feminist thought police' and creating more opportunities for opening up to fun, play, fantasy and desire (Lather 1991:39).
The notion of desire is one which will be taken up in detail in a later chapter.

Secondly, she viewed it as a way to be in and at the same time critique dominant discourses — especially academic discourse, dogmatism and reductionism — from a range of transitory points of resistance. On the other hand she sees the negatives in a more comprehensive way. Firstly, there is a valuing of aesthetics over ethics. Secondly, there is a centrality given to language that denies but reinforces power imbalances. Thirdly, there is a tendency to replace the lack of voice with a diversity of non contextually voices, and to deny the complexity of situated voices. Fourthly, there is the possibility of creating anti-enlightenment as a 'new regime of truth' (Lather 1991:40). Fifthly, it raises the question of who has access to the discourse, as postmodernism tends to have a very specialised audience. Finally, Lather (1991) has astutely noted that there is a need to also recognise and talk about the diversity of voices among the marginalised.

While Lather (1991) may see these moves within feminism as disrupting postmodernism, Nicholson (1992b) on the other hand sees these issues as inadequately articulated by feminism, which prompted her to seek in postmodernism a rupture of feminism.

The postmodern rupture of feminism
Nicholson (1992b), in a philosophical context, speaks of her questioning of feminist political theory and what she believes a postmodern discourse can offer. She referred to a 'postmodern turn' in feminist thinking and suggested that much could be gained from this concept in that it offers a challenge to what is legitimate 'subject matter' (Nicholson 1990:1-16), for example: real world vs fiction; story-telling; and cultural production as an object of study.
This 'postmodern turn' also supports a fragmentation of discipline boundaries and a reflexivity or 'self-referentiality' which Fox (1993:158) proposed would limit the move to a 'postmodern metanarrative'.

In other words, save postmodernism from producing the exact context it seeks to subvert.

As a feminist philosopher, Nicholson (1992b) explained what she meant by postmodernism from a philosophical perspective. Essentially she views postmodernism, as derived from Lyotard, Rorty and Foucault, as a critique of foundational concepts such as universal ideals of truth and the power of science in determining universal criteria by which these concepts can be measured. Consequent to this there is an emphasis on locally, culturally and historically specific situatedness of the subject, and a challenging of the oppressive nature of single categories to account for life. Nicholson (1992b) also recognised the political nature of foundationalism and therefore the relationship between power and knowledge. On the basis of this she believed postmodernism to be politically useful for feminists, as she viewed the perspective as one which could refute the totalising grand narratives of liberalism and Marxism.

Nicholson (1992b) also detected in feminism, however, a more subtle form of theoretical arrogance than articulated in modernity, especially in the areas of race, ethnicity, culture, class and sexual orientation.

In summary she stated:

Postmodernism appeared to me an important movement for helping feminists uncover that which was theoretically problematic in much

And in an astutely pragmatic voice she referred to feminism's appropriation of postmodernism in the following way:

[i]t was necessary for feminists to read such writings critically to accept what was useful from a feminist perspective, and respect that which was incompatible with feminist purposes (Nicholson 1992b:60-61).

As identified earlier, Nicholson (1992b) saw the major problem in the appropriation of postmodernism for feminism to be that associated with poststructuralism.

There are those feminists (Alcoff 1987; Bordo 1989; Brodribb 1992) who problematise Derridian deconstruction as posing binary categories of opposites with endless deconstruction the only possibility, which creates a situation where generalisability is impossible.

What this assumes, therefore, is that generalisability is desired.

Further to this, deconstruction is seen as creating a ceaseless heterogenicity of movement which results in multiple perspectives and possibilities which further detracts from the possibility of political action (Nicholson 1992b). Based on the above, Nicholson is drawn to postmodern rather than poststructural theory of language. She suggested that the post-structural view of language as a symbolic system tends to be ahistorical, homogenising, and unrelated to local and contextual human action.
In other words, Nicholson (1992b) is doubtful of a universalised symbolic order of language. However, contrary to this, she articulated, along with Nancy Fraser (1992), a pragmatic theory of language. Her thinking is derived in part from the latter writing of Wittgenstien and the American pragmatic philosophical tradition.

This perspective emphasises discourse rather than structure, and locates language within a local and contextual practice. The benefits for feminism are that discourses are then viewed as contingent, historical and posing the possibility of change (Fraser 1992). 'Signification ... [is seen as ] ... action rather than representation, therefore the subject is viewed as socially situated agents' (Fraser 1992:177). Discourses are multiple, allowing for conflicting schema of interpretation to be held by agents as they occupy different communicative sites. Occupation of these discursive sites allows a focus on power and inequality, politics, and value/theory ladenness based on a siting of discourse both within society and within agents who are acting in the world (Fraser 1992). Nicholson (1992b) suggested, on the point of who gets to speak, that discourse should be viewed as a context of contestation. She rejected the charge of relativism by placing discourse within the process of agent interaction, also avoiding the necessity to speak about a criterion for legitimation or procedural rules. Further to this, she saw the charge of relativism as being related to communication breakdown.

In summary, Nicholson (1992b) viewed discourse as a communicative process which is epistemically political. She believed that postmodernism could be viewed as rejecting epistemic arrogance and replacing this modern stance on epistemology with 'epistemic humility' (Nicholson 1992b:62).
Fraser and Nicholson (1990:34) ask the question: 'How can we combine a postmodernist incredulity towards metanarratives with the social-critical power of feminism'? How can this be done without a philosophy to underpin it, yet be adequate to the analysis of sexism?

Further to this, Richardson (1991), although discussing a feminist postmodernist reframing of sociology, is also in doubt about the need to forego sociology's own metanarratives. She believed that there is no philosophical basis within postmodernism which requires sociology to give up the theoretical tools necessary for a critique of the macro structure and processes which maintain inequality. Moreover she suggested that postmodernism itself has just substituted its own 'metanarrative based on loss of a privileged position for Andro-Eurocentric truth' (1991:35). She stated: '[L]ike nasty little boys on a playing field who are losing the game, some are not content to simply take their bats and go home; they want to tear up the field so no-one else can play' (Richardson 1991:35).

In reply, Fraser and Nicholson (1990) suggested that it was still possible to keep the analytical tools and this is not contradictory. However, the theoretical tools needed to take account of the historically socio-culturally and locally situated understandings; to be in touch with change; and to be non-universalising and comparativist.

Further to this, Fraser and Nicholson (1990:35) they contended that researchers should utilise multiple feminist methods and methodology and look for no single solution, concluding that 'while some women share some common interests and face some common enemies, such commonalties are by no means universal'.
In this context the questions could be asked: How is it that those definitions and interpretations that work against women gain authority, and what is the hope for counter-hegemonic views in creating alliances among feminist groups?

In answer to this, Fraser (1992:54-55) contended that a pragmatic theory of discourse would assist in the understanding that '... even under conditions of subordination, women participate in the making of culture'. Furthermore, in relation to pragmatic theory Fraser contended that it allowed study of language 'at the level of discourses, as historically specific social practices of communication.' Having critiqued Lacan and Kristeva, Fraser (1992:57) suggested:

... pragmatic theories insist on the social context and social practice of communication, and they study a plurality of historically changing discursive sites and practices. As a result, these theories offer us the possibility of thinking of social identities as complex, changing and discursively constructed.'

Continuing to build on Fraser's ideas, Nicholson (1992a:90) called for a 'pragmatic understanding of theory as a tool.' She put forward the idea of a pragmatic approach to theory — for example, its usefulness is in continuity with aspects of modernity. However, where it is discontinuous with modernity is in the aspect of universalisation of theory. Nicholson suggested 'that we think of postmodernism as linked in both continuous and reactive ways to modernism and evaluate it in the light of the political needs of our time' (1992a:91). Further, she contended that the generalisation of postmodern theory has resulted in the same problem as the universalising theoretical approach of modernity. This problem can be avoided, she contended, 'by more
consistently conceptualising postmodernism as a stance which arises out of modernism' (1992a:91) rather than as an absolute break from it. In a lengthy discussion of the problems of generalisation within feminist theory, Nicholson posited that while it is understandable it is also problematic, and commented that 'feminists can produce better theory - and politically stronger theory - by more consistently abiding by their postmodern inclinations' (1992a:93).

Feminist postmodern rupture of nursing
This methodological framework raised such questions as:

... how claims to presence are constituted in discourse? 'How do discourses on health and illness ... claim authenticity, ... authority, and how is it that we are willing to accept their 'knowledge' of the character of health and illness? (Fox 1993:9).

While discussions of postmodernism, feminism and nursing have been present in the nursing literature for many years (Holmes 1991, 1995; Owens 1995, Kermode & Brown 1996, Fahy 1997), a well entrenched scepticism concerning postmodernisms value to nursing continues to be espoused. Along with the scepticism there is an articulated degree of unease. This unease reflects what postmodernism intends, and that is, to create a destabilising effect. The intention is to interrogate the comfortable intellectual positions and open everything up to question — an uncomfortable space for those who require an untroubled relationship with truth and absolutism.

It is evident that both feminism and postmodernism are discourses which are changing (Flax 1992). Taking this into account, however, several predominant debates concerning postmodernism have been conceptualised by Glass and Davis (1998). These are the dissatisfaction and fragmentation debates.
Rather than viewing postmodern feminism as being the meeting of binary opposites, there is as I suggested earlier a degree of shared epistemological and ontological ground where the boundaries overlap. Therefore, an integrated solution is proposed. Postmodern feminism is put forward as that solution, one which offers a new intellectual and political terrain for nursing.

Dissatisfaction debate
From a postmodern standpoint there is a distinct discontent with monolithic approaches to theory. The 'truth' of grand narratives is viewed as one of the inadequacies of modern critical and feminist theory. Within feminism, marginalised women have clearly challenged the grand narratives which attempt to speak for all women (Seidman 1992; Glass 1997). Furthermore, Lather (1991) has claimed that the very survival of some oppressed groups was dependent on their ability to resist the universalising effect of feminist theory. Those left out or marginalised by general theorising have sought to decentralise the dominant focus group (Lemert 1992). For example, it was the marginalisation of gays and lesbians as deviant groups in general social theory, and lesbians ignored in feminist theory, that prompted the development of queer theory (Seidman 1992).

An example within nursing is the work of Glass (1997), who voiced a discontent with a unified theory to account for the oppression of women and nurses. Furthermore, as claimed by Glass and Davis (1998:47) 'it was the lived
experience of those marginalized ... and committed to an active or emancipatory stance as a solution to the inherent problems of universality, totalization and generalization ... [which] therefore sought to disrupt feminist' and general social theory.

On the other hand, and also from a nursing perspective, reactions were prevalent in the work of Kermode and Brown (1996). For example, while they were adamant that postmodernism had denied the importance of grand theories such as patriarchy and capitalism, they further believed that this denied future nurses a political heritage.

It is, however, a generalising of nihilistic and relativist postmodern thinking to try and account for all the postmodernisms which is problematic. It is the failure to recognise the emancipatory intent of the more philosophically pragmatic postmodern philosophers such as Lemert (1992) which denies nurses a political heritage.

Fragmentation debate
The fragmentation debate is inextricably linked to the dissatisfaction debate. It expands upon the discontentment discussed above but also questions the acceptability of postmodernism as an alternative to the Enlightenment narrative (Emden 1995).

The disruption of the Enlightenment narrative is supported by Walker (1994:164) who invited nurses 'to refuse what we are ... be deeply suspicious of the "grand narratives" of modernity ... those particular stories which attempt to tell us how to live our lives'.

While this may be so, postmodernism is not atheoretical. Rather, the postmodern approach is to support theory that is locally and contextually developed and applied. Therefore, theory for some postmodernists is based on multiple explanations of reality (Flax 1990; Wicke 1992; Natoli 1997). Some
nurses, however, view this approach as fragmentary rather than cohesive (Clarke 1996).

While this might be so, as I have pointed out earlier, this stance should be perceived as a further celebration of individualism and another way of viewing the world. Postmodernism is celebratory because it is concerned with the subject in process, and it can be resisting, struggling and visionary (Davis 1996).

A failure to consider the multiple constructs of the postmodernisms has led many scholars 'to maintain a negative view of postmodernism as fragmentary, chaotic, non-political, and therefore without emancipatory intent' (Glass & Davis 1998). The tendency to concentrate on scholars such as Baudrillard and Sherpe, whose ideas are related to nihilism, negativity and hyper-reality, has discounted those postmodernisms which claim fragmentation as a fundamental concept while at the same time believing that postmodernism is capable of producing a general social theory (Lemert 1992, 1997; Harvey 1989; Stedman 1997).

An integrated solution
Lather (1991) drew links between modernist feminist theory and postmodernism, and explained a possible integration. By example she cited the notion that modernist feminism has at times had conflicting theories (related to the causation of women's oppression) within it, and yet has been able to provide a political platform to launch social action.

Therefore, in the same way, feminism can provide this for postmodernism.
What feminism and postmodernism demand of each other, then, is the claiming of a resituated emancipatory stance which does not dominate any group. It is a demand for a balanced view arising out of the above debates which neither 'polarizes these diverging views nor creates dualistic theoretical relationships' (Glass & Davis 1998:48). To do this, an interdisciplinary approach has been taken. This solution is informed by ideas drawn from within the nursing literature (Druzec 1989; Lister 1991; Doering 1992; Walker 1994; Cheek & Rudge 1995; Parsons 1995; Hegney 1996; Fahy 1997), feminist postmodernism (Nicholson 1990, 1992b; Flax 1992), and postmodern sociology and philosophy (Bauman 1992; Lemert 1992, 1997; Seidman 1992).

What then does postmodernism feminism offer nursing?

Parsons (1995:24) claimed a 'renewed attention to objectivity, reliability and validity in research'. Moreover, constructs of subjectivity and power within postmodernity provide a different framework for the analysis of medical dominance (Hegney 1996) and nursing submission and resistance. Postmodernism allows the framing of emancipatory intentions to destabilise organisations and structures and uncover the ontological problems of modern political and social theory. Feminism, on the other hand, provides the political strategies for this destabilisation (Nicholson 1990, 1992b). Drawing on the ideas of Flax (1992), an integrated postmodern feminist frame of reference also allows for a destabilising of the nature and status of theorising within nursing by questioning the right of those involved in metatheoretical work to speak for all nurses.

Furthermore, Walker is strongly committed to an integrated postmodern feminist stance as they 'are "discourses on the move"... [t]hey ...open up possibilities through critique at multiple levels and allow us to write the
epistemological codes which have hitherto constrained the meanings available to us' (1994:163).

Bauman's exploration of a postmodern sociology considered multiplicity as the 'widening of horizons' (1992:199) whose essential quality was supplementarity rather duality.

It is precisely the widening of horizons that an integrated feminist postmodernism offers.

For example, within this frame, potential exists for deconstructing the dualistic relationships within nursing evident in the dualism between those who talk (teach) and those who do (clinicians) nursing (Davis 1993a). The idea of multiplicity is also complemented by the possibility of celebrating the difference (Lloyd 1989; Cheek & Rudge 1995). Given the diversity within nursing (Emden 1995), not only in terms of subjectivities but also in areas of practice, an integrated approach offers the scope to validate and encourage such diversity. It destabilises the arrogant position of those who require homogeneity and who further support an elitist position for those who speak with an authoritative voice (Cheek & Rudge 1995).

As just suggested, another component of an integrated postmodern feminism is the celebration of the non-authoritative conversational voice (Kipnis 1992) of women in nursing. Women's voices are therefore given new scripts, texts and discourses (Farganis 1994). While these voices may be non-authoritative, they have the potential to open up a space for critique and a reassertion of their rightful place within an interrogation of nursing and health discourses. This is particularly relevant for those 'marginalised voices' (Farganis 1994:109) within the nursing and health discourses — for example, those voices of nurses within the aged care setting (Stevens & Herbert 1997), the remote/rural setting (Hegney 1996:1997), or working in sexual health/HIV (Miller Dolan & Boswarva 1995), or Indigenous health (Johnson 1992).
The questioning and reframing of notions of subjectivity and identity are also components of this integration. Identity is viewed as constantly changing. Therefore the notion of a fixed, unique identity is rejected (Hekman 1990). Furthermore a 'postmodern feminist standpoint accepts that there are no ideal observers who can be abstracted' from their social situation' (Glass & Davis 1998:50).

Nursing research implications
The implications for health and nursing research within this framework would be a re-focussing to encompass an emphasis on the contexts which create meanings and which are then open to further interrogation. For example, research in this frame would seek to re-situate perceptions of identity, subjectivity, agency, language and power. Further, these research directions would 'potentially destabilise previously held assumptions concerning interpretative validity and concurrent emancipatory research and would involve inscribing and subverting of those who speak rather than what is said' (Glass & Davis 1998:50).

Moreover, drawing on Strickland's (1994) view, nursing research would become re-directed towards difference, partiality and multiplicity by incorporating the inherent philosophical beliefs of postmodernism. This move further eliminates the search for a universal truth or the 'right' answer, combined with a critical wariness regarding any generalisations (Nicholson 1990). Integrated epistemological and ontological links between postmodernism and modernism is a way to 'develop theories about processes of enlightenment and empowerment for both nurses and clients' (Fahy 1997:27).

Summary
Although Hekman (1990) warned that feminists could not simply take from postmodernism what they wanted, Nicholson (1992b), on the other hand,
considered it appropriate to take what is useful in postmodernism and to
discard that which is not compatible with feminism.

The challenge is Emden's (1995:35) vision of the
possibility for the discipline of nursing to cross borders
and be 'sufficiently self-aware as to be able to make
wise judgements about the extent to which the latest
philosophic ideas are to be celebrated'.

It is strongly evident, however, that what is needed is a multicentered,
multivocal, contextual discourse with emancipatory intent which is freed from
the oppressive features of false consciousness and which is critically self-
reflective and reflexive. It needs to be one which takes account of our collusion
in the domination of the marginalised and which underpins how we interpret,
represent and interact with 'otherness' in research and nursing practice (Glass
& Davis 1998). Looking through a postmodern feminist lens may allow for a
potentially 'fragmentary postmodernism to stay within the reach of social
critique, while still acknowledging its celebratory plurality' (Stedman 1997:88).

My thoughts echo Owens' (1995:372),
who challenged 'nursing scholars and
practitioners ... to relocate away from
secure, one best way approaches ... to
[engage in] a complex heterogeneity of
discourses that will allow a re-inscription
of nursing'.

As I suggested in the beginning of this
text, ethnography has been referred to as
both genre and method. It is this further framing of the research that will now be explored.

**Ethnography**

Ethnography has, perhaps, never been so popular within the social sciences. At the same time, its rationales have never been more subject to critical scrutiny and revision (Atkinson and Hammersley 1994:249).

The question could be asked, why ethnography? I had completed an Action Research Masters degree, why not continue within this research frame? There are several levels on which these questions can be answered. Firstly, while undertaking the Masters degree I had come to the realisation of the difficulties of conducting action research as part of an educational qualification and wrote at length within the ethics chapter of the thesis of my concerns. I was hesitant to again take on these difficulties. By that
time I was a little less naive and had developed an ethical framework for Postmodern Feminist Ethnography that I believed could be implemented. Secondly, I am by nature an observer fascinated with the cultural production of knowledge. Thirdly, I sincerely wished to expand the breadth of my research expertise so that my knowledge base would be broadened and my potential ability to share that knowledge would be enhanced. Fourthly, I was influenced by reading some work by Ong (1993) concerning the usefulness and flexibility of ethnography for studying health services management processes and relationships from within.

The question of why postmodern feminist ethnography has already been partially answered; however, I intend to discuss this further within this chapter.

While this is so, as I returned to this chapter for a final revision I was further
heartened by Lupton’s words in support of my decision when she stated that:

... awareness of and debate about the postmodern critique as it relates to public health may go some way to formulating important questions (if not neat answers) about the future directions of the field (Lupton 1998:5).

The writing strategy taken up here is the same as in the previous section. While the reading on ethnography was carried out quite early, before the fieldwork commenced, the substantive content was not written for several years.

Overview of traditional approaches
There is some debate about the historical roots of ethnography, with various notions of its early beginnings situated within anthropology or further back in the Renaissance or even earlier, with Herodotus (Atkinson & Hammersley 1994). Ethnography has been influenced by major strands of thinking such as historicism, which slid into hermeneutics and natural science, which slid into anthropology and sociology. In later years a radical critique of ethnography within critical sociology (feminist, Marxist) and post-structuralist has challenged the realist positions (Atkinson and Hammersley 1994; Bruni 1995). Each of these epistemological positions presents a different version of ethnography.
Furthermore, Atkinson and Hammersley (1994:258) have posited that this tendency 'has produced a highly complex and contentious discursive field'. Based on this, therefore, it would be unwise to view ethnography as a 'quasi-paradigm'

Therefore, what becomes important is a full and comprehensive siting of the ethnography within a particular theoretical orientation.

The above point provides clear justification for the previous in-depth exploration of postmodern feminism. As suggested above, while many disciplines have applied ethnographic approaches, the conversation which follows is situated predominantly in nursing, where the major theoretical orientation has been interpretive. The last 10 years or so, however, have witnessed a proliferation of critical and the beginnings of poststructural and postmodern theoretical orientations in ethnography.

Ethnography has been conceptualised in several ways; however, most writers have spoken about this type of research as being the investigation of
'commonsense' (Kelleher 1993:21) meanings held by members of a social or cultural (or subcultural) system (Aamodt 1991; Streubert & Carpenter 1995; Glesne Peshkin 1992; Harvey 1990; Ruffing-Rahal 1991; Mitchell & Cody 1993). This understanding is elicited from an insider's (emic) or an outsider's (etic) viewpoint (Miller 1991; Robertson & Boyle 1984). The investigation may involve large cultural studies, such as comparisons of death and dying beliefs and rituals in Australia and the United States of America.

On the other hand, an institutional study, similar to a case study, such as the investigation of death and dying beliefs or rituals in a small country hospital, would also be suitable for an ethnographic inquiry (McMurray 1994).

Various methods have been employed to provide an in-depth understanding of the culture being studied. Predominantly, nursing has drawn on sociological and anthropological approaches (Aamodt 1991; McMurray 1994; Roberts & Taylor 1998). Therefore, interviewing and participant observation are major techniques utilised in data collection. In this form of empirical research, data is highly descriptive.

The debate about the potential for theory development and theory testing arising from the data analysis continues.

On this point Hammersley (1992a:13) stated that 'descriptions cannot be theories, but all descriptions are theoretical in the sense that they rely on concepts and theories'. Analysis is capable of theory development if a grounded theory approach is utilised (Layder 1993). Further, Hammersely (1992a) has posited that ethnographic data is capable of theory testing if variables can be
expressed quantitatively and the research has a narrow focus, such as a case study.

Rosenthal (1989) was of the view that nursing had failed to implement ethnography to any great extent. While this may have been so in the past, the last ten years or so has seen an explosion of this type of nursing research, particularly in the USA (Roberts & Taylor 1998). In Australia the attention given to transcultural nursing has encouraged the use of ethnography to increase the knowledge and understanding of the differing beliefs and experience of health and illness of the various ethnic groups in this country.

Taking a descriptive and interpretive approach, Aamodt (1991:40) reiterated that ethnography explores:

> The conceptual models of the world held by human beings [that] can be discovered by observing patterns of meanings in communication used during individual reflection on and social interaction with the objects and events in one's environment.

Within nursing Aamodt (1991) further believed, like Hammersley (1992a), that these meanings could be utilised for theory development and for increasing our understandings of the experience of health, illness and the caring context.

Often, the ideas at the beginning of an ethnographic study have their origin within the psyche of the researcher.

> The interest in PHC and Ethnography arose from a recommendation that I made in the closing chapter of my Master's work.
The ethnographic-inductive framework provides for different methods of investigation and a different focus of interest; as a consequence, a different set of scientific assumptions will emerge. Ethnographic data is grounded in the cultural concept and seeks to understand the informant's view of a cultural system. Therefore, what is important is the culturally relevant domains of meaning, researcher-informant experiences, and cultural themes. Aamodt (1991:44) spoke about fitting ethnography into the social context and generating nursing knowledge, and referred to this as 'semantic ethnography'.

What she meant by this term is that ethnography explores the meaning of language in the context of the philosophy of knowledge generation (Aamodt 1991). As a consequence what is relevant is people — what they do, say they do, and want to do.

I was influenced by this early reading to the extent that the ethnography was so designed as to explore in conversations and participant observations what nurses and their clients did, said they did and said they wanted to do.

Therefore there are two underlying assumptions according to Aamodt (1991:45):

... culture is viewed as a system of knowledge used by human beings to interpret experience and generate behaviour ... and ...linguistic expressions used by informants during social interactions are the structural blocks of meaning for constructing systems of cultural meaning.
The steps in ethnographic research have been formalised in several different ways. Table six draws together the ideas of both Aamodt (1991) and Field (1991). Although they appear different at first glance, the commonalities become obvious on examination of the steps.

<table>
<thead>
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<tr>
<td>1. Observing the cultural scene.</td>
<td>1. Making contact with individuals and the community.</td>
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<tr>
<td>2. Constructing and asking sample questions.</td>
<td>2. Establishing role expectations.</td>
</tr>
<tr>
<td>3. Abstracting answers from the linguistic material.</td>
<td>3. Identifying the informants.</td>
</tr>
<tr>
<td>5. Developing a taxonomy of meaning domains (application of data to theory and practice).</td>
<td>5. Analysing data.</td>
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Questions are a structural feature of ethnography (Ong 1993). Some common questions are:

- Could you tell me about a time when ...
- Could you tell me about what you did when ...
- Could you tell me about what others did when ...

In Ong’s (1993) study of health services’ organisational culture, she suggested that the questions she asked were loosely structured and resembled conversation.

The reading of Ong’s (1993) work influenced me greatly and pushed me in the direction of dialogical or conversational
techniques rather than structured or semi-structured interviews which seemed inconsistent with a postmodern feminist approach.

Obtaining a 'thick description' (Ong 1993; Denzin & Lincoln 1994; Schwandt 1994; Vidich & Lyman 1994) means asking further questions which will provide more meaning to the above questions, therefore allowing 'thick interpretations' (Vidich & Lyman 1994; Janesick 1994).

What can be noticed about Table six is that there is no mention of participant observation, which is a major methodological tool of ethnography.

Perhaps this is so because Atkinson and Hammersley (1994:248) contend the meaning of this term is not easy to 'pin down'.

There are two constructs which are closely related and now require exploration, that is: participant observer constructs and insider/outsider status.

It is argued that the typology identifying four categories moving from complete observer to complete participant is useful.
1. Complete observer
2. Observer as participant
3. Participant as observer
4. Complete participant

(Davis 1986; Atkinson and Hammersley 1994; Bruni 1995).

However, a more accurate representation is that in Figure one (below).

Figure one: An Iterative Representation of Participant Observer Status

There is movement between each of these categories and a researcher could find themselves positioned at any point between categories. Points of rest could occur, however, at each category, in different contexts of the study.

The point to make, however, is one which echoes Atkinson and Hammersley (1994) and that is that one cannot be in the social world and study it without being somewhere on this circle. And Ong (1993) is of the view that the categories become blurred and fixed positions difficult to maintain when carrying out ethnographies in organisations.
On this point Rudge (1995) spoke of the ethical and methodological dilemmas created with traditional ethnographic participant observations in nursing. In particular she identified and iterated specific instances where she was 'both ... [and] ... neither ... [where she ] was something else all together' (Rudge 1995:58).

Contrary to this, Hanson (1994) spoke of the value of insider knowledge in her ethnography at a regional oncology unit where she had previously worked. The value of having insider knowledge, being able to participate in reciprocal interactions and also having time away from the setting enhanced her ability to conduct the research.

So, where the researcher is positioned raises pertinent questions. For example:

1. Does the whole group know the researcher is conducting the study?
2. How overtly has the researcher adopted the role of the 'native'?
3. What activities will be engaged in or not engaged in by the researcher?

While earlier research may accept the 'hidden' researcher or covert research (Davis 1986) I believe that generally, in the moral climate of today, this strategy is no longer acceptable. It was not the ethical model implemented in this research, and the subsequent theoretical model which was developed will be discussed further on in this chapter. Furthermore, in the chapter
Shaping the Research I will explore the way in which ethical considerations shaped the research.

On the other hand Wing (1989) does identify three grounds for covert research.
1. Where there are large numbers of people for a short period of time, for example, at a rally.
2. Where the identity of the subject is impossible to determine, for example a person on the street.
3. When the group changes rapidly, for example in an emergency room.

Extending these ideas and commenting on interpretive ethnography, Bruni (1995:46) noted that this approach seeks a 'good' balance between insider/outsider and a deferring of writing the report to ensure distance and objectivity. Moreover, not disturbing the field leaving — it untouched, so to speak — was deemed to be important in this approach.

In other words the neutrality of the researcher was seen to be paramount.

Observational data was also seen as more trustworthy than that obtained from informants.

Here the distrust of subjectivity and the valorisation of objectivity is reinforced.
Furthermore, as the post-colonial ethnographies asserted, traditional forms of ethnography, especially those situated in anthropology, tended to construct the 'natives' as ignorant and illiterate; therefore their words could not be trusted. Cultural themes are multiple, being the 'patterns of recurring messages that represent the organising principles in the culture under study ... and ... are the researcher's view of the whole cultural system' (Aamodt 1991:47). In an analysis of the researcher-informant experience Aamodt (1991:48) stressed the importance of reflexivity and the need to 'focus ... on what characterises the immersion of the ethnographer in the setting'— and just about any type of reflective process can be utilised to record this.

The characteristics of an epistemology of ethnography in the nursing context for Aamodt (1991) are

1. linguistic expressions
2. cultural contexts
3. aggregation of data
4. transformations in the level of data analysis
5. application of data to theory and practice.

Further, the transformation of data from one level of analysis to another requires sense of the whole of the data as well as the context in which the abstractions are situated (Rosenthal 1989; Ruffing-Rahal 1991; Aamodt 1991). Truth is taken for granted in this conventional perspective; however. some nursing researchers (Aamodt 1991; Field 1991) believe it does not predict absolute outcomes only probabilities. These ideas lead to questions of insider/outsider status and the role of language. In the work culture of nursing in particular, it may be necessary for the researcher to be familiar with specific linguistic expressions to become a 'native' in the research process.

The self as instrument
Juliene Lipson (1991) initially discussed positivism in relation to the need for objectivity and reduced bias, and cited her discussion of her own work in new paradigm research referring to Reinharz's 1981 work. Ethnographers, she
commented, utilise informal interview and on-site participant observation. Further to this she commented that the literature states that the researcher is the major instrument in data collection, [but] until recently, there has been little guidance for learning to use self as an instrument' (Lipson 1991:75). Few researchers have considered reflexivity as important and most have spoken in terms of self as an instrument of data collection which must be fine-tuned to ensure validity. Few discuss the 'cultural baggage' (1987:76) they carry with them or ask themselves who they are in relation to the research. Whereas Lipson (1991:77) suggested similarities in use of self in ethnography and clinical nursing, that 'skills and qualities that enhance rapport and trust are similar and will yield better data'. Researchers need to know and understand themselves, especially how their feelings and behaviours impact on the data gathering and analysis.

Lipson (1991:77-8) identified the influences on the use of self as:

1. 'The characteristics of the field-work setting (e.g. rural or urban), the characteristics of the population (e.g. sophistication of the informants), and the structure of the social relationships'.
2. Also, according to Lipson (1991), the data is influenced by the informants view of the researcher, especially by such characteristics as age, gender, cultural background, social status, personality and professional background.

*It is obvious that the critique of traditional approaches questions binary construction of nature/non-nature, subjective/objective, the simplistic and naive approach to truth and the politically naive emphasis on language rather than discourse.*

**Critical social science and ethnography**

Reflecting on the above, and gazing towards other frames to assist, the words of Rudge (1995) are relevant. Rudge contended that what was needed was a
'(re)writing of ethnography ... [within] ... feminist, postcolonial and similar explorations of otherness' (Rudge 1995:58).

Critical social science has resituated ethnography to ask important questions concerning structure, agency and power in social systems. The main reframings include critical, realist and feminist ethnographies. By way of example I have theorised these approaches and then selected research examples of each.

Critical ethnography

Mary Simms, in her research on health care choices for the aged, has demonstrated how interpretive ethnography has not only failed to problematise the legitimacy of the status of the aged, but also how 'official legitimisations enter into public accounts of staff in the caring professions' (Simms 1989:10).

Simms' (1989) ethnography examined the way that community nurses and social workers had contributed to the above process which had limited the choices in public care available to the aged. In the context of the personal is political, Simms (1989) suggested that, from a structuralist perspective, the research on social policy had viewed the macro as political but not the personal.

Drawing on Giddens' work (1976) on differential professional power relationships in the context of knowledge generation, Simms (1989) was able to demonstrate symmetries and asymmetries in power relationships which accounted for changes in social processes and official rationality. On this point she stated:

As new relevances [knowledges] are imposed on to, for example, a community nurse by a general practitioner, this disrupts the sedimentsed knowledge of the former and her knowledge is subsequently reconstructed. This reconstruction takes the form of the extension of knowledge to incorporate former 'medical 'relevances and the
covering over ' of aspects of knowledge formerly 'intrinsic' to nursing care (Simms 1989:177).

Further Simms (1989:178) suggested that a decline in the 'commitment' to aspects of care meant that this care was then given over to subordinates with the creation of a type of 'segmentalisation of knowledge/care' ... the degree of which accounts for the changing 'politics' of the carers'.

In the context of nursing Bruni (1994) spoke of a 'new ethnography' as opposed to an old ethnography, which she, like Simms (1989), considered to be descriptive and interpretive. Critical ethnography for Bruni (1994) has drawn on post-positivist positions, especially postmodern themes which problematise absolute truth and grand narratives. Critical ethnography has tended to utilise a post structural approach to gain 'insights into the relationship between power, knowledge and subjectivity' (Bruni 1994:1).

In terms of critical ethnographic research and empowerment, Bruni commented:

empowerment involves the research participants in an exploration of the politics of the production of their knowledge. By exposing the political nature of the discursive field under study, such as that of nursing education, the possibility for challenges to be made on a number of fronts is enhanced (1994:11).

In summary, Bruni (1994) viewed critical ethnography as providing the methodological framework for:

1. the imperative of revealing the insider's reality as problematic
2. the contestation of discourses of nature, science, and objectivity
3. the problematics of repositioning the researcher as part of the field
4. conceptualising the discursive construction of experience
5. identifying and exploring subjective positions.

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In a later exploration of critical ethnography Bruni (1995) raised the notion of a continual interrogation of power, validity and the crisis of representation.

On the other hand, critical realism is seen by Porter (1993) as an answer to Hammersley's (1992) concern with ethnography's epistemological struggle with representation, theory and explanatory power. Porter (1993:596) stated, '[e]xclusive concentration on, and uncritical acceptance of, subjects' own accounts is the Achilles heel of phenomenological ethnography'. Further to this he suggested that knowing the subject's viewpoint is basic to the hermeneutical point; but this is insufficient and there must be some consideration of the social structures which shape the ontological.

Critical realism demonstrates an abandonment of the methodology of interpretive ethnography. This move has arisen out of the need to come to grips with the relationship between structure and agency. According to Porter (1993), while support for other theoretical alternatives to the interpretive paradigm is seen in the work of Berger and Luckmann's social construction of reality and Giddens' structuration theory, critical realism offers a more comprehensive ontological grounding which is not dialectically related to structure. Furthermore, it enables a deeper understanding of the role of structure.

Like Simms (1989) and Bruni (1994), Porter (1993) believed that although the gaining of knowledge of social structures can be problematic, it is possible to achieve through the examination of events. Further to this he warned: '[b]y ignoring the possible constraining nature of social structures, commentators are in danger of giving consent, through silence, to their oppressive effects' (Porter 1993:596).
In support of critical approaches Clifford (1986) also suggested that although ethnographic work is inherently embedded in power relations it is also complex, ambivalent and possibly counter-hegemonic. Cultures are not static and any attempt to represent them as such usually results in over-simplification, especially also the construction of a particular self-other relationship. Researchers continuously reconstruct themselves and those they study during the research process. Clifford (1986) problematised the objective gaze (what is observed) from the outside so typical of traditional ethnography, and recommended a move to voice ethnographic ear.

However, he does warn about just ‘imitating speech’ (Clifford 1986:12).

Further points he raised are:

1. The discursive aspects of cultural representations focus on their relations of production rather than interpretation.
2. The idea of self-reflexive fieldwork accounts.

The objective participant-observer ideal which has been seen to be a problematic topic in a marginalised ethnography, such as an ethnography dealing with violence and desire, now has a more central role.

The problematising questions that arise from the above concern, when and who perceives gaps in knowledge.

In this context, however, it is not a case of ‘filling in’ the gaps because this very process only serve to make us more aware of other ‘gaps’. Representation either by insiders or outsiders must take into account the partiality of culture that is based within its historical, emergent, discursive, self-reflexive aspects rather than a ‘unified corpus of symbols’ (Clifford 1986:19).
Feminist ethnography

Reinharz (1992:51) stated the main goals of feminist ethnography to be the documenting of women's lives and activities; 'to understand the experience of women from their own point of view, and ... to conceptualise women's behaviour as an expression of social contexts.'

Commenting on Sheryl Ruzek's study of workplaces in the women's health movement, Reinharz (1992:55) stated:

In her view of feminist ethnography, the boundary between her life and her field site disappeared. ... Because every field setting can be thought of as immersed in a larger social system, field settings can be amorphous. ... Information can be obtained from many places. ... it is significant for feminists who seek an understanding of the links between the micro- and macrosystems of gender politics.

For Anne Williams (1993) and Patti Lather (1992b), feminist research is very diverse in content, methodology and method. While this is so, Williams saw the main characteristics of ethnography to be reflexivity and a concern with power relationships. Moreover, this concern entailed the utilisation of methods to prevent the subordination of knowledge associated with experience.

In Lather's (1992a:91), view 'every issue is a feminist issue'.

Anne Williams (1993) contended that feminist ethnography recognises that: ways of knowing are culturally bound; the researcher cannot step outside their own values; feminist research is advocacy-based and change-oriented; and prediction and control are replaced by contextualised, interactive meanings. Furthermore, personal reflexivity is present in the research and the writing of
the ethnography, and strategies are directed towards equalising power relationships and the non-subordination of self-other relations in knowledge production.

Feminist researchers are therefore concerned with 'the possibility of alternative accounts, a sensitivity to difference, and intellectual uncertainty about adequate means of describing reality' (Williams 1993:584).

Clifford (1986) has suggested that feminism has made a considerable contribution to a re-examination of ethnographic texts.

This is obvious in the challenging of taken-for-granted notions concerning the 'historical, political construction of identity and self/other relations, and it probes gender positions that make all accounts of, or by, other people inescapably partial' (Clifford 1986:19).

Clifford's argument concerns the separation of the form and content and the valuing of content over form in modern ethnographic texts.

While it is Clifford's belief that feminist theorising on writing texts has much to offer, Hammersley (1992b) is critical of many important tenets of this form of theorising. Especially critiqued is the emphasis on gender, experience, politics and feminist concerns with power relationships within research.

The above exploration has been relatively brief, as much that is relevant in feminist ethnography overlaps with the following conversation.
Postmodern feminist ethnographies

Fontana (1994:203) is of the view that what is emerging is a variety of 'ethnographic modes'. This trend is based on an interrogation by postmodernism of anthropology and the social sciences. The result has been a destabilisation of previously held assumptions concerning scientific method and methodology, and a questioning of the authority of the ethnographer as an observer, recorder and writer of the culture. Furthermore, conventional ethnographic research has been challenged to rethink accepted constructions of culture, representation, subjectivity, reflexivity; truth, structure, agency, power, and knowledge.

Both Fontana (1994) and Lather (1992b) further believed that this challenging of traditional ethnography has widened the horizons rather than created something entirely new. The scope has been widened to accommodate multivocality. There are three main areas where this has occurred. Firstly, there has been a re-examination of the concept of the fieldworker's understanding and interpretation of the cultural context of the 'natives', with an emphasis on presenting more voices than past approaches have allowed. Secondly, an increased importance has been placed on the styles of reporting which provide for multiple voices. Thirdly, there has been an expansion of the phenomena of interest considered suitable for ethnographic research. For example, Fontana (1994:219) considered that there was no 'subculture too trivial to study ... [or] ... field work too esoteric to inform us about society'.

**Reality in postmodern ethnography is not there waiting to be discovered; rather, it emerges within the cultural construction (Tyler 1986).**

Within a large body of scholarly work, Fox (1993) discussed postmodern ethnography/ethnomethodology. In his ethnographic research of surgery, Fox (1992) sought the social meaning of surgery rather than 'truth' discourses concerning everyday life in a hospital setting. Utilising a postmodern frame for
Part One — Mapping the Terrain  
Chapter Two — World Views and Paradigms

the ethnography and a deconstructive strategy, Fox (1992) uncovered the obscure, the silences and the gaps, and made them visible in the writing of his report.

On the other hand Manning (1989) has drawn heavily on the European despair and European thinking on the postmodern. Without considering the American pragmatists, he concluded that ethnography could not ignore the anti-theoretical moves and nihilistic and relativistic modes of the postmodern.

Postmodern feminist ethnography, rather than departing extensively from traditional ethnography, seeks to focus on those areas taken for granted in past fieldwork. For example, new emphasis is given to the role of gender and gender-biasing modes of ethnographic research. Furthermore, there is an attempt to privilege the voices of those non-privileged, marginalised or oppressed women, and the colonised (Fontana 1994, Lather 1992b; Richardson 1991).

Richardson further suggested that collective narrative could be the way out of the above problem. She stated that:

*collective story displays an individual’s story by narrativizing the experiences of an historically situated social category, such as abused children, recovering alcoholics, divorcees or cancer survivors* (1991:36).

Individuals moreover respond to collective stories as if it were their own story, and this helps empower them and reshape their lives.

*Therefore, there is a liberatory and transformative impulse to postmodern feminist ethnography.*
At a group level, collective stories help overcome the isolation and alienation of contemporary life and link disparate persons into a collective consciousness ... [therefore] ... we can write here a postmodern culture that is a product of situated persons, creating transformative and libatory narratives (Richardson 1991:37).

Research conducted by Wicks (1995) is an example of Australian post-structural feminist ethnography conducted, like Fox's (1992), in a health care institution. Wicks’ study explored the healing discourses of nurses and doctors in the hospital setting, and was particularly concerned with documenting examples and consequences of speaking and actioning discourses which are resistant to oppressive discourses articulated in the literature.

The value of post-structuralist ethnography is that it allows the consideration of agency and resistance, together with the discursive formation of personal and professional subjectivities.

Wicks viewed post-structural feminism as a 'paradigm shift' away from the modernist conceptualisation of feminism. The Foucaulian context for this institutional ethnography enabled the study of the effects of 'truth' produced within the dominant discourse, the way in which nurses resisted this truth, the tensions that this created, and which discourses were marginalised in a local and specific setting (Wicks 1995).

Postmodern feminist ethnography freed from authoritative and restrictive paradigms would create a space for the free play of ideas and take into account the historico-political context of the research (Lather 1992b). Furthermore, there would be a consideration of an aesthetic reality with an emphasis on narrative and lived experience represented in the form of interactional communication.
(Richardson 1991). Richardson (1991) reframed traditional ethnography and concluded that a postmodern feminist research would emphasise praxis and consider that the personal is political and visa versa. She believed the postmodern insistence on historically, culturally- based theorising was 'is searching for difference (1991:35)."

The text: Writing ethnographies

A major thrust of postmodern feminist ethnography is an interrogation of the crisis of representation. I wish now to explore this fertile ground for two reasons: firstly, because of the contribution it makes to theorising on postmodern feminist ethnography and, secondly, because it informs the decision to choose the writing strategies evident in this ethnography.

The conversation which follows therefore draws on both feminist and postmodern discontent with the writing of traditional third person ethnographies, and provides an expansion of the theoretical underpinning of the writing strategy for this research.
Postmodernism is concerned with intertextuality and drawing together both the research activities and the written representation of the research.

Judith Aldridge (1993), however, questioned the extent to which the text represents a set of facts about life. While this may be so, it is also evident that she supported some aspects of postmodernism and contended that feminism may hold the answer to some of the postmodern problems.

Concepts such as authorship, self, time and memory are problematised to the extent that 'proper' research accounts insist on a dis-embodied account which hides the complexity of the research process and renders the research experience simplistically. Aldridge (1993) takes a postmodern approach, moving towards the idea of 'factual fictions'. On this point she commented:

This epistemological concern is similarly reflected by critics who identify a postmodern condition, and object to the idea of a coherent and stable self with insight into societal mechanisms (Aldridge 1993:53).

Aldridge referred to feminist challenges to transcendental claims to truth made by the dominant culture, and stated she is interested not just in the 'product of knowledge but its production' as well (1993:53). On the other hand, Giroux and McLaren (1992) were discouraged by the post-structuralist heritage within postmodernism and academia. They took a sceptical position, arguing that the construction of textuality creates a context of narrowness, alliance with the intellectual elite within academia, a distancing from the colonised, an apolitical and non-activist position, and conventionality sliding into conservatism. In their view, not only did language construct reality, it also accommodated it (Giroux and McLaren 1992).
The writing strategy – conversation – chosen in this research, however, is consistent with both postmodern and feminist emphasis on irony and reflexivity.

By way of example, Williams (1993) has suggested that the juxtaposition two forms of reflexivity: that which occurs in the field, and that which occurs in the writing of the text.

I have called these 'methodic reflexivity' and 'textual reflexivity', both of which will be discussed further on in the chapter. What follows now is an exploration of the contribution of several postmodern feminists' interrogative efforts into such things as life story, autobiography, sociopoetics and dialogue. Justification is provided for the choice of dialogue as method in this research.

Life story
The challenge of representation is taken up by Chanfrault-Duchet (1992). She suggested that oral history is an appropriate mechanism for the representation of women's voices and for reaching groups whose discourse has been considered illegitimate. Her work sets women's words in narrative
meaning as a particular way of making sense of what is said. In her research she has presented two life stories which are similar but which produce quite different narratives. She raised the global nature of the life story and posited that although it concerns actors and events which occur over time, it also involves 'the value judgements' which the person makes in order to make sense of their life (Chanfrault-Duchet 1992:77).

Therefore, it is not just the answers given to the questions asked, but the narrative organisation which is important as well.

Chanfrault-Duchet (1992) saw life story as a meaning system complete in itself; therefore it is seen as text. Furthermore, it was important to contextualise the self, the social sphere and how women have been collectively represented and shaped by that representation.

As a methodological tool Nicholson (1992a:97) further contended that a narrative approach as an explanatory force, with 'big categories utilised to focus on structural features of social organisations over time', would be appropriate to postmodern feminist methodology. On this issue she made the point that:

"The use of such categories becomes suspect only when we treat what such categories pick out as endemic to human existence per se, do not focus on the possible need to reinterpret their meanings to adequately deal with changing phenomena's, and inadequately allow for their possible inapplicability (Nicholson 1992a:98)."

Stories which bring together different accounts are powerful because their strength is derived from the celebration rather than suppression of diversity.
Reinharz suggested that feminist fieldwork and 'institutional ethnographies' have the ability to 'generate grounded concepts that will lead to new theories' (1992:46).

Having reviewed some of the literature she concluded that 'for some feminists, fieldwork represents a struggle against positivism and androcentric concepts' (1992:47). She goes on to say that:

*The challenge for feminist ethnographers is to use the potential for fieldwork to get closer to women's realities. Ethnography ... makes women's lives visible, just as interviewing ... from a feminist perspective ... 'makes women's voices audible.'* (1992:48)

Autobiography as a strategy for writing culture was utilised by Clough (1990) to challenge the transparency assumed within conventional ethnographic representation of subjectivity / authority and fact/fiction.

Richardson (1991), however, warned that postmodernism seeks to delete the author, thus disempowering them. Therefore she sees this as creating problems for a union between feminist-postmodernist writing.

As noted in the previous chapter, however, the view I have taken is that it is not the death of the subject but the return of the new postmodern subject that is central to some strands of postmodernism.
Sociopoetics
While this may be so, in a later work Richardson (1992:24) provided a challenge to the crisis of representation in ethnography in the form of 'sociopoetics'. As a postmodernist move both to frame and represent the social, she represented her research (36 pages of data in transcript form) on the life of 'Louisa May' in poetic form. She viewed this as a political act of linking the research enterprise with that of writing sociology. This writing act raised questions concerning the nature and representation of data, and what counts as knowledge. In this project she challenged the way in which the research is shaped by the usual approaches to representing research. While traditional researchers viewed ethnography as a truthful account situated in a scientifically valid framework, it nevertheless ignored the co-production of the text within an interactional context which holds the fingerprint of the researcher in the final report. Moreover when data is transcribed there is an areflexive element to the narrative (Richardson 1992).

While 'interactional speech events' are situated in and represent lived experience, this lived experience is also co-produced, situated within the 'intersection of two subjectivities' (Richardson 1992:24) who are different.

At the time of writing this document I was aware from the emerging realities within the conversations that these notions would form the basis of another chapter.

Richardson agreed with Dennis Tedlock (1983) that when people speak it is closer to poetry than prose.

There are three interpretive layers: the storytellers, the poets and the readers. According to Richardson (1992:25), 'k'nowledge is thus metaphored and
experienced as prismatic, partial, and positional, rather than singular, total, and univocal.

Furthermore, poetics allows the processes of self-construction and reflexive self-knowledge to become visible. Life is not viewed in totality. Rather the focus is on the inconsistent and contradictory nature of social existence.

Dialogue
Reflexivity, specifically aimed at specifying the discourse of informants, is demonstrated in such strategies as dialogues or the narrating of personal confrontations. The cultural text is transformed 'into a speaking subject, who sees as well as is seen, who evades, argues, probes back' (Clifford 1986:14).

The dialogical mode of textual production has the ability to put forward; specific discourses, reciprocal contexts, and negotiated realities. All of these require a particular way of making them visible in the research in a way that acknowledges them as 'multisubjective, power-laden and incongruent' (Clifford 1986:15).

As Clifford claimed '[c]ulture is always relational, an inscription of communicative processes that exists, historically, between subjects in relations of power' (1986:15)

Dialogical modes allow 'polyvocality' and the recasting of authority and asking different questions in terms of cultural descriptions. On the other hand 'monovocality' assumes 'authority to represent culture' (Clifford 1986:15).

Clifford (1986) has described his writing on ethnography as postmodern, post-anthropological and post-literary (1986). For him, ethnography begins not with participant observation or cultural texts but 'with writing, the making of
cultural texts' (Clifford 1986:2), which has become the central activity of anthropologists both in the field and away from it.

By way of example, Lather (1996) has constructed an interrogative text in her book Troubling Angels. The writing strategies involved 'a multi-coded text on women, AIDS and angels' (Lather 1996:530). In creating this text, Lather (1996) structured the book using the women's words; sidebars, with references to resources and other information concerning HIV/AIDS; intertext concerning angels in pop culture (including poetry and sociological aspects of HIV/AIDS); and at the bottom of each page she inserted the story of the research process. Figure two (below) is a visual representation of her text.

Lather describes her writing strategy as based within Nietzschean philosophy, which forms a 'resolute provisionality ... via a style that is multivalent, heterogeneous, multivoiced, even choral' (1996:530).

Nietzsche's aim, according to Lather (1996), is to catch the thinking reader with a constantly moving text which evokes varying reflective understandings within each new reading.
Furthermore, she saw her writing strategy as problematising her location; displacing her authority; accommodating self-criticism; promoting a reflexive reading; enabling a reading between the lines to engage in a reading beyond the rational; engaging differing subject positions; encouraging an engagement with multiple voices; creating a fluidity and movement through time; promoting a dramatization of lived experience; and a problematising of the object/subject, reader, writer and what is written (Lather 1996).

Moreover Lather viewed this as a strategic move which decentred academic writing and revealed the collusion of academia in exclusive and exclusionary tactics pertaining to accessibility to knowledge and knowledge production (1996).

In a self-reflexive move, Lather (1996) exposed her work to multiple readers, seeking comment. The readership involved students in the program she was teaching, the women she interviewed and the academic community.

Not surprisingly, some academic reactions were not favourable.

The reading of the following responses sent me into ‘onto-epistemological panic’ (to use Lather’s word’s) (1996:539).

The range of comments included reference to a lack of:

- a sense of reality concerning women living with HIV/AIDS
- substance
seriousness concerning a serious topic in that it was seen to romanticise and avoid contestation

participant control over the text structure and too great a tolerance for their non-participation.

Further, it was considered to be excessively stylistic and supportive of disempowering strategies which contributed to an elitist product.

By this time I began to feel the resurgence of panic. However, I was somewhat reassured by the following comments.

While this was so, there were other readers who reacted less negatively. These readers suggested that the writing strategy prevented premature closure by enabling multiple sites of interrogation; created a 'de-demonising discourse' that decentred; created a metaphor consistent with the nature of this pan epidemic; represented an interrogation of the power of science to control life and death; and the complexity of the ethnographic story, paralleled the complexity of the women's lives (Lather 1996). Further to this, these readers commented that the writing strategy interrogated the 'data' in relation to each other, other women's lives, academic constructs, knowledge production, difference, silence, and voice (Lather 1996).

However, Snow and Morril (1995:361) are doubtful of such writing of ethnography and view what they term 'performance narrative' as risky 'boundary crossing'. They stated that while this:

can be illuminating and edifying ..., it also obfuscate, defame, and profane ..., therefore it means that boundary crossing should be pursued cautiously and for reason other than the therapeutic value it might have for the

... My panic and self-doubt is somewhat allayed and I am saved by the notion '[t]hat ... no texts are meant the same way by readers who occupy different contexts, at different historical junctures ... it is wrong to assume that ... [all]... readings are homogeneous' (Giroux & McLaren 1992:18).

Clifford (1986) is critical of traditional third person writing and is of the view that it has persisted because the dominant ideology of the discipline holds that representation is transparent and experience is immediate. The implications of this are that writing an ethnographic account has been reduced to method, such as recording good field notes, making accurate maps, and 'writing up results' (Clifford 1986:2). What Clifford puts forward is that:

1. Culture is contested by codes and forms of representation.
2. Poetics and the political are inseparable.
3. Science is situated within historical and linguistic processes.
4. Academic and literary genres interpenetrate.
5. The writing of cultural descriptions is experimental and ethical.
6. The making of texts and rhetorical strategies reveals the artificiality of previous cultural stories.
7. Ethnography invents rather than represents culture.
Furthermore, Clifford believed that the above characteristics had become important in any 'field where "culture" is a newly problematic object of description and critique' (1986:3).

Therefore, ethnography:

... poses its questions at the boundaries of civilisations, cultures, classes, races, and genders ... it ... decodes and recodes, telling the grounds of collective order and diversity, inclusion and exclusion. It describes processes of innovation and structuration, and is itself part of these processes (Clifford 1986:2-3).

In this context disciplinary boundaries are open to question.

In anthropology the debate between art and science has been polarised towards scientism. Certain forms of expression are therefore valued over others. For example, transparent signification is preferred over rhetoric, fact over fiction and objectivity over subjectivity.

In the move away from a natural history approach to cultural knowledge production, ethnographic writing is therefore seen to be constructed by fictions which are inscribed:

1. contextually
2. rhetorically (expressive conventions)
3. institutionally (disciplines and audiences)
4. generically (and distinguishable from a novel or travel account)
5. politically, in that there is inconsistent contestation of the representation of cultural realities by authoritative voice
6. historically (changing conventions and constraints) (Clifford 1986).
Furthermore, Clifford sheds some helpful light on the question of truth. He has suggested that the interpretive social scientists view their work as 'true fictions', while he is using the term 'in the sense of something made or fashioned' (1986:6).

This point has raised the issue of the partiality or incompleteness of ethnography as embedded in exclusions which are systematic and contestable.

The exclusions are witnessed in the voicelessness of the incongruent; the consistent strategy of 'translating the reality of others' (Clifford 1986:7) and the imposition of meaning by the ethnographer; and the exclusion of information considered irrelevant.

'In this view, more Nietzschean than realist or hermeneutic, all constructed truths are made possible by powerful "lies" of exclusion and rhetoric' (Clifford 1986:7) Furthermore, 'systems' and 'economies' of truth which were not fully controllable by the author were produced through history and power. This idea, Clifford (1986) stated, was resisted by those who sought clear verification and wanted to develop strategies to arrive at truth.

For example, the use of tracking audits in ethnography.

The recognition of partiality should not lead to the conclusion that we cannot ever know anything for certain about other people, because what we do know is the partiality or the incomplete and, perhaps, the processes and reasons why it is incomplete. Allowing the holes and fragments to exist within an ethnographic account may undermine the completeness but not the seriousness of a piece of work.
The field

Ethnography has inherited notions of the field and fieldwork from the natural sciences, and is traceable to the power of science with its roots in anthropology. Traditional approaches in ethnography have constructed the field as idealised, romantic, secret, unproblematic; objective and unbiased (Berger 1993; Punch 1994; Bruni 1995).

Snow and Morrill (1995) are in agreement with Berger (1993) and argue that the post-structural emphasis on text has tended to subordinate the experience of participant observation. There has been an emphasis on discourse over observation. Furthermore, they believe that little guidance has been provided for fieldworkers undertaking postmodern observational strategies.

**On the other hand, Denzin and Lincoln (1994) are of the belief that postmodernism has attempted to balance the attention afforded observation over discourse.**

Interestingly Punch (1994) has argued that it is the lack of emphasis on narrative that has unwittingly served to emphasise observational work. Furthermore, in a deconstructive move, Berger (1993) has interrogated ethnographic texts on the field and fieldwork and has proposed that both the researcher and the field are instruments. Self is discursively constructed as 'part of disciplinary knowledge' (Berger 1993:178) and the field is viewed as a discursive formation of anthropology inheriting its disciplinary power. The field metaphorically fixes the subject within naturalistic, geographical and political boundaries (Berger 1993).

Berger (1993) interrogated traditional ethnography's constructions, contending that the naturalistic metaphor of the fieldworker as a microscope is a common theme. The choice of field site is not a neutral decision. It is determined by personal choice, chance, disciplinary considerations, and political access.
A description
Kellehear (1993:23) suggested 'ethnographic description describes social life, sometimes organised around themes or case studies'.

In this particular ethnographic study the intention is to explore the therapeutic/practice environment of the nurse and the person receiving health care. The ethnographic field, then, is the practice setting of primary health care nursing in the context of community nursing.

Members of the therapeutic culture

The ethnographic field included nine nurses, seven of whom were generalist community nurses with a client load and two were nurse managers. The client group of community nurses were men and women in the older age group and totalled seven.
Table seven: Participants

<table>
<thead>
<tr>
<th>Groups</th>
<th>Interviews</th>
<th>Participation/observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse clinicians</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Clients</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Nurse managers</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>7</td>
</tr>
</tbody>
</table>

Entry to the field

An application for ethics approval to conduct the research was submitted to the Human Experimentation Ethics committee for the health region (See Appendix one). In fact, the application was submitted three times before it was approved. The members of this committee had extreme difficulty with the methodology. It was outside the 'normal' scientific paradigm; therefore, was it really a valid paradigm for knowledge generation within nursing and health? I was amused when I heard from a friend working at the local hospital that one of
the medical doctors on the committee actually spoke to her concerning my research application, naming me as the researcher and thus breaching confidentiality. He really didn't understand the work. It was only after the appointment to the committee of a Professor of Nursing whose major area of interest was post-positivist paradigms that my application was favourably considered. Six months later I was able to consider beginning the fieldwork. The ethical framework utilised for the research was developed from a previous model I had utilised in earlier research in critical social science (Davis 1993a). The older model was reframed and developed within a postmodern feminist ethic.

Participants

An approach was made to the Manager of the Health Area and subsequent
discussions concerning the research were conducted with that person and the Nurse Unit Manager (NUM). Arrangements were made for me to speak to the community nurses concerning the research at the next Area meeting. This duly occurred. The research was explained and letters of invitation, together with a written explanation, were distributed (see Appendix two). The nurses were asked to sign and detach and return an expression of interest form (see Appendix two) to a sealed box. Once this occurred I met with the nurses who had returned the forms. At this point the research was re-explained, questions sought and answered, and arrangements made for interviews following the signing of consent forms (see Appendix three). This process took some time and the following field note entry demonstrates my concern during the early period in the field.
'Only 2 people have responded so far. Is this a reflection of the culture, in that individuals have particular attitudes to research that are somewhat negative. Are they too busy, pressured – asked to do too many surveys, undecided? I may need to involve other sections of the service, however I will need to move fairly quickly on this and see if I can organise it. I have arranged to go to a meeting at 2.00 pm on Thursday as there is a PHC team meeting at Yarraville. Attending this meeting will provide some insights in team interactions and issues related to service delivery. It will also provide an opportunity to remind people about the project'.

I waited for two weeks. By that time nine nurses had responded and no other nurse expressed and interest in being involved in the research after that time.

Each nurse participant was also asked to select one client from their case load. To preserve confidentiality, it was the nurse in each case who selected and initially approached the client and delivered the letter of invitation (see Appendix four). Clients who were willing to be involved in the research signed the expression of interest form (see Appendix five). I then
accompanied the nurse on a visit, explained the research, encouraged and answered questions. Following this, if the clients were willing to participate in the research, they were asked to sign a consent form (see Appendix six) for the participant observation of the nurse/client interaction, and an interview, to be conducted without the nurse present.

Method of data collection and recording
Dialogues
Nurses

Iterative cycles of in-depth critical conversations (dialogues) with individual community health nurses were tape-recorded. The individual dialogues utilised themes derived from the literature review and included spontaneous conversations in such places as the tearoom and meetings. The individual dialogues were also flexible, in order to pursue other themes that arose during the
process. However ethnographic structural
questions were posed during conversations
and included, for example:
What were your beginning experiences in
community nursing like?
Can you tell me about an example of
DHC?
Can you tell me about what others did
when you complained?
The tapes were transcribed and then
returned to the participants to check and
add or remove any material they wished.
The tapes were subsequently returned to
me with the changes.

Clients

The dialogues with the five clients
occurred in their homes. One client was
interviewed in hospital as he had had a fall
the day before our scheduled interview and
was admitted for assessment of mobility.
These clients were all elderly and were not
willing to be tape-recorded. Therefore, notes were taken by myself during the interviews. The seventh client interview was conducted in a workplace and was tape recorded. This interview was with the personnel manager of a company which was participating in a Health Education in the workplace program initiated by one of the nurse participants. This was her example of a client. The conversations with clients used similar questions to those used with the nurses. The questions included 'Tell me, what is it like for you when the community nurse comes to visit? What is it like for you if the nurse cannot come for a visit?'

Participant observations

Participant observations of the therapeutic interactions tended towards the observer end of the continuum. In some cases, however, I did participate in client
care, although in a minimal way, such as assisting with a dressing, imparting current knowledge on a particular topic or checking medication lists or blood pressures. Current state registration was made a requirement for me to conduct the research, and the status of this was checked by management before commencement of the research.

Participant observation of the work culture of community nurses again veered mainly towards the observer end of the continuum in work culture situations. Observations occurred while accompanying nurses to their clients. Also, one full day accompanying a nurse on visits to all the clients for that day was carried out in order to achieve some sense of the work life of a community nurse. For this to occur, all clients were contacted first and permission sought for me to accompany the nurse to their homes. The clients were
informed that no information concerning them was being collected and that I was there only to understand what the nurse was doing. These clients were not part of the group that were eventually interviewed and observed. Verbal permission to accompany the nurse into their homes was gained. It was not considered necessary for a consent form to be signed. More time than this 'wandering' the clients' homes was viewed as an invasion of privacy by the area management, who considered issues concerning permission and confidentiality difficult a 'minefield'. This aspect is discussed in detail in Chapter six. Time was spent, however, in observing the work culture in the tearoom at the central office, at district meetings, educational days and team meetings, and in three other community health centres. Participant observation of the therapeutic setting and workplace culture was recorded
in field notes in the form of a reflective journal recorded immediately after encounters.

The taped conversations with each individual nurse and recipient of care was carefully listened to in order to identify the cultural meanings in relation to primary health care.

The insights from each individual case were then utilised in each subsequent critical conversation, thus providing a framework for the next conversation. The research was built in such a way that each conversation influenced those that followed.

Conversation or dialogue is a method that many feminist researchers utilise to dismember the authoritative voice of the researcher and create a context of multivocality. It is also a method aimed at desilencing and revealing that which is hidden by monologue (Reinharz 1992). Pam Shakespeare (1993) also made the comment about conversational research that it provided a context for understanding the nature of the interactions between researcher and participants, and also the emotional context of the information exchanged. In a review of some 1924 research by Helen Merrell and Faith Williams, Reinharz (1992:50) comments:
Faith Williams' idea of combining fieldwork with interviews enabled the study to move from generalities to specifics, from examining the community as a whole to examining the individual in the community. This combination allowed them to see people in contexts, and to understand women (and men) from their own perspectives.

Reinharz (1992:71) made the point that feminist analysis of ethnographic data 'includes many components such as understanding women in their social contexts and using women's language and behaviour to understand the relation between self and context'. Further to this, she suggested there was also a place for autobiography and fiction. She also commented that there is a need to distinguish between 'drawing on feminist theory and imposing feminist theory' in an effort to avoid its rejection by the very people it is attempting to explain (Reinharz 1992:72).

Field (1991) commented on the use of self and suggested self-knowledge, especially of cultural background and personality, are important. As most inaccuracies in ethnographic work seem to be related to lack of self-awareness, this can be assisted by the formation of a reciprocal relationship within the fieldwork. Also, the use of regular observational field notes and a personal journal noting both the content and process of interactions is helpful. Field (1991) also suggested that modelling, videotaping, peer supervision and publishing what is experienced in the fieldwork would be helpful. In a concluding comment (1991:99-100) stated: 'the questions are broad rather than specific, and the interpretation is rooted in the meaning informants give to the events'; and that researchers needed to be open to what was found, and 'concepts and categories must arise from the data'.

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Nursing research in the context of a postmodern feminist ethic

The proposed model explores the implications of postmodern feminist ethnographic research methodology in the nursing context. Dodds, Albury and Thomson (1994), in their Report to the Department of Human Services and Health stated that the major ethical issues in the research process were respect for others and justice. As a major component of the model under discussion is postmodernism, it is relevant to note that, as an epistemology, postmodernism tends both to reject and accept some of the foundational aspects raised by Dodds et al. (1994). It also rejects modernism's conceptualisation of justice and how that is evaluated. Part of this rejection is based within the 'failure of modernism to generate a morality which does not reflect partial, political interests' (Fox 1993: 121).

Without naming a particular frame of reference, the Report to the DHSH (Dodds et al. 1994:52) stated:

> Concern for the specific areas of participants' agreement to participate, protection against harm to their welfare and protection of confidentiality are all aspects of respect for persons; but by employing the umbrella notion of respect for persons, a much richer set of ethical issues in research emerge and the risk of a limited focus on consent, confidence and harm is avoided.

The postmodern turn in feminist ethics would therefore consider the following statement:

> Postmodernists tend to favour forms of social enquiry which incorporate an explicitly practical and moral intent, that are contextual and restricted in their focus ... and that are narratively structured rather than articulating a general theory (Seidman & Wagner 1992:7).
Just as some Australian action researchers have suggested that action research is more ethical than other research because of its methodological constructs, Bent Flyvbjerg (1993:20-22), has reviewed those postmodern writers who have explored 'public philosophy', and has developed methodological guidelines for research situated within phronésis or practical wisdom. Drawing on his work and my previous model (Davis 1993a), ethical concepts become a series of questions to be negotiated and renegotiated as the research is formulated; implemented and written up, thus representing a reflexive moment in the research.

Considerations and questions for ethical research within this methodological framework include:

1. An emphasis on value-rational action
   (where are we going? What should be done?)
2. The consideration of power
   (Who will gain and who will lose? What are the mechanisms and possibilities for changes in power relations? What system of power does this particular ethics form a part of?)
   a. Is the research trustworthy, honest, fair, responsible, confidential supporting anonymity (if requested by participants) and respectful, avoiding manipulation and control?
   b. Is the text constructed utilising 'language that is non-exclusive, accessible and de-mystifying' (Nebraska Sociological Collective 1983:542)?
   c. Is there sharing of knowledge (Nebraska Sociological Collective 1983:542), acknowledging the involvement of all concerned in the conception, development, implementation, documentation, interpretation and presentation of a project?
   d. Is it supportive of harmonious, non-hierarchical, non-dualistic intra/interpersonal relationships that are caring and growth-oriented (Davis 1993a, 1993b)?
3. Closeness and a need for being embedded in the research and for self-reflection, self-reflexivity and accountability.
4. The asking of small questions and the provision of thick descriptions.
5. Is there a focus on actual daily practices, utilising concrete cases or exemplars within a specific context?
6. Are there how questions, which place the emphasis on process rather than cause?
7. Are there elements of narrative and historicity present, with actors, a plot and events which happen over time?
8. Is dialogue a feature in relation to, ‘those being studied, ... fellow researchers ... policy makers ... and the general public’ (Flyvberg 1993:20-22)?
9. Is the research proceeding on the basis of a declaration of intention and informed consent and collaborative relations with the IEC?

Summary
The above discussion traces the changing conceptualisation of ethical research within postmodern feminist methodology with an emphasis on applied ethics as situational ethics. In summary, the discussion of ethical research in the context of postmodern feminist ethnography demonstrates a model which seeks to avoid the discrepancy between moral theory and social reality. It can be summarised in the following way.

Identity is seen as a unity of multiplicities connected by integrity within a self-reflective, self-reflexive, process-oriented, contextual movement towards becoming that which one wishes to become. And, also, becoming that one who in the moral context, acts in the real world with mutual responsibility and respect validating 'otherness' and difference in a state of dynamic tension where moral questions produce more questions rather than final solutions to ethically problematic situations (see Figure three).
Figure three: A Model of Postmodern Ethics

Research Methodology/Method

Rights/Obligations Model

Research as Praxis

Research as Lived Experience

Narratives Dialogues

Self-reflection

Process orientated

self-reflexivity

contextual

Integrity

Unity of multiplicities

Responsibility to Self/Others

Respect Self/Others

Mutual Growth Validation of otherness and Difference

Becoming

Dynamic tension of questions and answers

Ethical Theory and Action Proposed as a Series of Q & A

Research as Ethical Praxis
The research was significantly shaped by its ethical context. Chapter six will discuss the degree to which the whole research project was framed by this discourse.

Upon approval of the research, the Senior Manager of Primary Health Care for the region was approached for permission to conduct the study with community nurses in the region. Advice was given that a particular area of the region was appropriate for the study. Only one area of the health region was nominated. This particular area was divided into four sub-areas, each of which had a community health centre. The involvement with the field occurred over a six-month period.

Working with the data

Deconstruction

Lemert (1992) has argued that the main concepts of a general postmodern social theory are decentring and difference, with deconstruction the method by which a social theory of difference follows from a decentred world view.
Therefore a deconstructive /reconstructive analysis of the discourse of critical dialogues and ethnographic data was undertaken. While this may appear a straightforward process, the various, sometimes conflicting, conceptualisations of the term 'deconstruction' became apparent to me early in the project. Not only that but feminists concerned with political struggle have also been in a constant state of negotiation with Derridean deconstruction.

Scott (1992:286), is in agreement with Lemert (1997, 1992) that the term 'deconstruction' has been inappropriately applied in the main sense of 'to take apart' or 'dismantle'. This problem is exemplified by Rosenau (1992), who examined the debate concerning deconstruction and intuitive interpretation in terms of the notions of pessimistic and celebratory postmodernism. While she does present a confusing picture at times, she has suggested that deconstruction attempts to reveal the hidden assumptions, hegemonies, inconsistencies, contradictions, and margins within a text by 'tearing' or 'teasing' it apart (Rosenau 1992:120).

For Derrida, deconstruction is a serious business. It is a:

fine grained, meticulous, scholarly, serious, and above all, 'responsible', both in the sense of being able to give an account of itself in scholarly terms
and the sense of 'responding' to something in the
text that tends to drop out of view (Caputo
1997:77).

Scott (1992), like others (Grosz 1989; Lemert 1992,1997; Denzin 1994a), posited
that Derrida's concept (above) was a more helpful approach. Deconstruction is
defined by Scott as being the analysis of 'operations of difference in texts, the
ways that meanings are made to work' (1992:286). Further to this, the analysis,
she suggested, involved two steps: firstly, the reversal of the oppositions and,
secondly, the 'displacement of binary opposites' (Scott 1992:286). This process
allowed what had been said, written or inscribed, to be recognised as local
contextual purposeful products of the operations of power.

Scott (1992) also stressed the role deconstruction
therefore plays in bringing to light those ways in which
the constructed meanings within the binary opposites
prevent us from attaining that which we seek, because
we fail to realise the interdependence of the two.

Rosenau (1992) suggested that postmodernists would not seek to reconstruct the
text, Denzin (1994a) and others (Grosz 1989; Collins and Mayblin 1996) disagree.
Rosenau's deconstructive method has posited principles and strategies; and is
summarised below.

1. Find a principle in the text.
2. Locate an exception and use it to subvert the principle.
3. Further subvert the text by postulating extreme forms that are
'sensational' (Rosenau 1992:121).
4. Use the exceptions to bipolar terms to undermine the terms
themselves.
5. Present multiple interpretations.
6. Subvert the familiar by creating new and different terms.
While Rosenau may be denying the reconstructive moment, there is an implicit reconstruction in the last point.

According to some scholars (Harvey 1990, Kellehear 1993), the deconstructive process involves a movement between abstract concept and concrete data; between what is overt and what is hidden; between text and image, and implicit and explicit ideologies; and between what people say they do and what they actually do. In the approach to deconstruction outlined by Kellehar (1993), the reconstructive moment is also neglected. He suggested that the steps in this analysis might include:

1. Drawing together the information.
2. 'Identifying the oppositional elements' (Kellehear 1993:48).
3. Following the source of the oppositions beyond the field setting.
4. Critically applying the chosen theoretical constructs which should be aimed at revealing the perspectives mentioned above.

The debate is even further confused by Denzin (1994a:185), who writes in terms of deconstructionism and deconstructive strategies as 'interrogation of texts'.

On the other hand, Lemert (1997:44) has argued that it is 'not an "ism", nor a method, nor a "destruction" ... rather it ... is more an attitude, a way of working with culture in order to reconstrue it'.

While this might be so, Derrida disagreed with Denzin's (1997) view. In Derrida's terms, deconstruction is an analysis which is aimed at simplifying the elements. It is a critique which engages the movement and method which creates the new term (Collins and Mayblin 1996).

A deconstructive reading, according to Denzin (1994a:193), 'identifies the preferred or hegemonic, the negotiated, and the oppositional readings that can be bought to bear on each character and level of the text'. Further, Denzin
(1989:140) defines deconstruction as 'critical analysis and interpretation of prior studies and representations of the phenomenon in question'. Scott (1992) contended that it is not only the power or privileging of the dominant or primary term that defines reality but also the relationship of the two terms. This is further supported by Game and Metcalfe (1996:167), who conceptualised '[a] deconstructive strategy [as being] concerned with undoing the principle of oppositions by which one term would presume to stand unto itself, as a presence, through a denial of another term'. They see this as a positive strategy (rather than a debunking) that allows for a valuing of the 'subordinate term' and a displacement of the power of the dominant term, as the repressed term holds a moving relational meaning rather than being static and fixed. The process therefore in their view is one of reversal of the terms and then a moving backwards and forwards between the two, conscious of the relational aspects of the two terms.

Bordo (1995:229), in critique of the above, refers to this as a restless 'heterogeneous reality'.

On the other hand, Game and Metcalfe (1996) acknowledge that there are moments of rest within this movement. Moments of rest are vitally linked to the movement. They occur when we realise that what we know is not just some form of indiscriminate knowledge; rather, an idea holds meaning for us, 'ideas come alive, we are moved by them' (Game and Metcalfe 1996:168).

The idea of fluidity is further supported by Grosz (1989) and Collins and Mayblin (1996) who suggested there are three moments to Derrida's deconstruction.

1. The identification of binary opposites and the dominant or positive term.
2. The inversion of the two terms.
3. The construction of the third term that expresses the movement between the two, or that contains both terms.
An example from Derrida is "pharmakon" which contains both the poison and antidote (Grosz 1989), and, is therefore, an 'undecidable' (Collins and Mayblin 1996:29). Undecidables are more than the oppositions, they act to destabilise the core of the oppositions, and unfix certainty.

Adding further insights to his ideas on the relationship of deconstruction to reconstruction, Derrida contended that deconstruction is a double movement, and contained both dis- and rearrangement (Collins and Mayblin 1996).

While there are those in philosophy (Grosz), cultural studies (Denzin), and sociology (Rosenau) who believe that the deconstructive strategy is a valuable tool, Brodribb (1992) does not agree. She accused Derrida of misogyny. Furthermore, she has argued that '[d]econstruction is a certain masturbation with the text, playing with the terms at hand', it is manipulative of meanings and a strategy of endless deferral of meaning (Brodribb 1992:8). Given this, she believes, deconstruction is incompatible with feminism.

However, I am more convinced by feminists who believe that feminism was using a deconstructive strategy long before Derrida and the French philosophers. And I have therefore chosen to apply this analytic strategy, at the same time understanding that while it may not necessarily be an entirely postmodern
strategy it certainly has many features in common.

Realism

Both Denzin (1992) and Lather (1992b), however, have suggested that a realist analysis should precede an oppositional analysis. What this move produces is a 'bifocality' (Marcus 1992), or two ways of viewing the 'data'.

Derrida speaks in terms of a first and second reading of the text and therefore links realism to deconstruction. The first reading (realist) is often seen to be the serious reading, and the second (deconstruction) facile and 'silly' (Caputo 1997:77).

According to Derrida, deconstruction catches what an analytic strategy like realism allows to go uncovered, and opens it up to interrogation (Caputo 1997).

More specifically, for Denzin (1992:193), the representation of realism is framed as a 'hegemonic and negotiated' reading. Hegemonic is the reading preferred by the dominant culture. The negotiated is formed by taking the hegemonic reading and setting it beside an analysis of, say, class and/or gender. These ideas are further supported by Layder (1993). He proposed that a realist analysis meant that the researcher looks beyond a descriptive approach to the observable and links the findings to the operation of structures of power (Layder 1993).

Without making any overt statement, Denzin (1992) and Layder (1993) are clearly referring to critical realism rather than naive and historical realism or relativism.
There are several constructions of critical realism. Guba and Lincoln (1994) suggested that reality claims need to undergo critical appraisal from numerous positions to ensure that reality is as closely approximated as possible.

From a different position, Porter (1993) contended that reality is mediated through social structures; therefore social reality is apprehended through the effect of social structures. Furthermore, actions which change the structures change social reality.

This view of Porter's (1993) is consistent with both Denzin (1992) and Layder (1993) in terms of the connections they make to structure, agency and reality. Although the deconstructive steps tend to vary slightly from author to author, deconstructive analysis may include: drawing together the information; looking for oppositional elements (deconstruction), and reversing and displacing the oppositions; and privileging the subordinate term/s, demonstrating both the interdependence and power relationships of the terms (reconstruction) and the construction of the new term to describe the movement between terms (synthesis) (Denzin 1989, 1992, 1994a; Grosz 1989; Lemert 1992, 1997; Rosenau 1992; Scott 1992; Kellehehe 1993; Game & Metcalfe 1996).

In order for this research to have resonance with as wide an audience as possible, the decision was made to follow the process outlined by Denzin (1992) and to include the realist analysis as the first step. Further, in order to avoid confusion, a
new language has not been created. An analysis of the relational aspects or the movement between the two terms, however, has been undertaken. The model I used is demonstrated graphically in Figure four.

Figure four: Relational Aspects of the ‘Data’ Analysis

1. Realist analysis

2. Oppositional analysis

   a. positive \(\leftrightarrow\) negative—deconstructive moment

   Movement between

3. Postmodern Reconstruction

   b. negative \(\leftrightarrow\) new positive—reconstructive moment

   Movement between

Marcus (1992) believed that 'bifocality' is implicit in ethnography. The analytic strategy (above), has the potential to produce, not a bifocality that Marcus (1992) spoke about, but a trifocality. A viewing of the 'data' through three lens. The move to structure this thesis as a conversation has allowed three different gazes (realist, oppositional and reconstructive) to be made explicit. This is a postmodern move in keeping with the rejection of realism and foundationalism. The conceptual nature of realism and foundationalism will be explored further in Chapter six.
Concluding thoughts

The present extended conversation has explored the framing of this research within postmodern feminism, and the relevance of this particular framing to nursing. It is a fairly complex terrain that has been traversed. Ethnography, as both methodology, and genre, have been explored together with the methods for discovering the everyday meanings of nurses and their clients. The strategies for making sense of the information, together with an ethical framework for the research (which will be discussed in Chapter six) has also been put forward.

Finally, according to Atkinson (1990:149), 'the combination of feminism and post-modernism produces a powerful critique of the complacency of texts that claim a privileged insight into a universe of stable meanings'.

The question could be asked: What then is the value of research which does not seek to speak for all? Or calls into question the nature of truth, generalisability and
 universality? Furthermore: What can nursing do with knowledge uncovered within such a frame?

Like Benhabib Butler Cornell and Frazer (Benhabib 1995), who I referred to earlier, not all my colleagues supported or understood my decision to undertake an ethnographic study framed by postmodern feminism. In fact, I was to lose an important and meaningful friend, and mentor, within the discipline of geography, because, I could not be talked out taking such a path. What use this research can be 'put' to will unfold as we now move to working with the 'data'.
Chapter Three

Mapping the Margins
But for how long can a group or movement stress the marginal without becoming marginalised itself? (Sarup 1993:100)

The field of the 'rurban'

Introduction
Henri Lefebvre (1996:120) used the neologism 'rurban' to describe the merging, confusion and oppositional construct of the rural-urban in the minds of people generally.

The area in which this study was conducted was (and still is) considered to be a rural health area.

Inherent in this notion is the idea of a homogenised and transparent space, where little consideration is given to the diversity and difference between urban-rural and non-urban-rural.

It is my argument that although there is some recognition that there are differences between the 'urban' (the centre) and the rural (the margin) by rural community nurses, the general thrust of health policy funding and infrastructural support in the 'the country' fails to take account of the rural fabric (National Rural Health
Alliance [NRHA] 1998a,b,c). By rural fabric I mean the different weft and warp of those spaces, places, communities, and social relations which characterise the rural. To some extent I was a collaborator in the notion of a single rural space devoid of significant heterogeneity, and part of the false notion that, it was without specific problems.

The context

What I did not envisage, and this was probably because I was an outsider (in that I was not nor had I ever been a community nurse 'in the country'), was the importance of such concepts as space, place, location and distance. In other words, when I began this project the concepts of rural and rurality, and the place and location of one particular marginalised group, Indigenous Australians, was taken for granted. The
major implicit themes that therefore arose from this fact was the need to deconstruct/reconstruct the concepts of rurality, those communities living on the margins, and those nurses working on the margins. Furthermore, there was a need to consider the way in which being on the margins and working with the marginalised framed these nurses as marginalised. It is these areas that now require exploration.

Making maps

Goodall (1987:56), from a traditional perspective, defines cartography as:

... the art, science and technology of making charts and maps, together with their study as scientific documents and works of art. It provides a formal system for presentation and communication of spatial data.

In the context of this research, however, a metaphor has been created. Cartography becomes the way in which the lifeworld of rural community nurses and their work with the marginalised is inscribed by notions of space, place, location and identity. Cartography maps the negotiated territories, deconstructs the spatial and temporal resistances and subjectivities, and reinscribes so-called 'transparent space' (Blunt and Rose 1994:15). Maps chart the way we understand the world, our experiences, (including our geographical understandings) and the value and symbolic meaning we give to the
environment. Mapping 'places' ourselves and others (Robinson 1994), and is a powerful tool of representation (Nash 1994) and history (Mohanty 1992). It scripts the subjective, the positionality and the intersubjectivity of our lives. For Deleuze and Guattari (1988) the map is open and heterogenous, capable of constant transformation in the same way that the landscape is in a constant state of movement. Jackson (1989: 'Foreword', no page number) names this as 'culture's geographies as well as the geography of culture'.

Working on the margins
My own story

The following reflections on my field notes demonstrate the questions and self-conversation that emerged from my own struggle with notions of spatiation. What was the nature of this taken-for-grantedness of things rural? Further, what was the nature of my own conceptualisation of the situatedness of the research? I was able to identify and own the ideological and political space (postmodern feminism) that I brought into the research project; however, the nature of the ruralness of the project only became apparent to me when I became embedded in
the fieldwork participant observations and conversations with the participants. What came to mind at first was what I conceptualised as two different spaces. The following extract from my field notes stated:

'There are two different spaces: urban rural and non-urban rural. The different conceptualisations seem at times to be based on distance from the main administrative centre and the implications this holds in terms of infrastructural and multidisciplinary support. Notions of isolation and distantisation are implied in conversations with both the nurses and their clients'.

Thus began my journey within the evolution and conceptualisation of spatiation. The journey by its very nature led to an exploration of the construction of rurality within the government and nursing literature, and the consideration of such concepts as space, place, location, site, region, tracks, time, distance, mobility, rootedness, spatial range, spatial pattern,
isolation, displacement, positions, social relations, persons and representation within the primary health care culture of rural community nursing. The exploration of the geography of rural community nursing led also to the realisation of the many geographical metaphors that are also part of our conceptualisation. As I further stated:

'The tyranny of distance, the friction of distance, the far west, the far north – the culture of rural community nurses is spatially constituted'.

A realist analysis is followed by an oppositional analysis of the conversations with the nurse participants. A postmodern reconstruction is then offered. Several metaphors are used by these nurses to describe the distance between the service areas; these metaphors refer to institutional settings.
Participants' stories

We are talking about the rural/urban nature of the service. I suggested:

'We are [a] rural area, but we have large pockets of quite high urban development with a lot of services'.

As a nurse working from central office at Yarraville and talking about those on the margins, Sally replied:

'You have to think all the time....globally ... it's a bit ... like being ... in a ward ... where you’ve got to think about the patients'.

The metaphor is broadened by Elenore, who also works at Yarraville. She says:

'Two types of worker ... we’re like the Base Hospital and they’re like the District Hospitals'.

This is intertwined with the oppositional construct of global/local.

Kierrynn: 'To think globally, but act locally ?'
Sally replied:

'Yes, that’s right. ... you’ve got to think about all your ward, and every patient, and every person that’s attached to that person in every thought you have'.

Notions of fragmentation, division based on landforms such as rivers and mountains, directions such as east and west, and natural disasters such as floods dividing the area were common themes. I am continuing the theme in another conversation, and ask:

‘In other words, it’s sort of think globally and then act locally’

And Mikalia replies:

‘That’s right. Yarraville’s fragmentation is not just within the Health system, it’s within Community Services – I mean ...within various departments ... There hasn’t been a lot of communication ... and having not lived here, I can’t really see why it’s so fragmented. I think also that the geography of the area has something to do with it. People keep saying to me,
you know there’s South Yarraville, and North Yarraville and there’s East Yarraville, and it’s divided by this river, and we have floods, and we’re separated. We’re different communities ...[it’s] ... the uniqueness of Yarraville that does that’.

Another common theme was the need for multiskilling in service areas away from the centre.

Kierryynn: ‘Yes, it seems to me, talking to people, that there is an Adult Health focus here in Yarraville, but when I talk to those outside of Yarraville, I get a sense that they are more multi-disciplinary’.

Mikalia: ‘Yes, they are’.

This is interwoven with an oppositional construct of small/large. Mikalia continues:

‘And the fact that ... we are a larger area and we have specialised teams. If you worked at Holliville, for instance, you all work under the one roof, and people have had to become multi-skilled, because there’s nobody else. So your generalist Nurse there ... is your school nurse, is your audiometrist, is your diabetes consultant, and so they’ve all had to pick up so many skills’.
Elenore's cartographic images of 'the centre' (Yarraville) are very clear. Although it seems a population focus is being considered, the divisions are actually based on patient loads. She says:

'It was ... a pilot scheme to divide Yarraville up into specific areas. Dividing the number of clients that we had. Where they were on the map. So then we could divide it fairly evenly for the staff. And that culminated in areas in Yarraville. We had a list. Basically South, Rainville, and East. And then we defined geographical areas from my research [pilot scheme].'

In order to clarify the issue, the conversation continued:

**Kierryn:** 'And that was a type of needs analysis [you did], or looking at the populations and the contexts'.

**Elenore:** 'Well, no. It was basically... they didn’t want it that way, because they weren’t generalists. They were only domiciliary nurses'.

**Kierryn:** 'So they’re just for personal care'.

**Elenore:** 'Right. So it was just the number of clients in a specific area, so that, say, South Yarraville didn’t get 50 and East get 20. So it was a division of the town [into] equal
clientele. Not only numbers, but time — including travelling as well.  

Again, this was interwoven with an oppositional construct of have/have not. Speaking as a nurse working from Yarraville (central office), Elenore says:

‘I’ve worked in Karaville, I’ve worked in Sunville, I haven’t worked in Mustville. And we have all the resources around us in Yarraville’.

One participant told the story of being ‘dropped off the map’. Various areas were represented by colours. There is a subversion of the term ‘regional’ with oppositional constructs of seen/not seen, present/absent, known/unknown.

Rachel: ‘We operate differently, we function differently ... we touch on four villages, and their rural areas ... we’re [less than 40 kilometres] from Yarraville, and if you look at it geographically on the map ... I have one on my wall in there, I’ve coloured it in green, and I would carry this map to every meeting that I ever had to go to and say “Look, we’re the
green hole, or we’re the black hole" and we were given the title Area 2C [central area was 2], you know, the bit that just dropped off. And until these [Area] Health Service changes, a lot of services were Regional Services, but only on paper were they region[al]. They never came down here, and we were the bit that was just forgotten’.

Again, ideas of isolation and divisions based on landform and local government responsibilities were articulated. The oppositional element is inherent in the availability of services, the have/have not.

Kierrynn: ‘Yes, so in fact it’s the rural nature of the service that dictates your close relationship with the [hospital]’

Rachel: ‘Yes ... In this isolated area. We call ourselves an isolated area. The other thing ... is that down here you have an area that [has] four villages in the one area. We don’t have one epicentre where we go out from and come back to. We have Sunville, if you draw a diagram ... you have Sunville down here, ... that’s where the Community Health Centre is. That’s where the hospital is. That’s where our cars are. Down the track a little bit, if you stay this side of the river, south side of the river, you’ve got Lightville. So you get to Lightville and it’s another village. In Lightville you have a Doctors surgery on the highway, you have a police station,
about the only other service ... the rescue squad operates from
there but we don’t have contact much with them. So then at
Lightville you have ... a lot of clients. Then you go south-
east and you come to Zaraville. Zaraville’s the biggest
population, that’s where most of our clients are ... one of us
has to go to Zaraville daily, because of the numbers. At
Zaraville you have two local MO’s, you have the third MO who
has a visiting service, he drives out there every Tuesday
morning, but he doesn’t have a surgery there. He visits people
in the home. The ambulance station for this entire area is
located there. It’s not located at Sunville. It’s located at
Zaraville. You have the fire brigade, and the police. But the
biggest population of your people are there. Home Care have an
office there ... it’s a part-time service Tuesday and Friday.
You have the HACC service and the neighbourhood centre there.
So you have all these functional things at Zaraville. But they
only operate in the Ross River Shire, which is south of the
River. Because down the top ... take off the top third of our
area, you’ve got a river, and north of the river is the
Yarraville Shire. So if you’ve got clients in the Yarraville
Shire from North Lightville, you have to go Yarraville And
once you go [there] for those services, it’s even harder,
because [the clients are] ruraly isolated because they’re too
far from Yarraville’.

Continuing this further, Rachel says:
'If you move everything to Zaraville, then you’re isolated, you’re totally isolated yourself, ... from the hospital, from everything. It’s just the geographics of the area that make it hard. There isn’t a solution. Like in this area, although it’s isolated, it’s a small ... overall it’s a smallish population compared to Yarraville ... So in fact, your geographical isolation means that most of those services are at Yarraville'.

Kierrynn: ‘And they don’t come out of their offices?’.

Rachel: ‘They don’t get down here, and secondly, you have very little contact with them’.

The notion of geographic distance and professional isolation is brought out by a participant working in another part of the service [away from Yarraville].

Kierrynn: ‘What do you think are the major differences?’ ...

Sonia: ‘It’s probably ... geographics ... this is a big thing, and you’re a sole practitioner out here. I mean, I find myself talking to the mirror sometimes. Now, if you’re in central office ... there’s a big chance that two or three of the people you work with, at least, are understanding and aware ... of what’s going on, and you are able to debrief and discuss things. Whereas out here none of that happens ... You have no option out here ... isolat[ed]’.
During the rewriting of this conversation in the final stages of the work, I became overwhelmed with the desire to represent these notions figuratively. What this evolved into was a desire to paint a representation of the cartographic images portrayed in my own response and the images created by the participants. I found painting extremely relaxing – reducing some of my panic. I became aware, while painting, that certain insights were being revealed. The visual representation again made me conscious of the distance and spatiation, the fragmentation and isolation and the problems of geographically established boundaries affecting access to services. Moreover, I became aware that while it was community rather than hospital nursing that was the focus, what I experienced most was nursing in the community rather than nursing the
community. And, while we talked about community projects the nurse participants were involved in, predominantly my interaction with clients was on an individual basis. Painting the landscape resituated me in that reality. I have included a photographic copy of the painting that represents my image of the landscape, the Indigenous people, clients, and the nurses' tracks across the terrain. (see Photograph one).

Rachel also spoke of the space in between. This was the healing space, the place to recover and take a rest when working life on the margins became overwhelming.

Rachel: ‘I get really frustrated. And you run out of energy, and there have been times, in the years that I’ve been here ... I’ve run away ... Run away means ‘That’s it. I’m not doing any more today that I don’t feel like doing’.”
Photograph one: A photograph of the painting representing the landscape, participants, clients, the community and the movement within the space.
I then attempted to explore this notion with her, firstly raising the idea of increasing frequency, to which she replied in the negative. Then I asked about resilience. She replied:

'I’m not talking about you’ve got a list of people and you look at them and you think "Oh, I’m not going there because I can’t face those people". I’m not talking about that running away. I’m talking about running away and doing something in inverted commas “really bad” ... Well, we can’t go shopping here because there’s no shops, but I imagine if you were in Yarraville running away and going shopping'.

The conversation continued:

Kierrynn: 'In other words, dropping out for a little while. You get your work done and then you just need to get away'.
Rachel: 'No, you don’t even get your work done. I’d had one of these days and I just went for a drive. I can’t remember the circumstances or I’d tell you. All I knew was I didn’t want to come back to the Hospital. It was when we were [attached to] the Hospital. I didn’t want to come back here. I didn’t want to go and see anybody. I didn’t want to see a client. I didn’t want to see anybody, I just wanted to go. I don’t know where I wanted to go. I can remember having that feeling. And I went for this drive, and lo and behold I found the State
Forest. And it's in our area, and I never knew it existed. And I just came back, and I was full of life all over again ... It happens, usually if I think back in hindsight, it creeps up on you.

Summary

The dialogue with nurses revealed aspects of their work that clearly located them as spatially and professionally marginalised. Some spoke metaphorically, likening their work away from the centre as similar to the organisational structure of hospital services. Here, the centre was the base hospital, and they, less specialised and more isolated, were like the district hospital or being on the margins. They likened their work away from the centre to a ward where the centre was constructed as the hospital administration. Other characteristics included the need for multiskilling due to geographical isolation, metaphorical black holes or dropping off the edge, and professional isolation.
The decision to site the analysis within marginalisation is discussed here, although I was in two minds as to where it should be placed. I wrestled with placing it at the very beginning of the chapter and, in the end, settled with such a discussion opening the realist analysis.

The hegemony of the urban centre: A realist analysis

Marginalisation

What is meant by the term 'marginalisation'? And why this term?

I was tempted by notions such as 'edges' and 'borders' as Walker (1997:3) had used in his discussion of 'Ethno(auto)biography'. Edges were particularly tempting, as at least one of the participants had talked about 'falling off the edge'. I decided, however, that 'margins' and 'marginalised' had the capacity to incorporate physical, social and psychological concepts.
Marginalisation is obviously related to notions of margins, edges, peripheries or boundaries. While Hall, Stevens and Meleis (1994:24) suggested that margins are established 'between the self and others', what is more relevant to geographical contexts is the establishment of a margin in relation to centres and peripheries. However, Hall et al. (1994:25) have proposed that the first property of marginalisation is intermediacy, and by this they mean 'betweenness'.

While they have used a biological metaphor to portray this idea, I was interested to realise that I had applied the same type of concept to describe the space that connects the centre to the periphery.

'Between', is intermediacy in their typology of marginalisation.

On the other hand, I have taken the position that betweenness is a hybrid space which exists within the actual geographical landscape. What I find problematic about Hall et al's (1994) biological construct is that, while they identify a centre, they do not name it. And, while they identify the periphery as the skin, they do not name the
'between'. One is left wondering if it is the nervous system or the vascular system.

A further characteristic that Hall et al. (1994:26) discussed was 'differentiation', which they described as the 'establishment and maintenance of distinct identities through boundary maintenance'. It is within this characteristic, they contended, that scapegoating occurs within marginalised groups. Hall et al. were critical of the postmodern rejection of realism and reiterated the reality of the powerful at the centre who are able to force policy on those at the periphery (1994). Furthermore, in an elaboration of this characteristic, the notion of the dependence of the powerful centre on the lack of contestation by, and invisibility of, those on the margins, is explored.

This concept is identified and discussed further on in this chapter.

Another characteristic in the typology was secrecy.

Some of the participants talked of how those 'in power' were often deliberately kept unaware of some of the aspects of the participants' work life. Some instances have already been identified; however, others arise in later chapters. As I have referred to earlier, the involvement of nurses in this study provided a process for
reflection and for voice to be heard and listened to.

Both reflection and finding voice are the final characteristics of Hall et al's (1994) typology of marginalisation.

Hall et al. (1994) have not viewed nurses as being marginalised when they care for the marginalised; LeBlanc (1997), on the other hand, saw nurses as marginalised in this context. In support of this idea LeBlanc stated:

Here, marginalisation may be understood as creating a community of experiences. Upon entering a community, the health care provider becomes a temporary member of that community and the marginalised experience (LeBlanc 1997:260).

Spatialisation

Much of what the nurse participants articulated concerning the landscape is exemplified in Jackson’s statement that:

[i]images of North and South, like those of country and city, contain a wealth of contradictory messages that need decoding as much in terms of culture as that of economic geography’ (1989:183).

From a modernist viewpoint, space can be physically measured. Created space, however, is perceptually dependent on constructed social relations, set in time, capable of change and responsive to the political context of the time. Location has been viewed in terms of the positives and negatives measured with reference to all competing locations (Goodall 1987).
Place, on the other hand, is that part of space which is occupied by an object or person, and involves the experience of living things.

A mechanism of control are the discourses on spatialisation in the health literature, and a critique of these follows.

Conceptualisations of spatiality in the health literature

There is an implied idea of the centre and margin in the NRHA statement that 'the rationalisation and centralisation of health services in the name of efficiency and deficit reduction have impacted most heavily on small rural and remote communities' (1998a:1). Moreover, there is general agreement amongst those writing in the area of rural health that the literature resounds with reference to the problematic nature of the concepts of space, place, and location (Department of Community Services & Health 1991; Humphreys & Rolley 1991; Thorton 1992a & b; Hodgeson & Berry 1993; Harvey 1995; Hegney 1996).

Further to this, definitions of the term 'rural' in the health context in Australia is problematic in that it is defined in multiple ways by different stakeholders and reflects international ambivalence about the concept (Hegney 1996).

Generally speaking, international classifications tend to utilise the terms urban/rural/remote. Hodgeson and Berry (1993) although recognising the problematic nature of the definition of 'rural', referred to the need to differentiate rural and remote as 'hairsplitting', and to the provision of services in a country with such a large geographical area and scattered population as Australia as logistically challenging. Moreover, on the matter of funding, the
NRHA (1998a:3) also stated: 'the Rural, Remote and Metropolitan (RRMA) Classification is inadequate as a funding formula to determine rural and remote health needs'.

Hodgeson and Berry (1993) raised the same issue as Hegney (1996) in relation to the difference between 'isolation' and 'remoteness', with the former referring to a 'psychological or social space' and indicating that 'remote' may not necessarily be isolated if there is appropriate support of network structures.

Further to this, Thorton (1992b: 65) supported the nurses' comments when he stated:

Confusion and lack of consensus appear to remain with us and it is probably the nurse working in a given community who would quickly enlighten any researcher about what constitutes a rural community and the responsibilities of a rural nurse.

Hegney (1996) has provided an extensive critique of the notions of 'rural' in health policy. She cautioned against 'global generalisations' (Hegney 1996:11), positing the view of the uniqueness of each rural area and the difficulty of equating 'remote' with 'isolation'. Further to this she, drew on the ideas of Parkes (1983), who located isolation as a possible sociological or psychological space, characteristic of people in places which are small, which could be equally applied to urban as well as remote areas.

Moreover, given the variety of conceptualisations and definitions of urban/rural/remote utilised by different federal and state departments that control or influence
health policy, funding and service implementation, the end result is that a lived space may be differently classified by different departments.

Hodgeson and Berry (1993:1.1) suggested that such factors as 'geographical milieu' (distance from urban centre), 'pattern of behaviour' and 'lifestyle' (social criteria), and 'population size' (demographic criteria) have been utilised in different classification systems. In an analysis of public discursive statements about rural nursing, Hegney (1996:190) found that isolation was referred to in the context of 'distance from support service (such as other health service)'. For nurses, however, isolation can be unrelated to distance, and more related to difficulty accessing an educational provider, the profession or peer networks (Hegney 1996). This lack of ability to share can create a feeling of isolation for sole practitioners in a metropolitan as well as rural/remote areas. Hegney (1996:190) suggested that 'CRANA continues to define "remote" as nurses who believe they are isolated regardless of their geographical setting'.

Wade and Aspinal (1992) and Wilson (1992) specifically discussed rural community nurses and the difficulties produced by isolation and distance. While they viewed the 'tyranny of distance' in terms of equity of access for community members and standardisation of service (Wade & Aspinal 1992) and isolation as distance from the nearest centre (Wilson 1992), these researchers suggested that these difficulties did not negate excellent nursing practice.

Tensions of working on the margins: An oppositional analysis
small/large, populations/individuals, have/have not, seen/not seen, known/unknown.

'Spatial distribution', Massey (1994:62) suggested, has been 'given its own autonomous existence' with space constructed as a 'dichotomous dualism'. The construction of the A/not A has resulted in resistance to change; only one of the terms is defined positively, and the not-A is defined as absence or lack.

Perhaps this is what accounts for the problematic nature of defining 'rural', in that it is viewed in terms of what is lacking in comparison to the urban.

This dualistic conceptualisation urban/rural is another example of the 'have A/have not A' dichotomy. In the policy of economic rationalism this dualism constructs a system of domination of the 'have A', where meeting the health needs of the 'have not A' areas is seen to be an extensive drain on the economic viability of the health dollar. Further to this, research in the rural has tended to focus on elements and characteristics such as 'a new set of dialectics ... globalization/localization ... regulation/deregulation ... cultural distinctiveness/exclusivity' (Marsden 1996:247), to name just a few.

Massey's (1994) analysis represents to some extent a possible explanation of the dualistic thinking in the minds of government administrators. The challenge, then, to policymakers is to continue the deconstructive moment. The least dominant term, and the power relationship between the two terms, must be recognised.
For space is relational, and it is these relationships which define space, and, especially the movement through space which joins the dominant and the least dominant positions.

Postmodern notions of spatiality and the implications for health policy and service delivery

There is a diversity of constructions of space, place and location within the postmodern/feminist literature. Speaking about affirmative postmodernists, Rosenau (1992:171) stated: ‘[o]ne of their main goals is to expose the oppressive dimensions of modern temporal assumptions’. There has been a discrepancy between ‘our mental maps’ (Harvey 1989:305) and the reality of current geographical representations or 'spatialisation[s]' (Smart 1992:193) in health care policy (NRHA 1998a). Moreover, in the past, space, like time, has been conceptualised as linear and against this there has been the move to the idea of specialisations of space that is referred to by Smart (1992:75) as the 'synchronisation of space' and 'linearisation of space'. Further to this, Harvey (1989:219) speaks of 'the "friction of distance" in human affairs' created by 'accessibility and distanciation'.

The problem that continues to exist for those dealing with health issues in remote and rural areas is the present conceptualisation of space and place as a purely physical geographical concept, with little consideration given to different models articulated within humanist and cultural geography and social science. The consequence of this is that both historically and at the present time there is under-servicing and an inappropriate level of service (NRHA 1998a,b,c).

The consideration of a strictly physical geographical conceptualisation has limited the consideration of the human condition. There needs to be, as Massey (1994) has suggested, a more expansive reconceptualisation. On this point she commented:

*The stimulus has come, at least in part, from the need to set "places" ... in the wider context of the*. 200
forces and relations which lay not only within but also beyond them and which played so important a role in determining their fate (Massey 1994 : 117).

The regional problem has tended to be thought of as being due to spatial differentiation or geographical distribution, rather than based on the nature of the communities sited within these spaces.

A postmodern reconstruction: Transforming the margins

A differentiation between space and place is found in the work of Fornas (1995:52), who defined space as 'a stretch or an extension containing something ... [which] can be used ... as the most general concept for three-dimensional expanses', and place as 'a particular location, whatever its form.' Like Soja (1993) and Foucault (1993), Fornas speaks of the historically situated power relations inherent in the conceptualisation of space as if it were devoid of life when he stated: '[s]ocial cleavages and dominance patterns between ages, genders, classes, ethnicities and geographical regions decrease the freedom and capability of action of the weaker parts of the population' (1995:92). In some earlier writing, Harvey (1973:125) referred to the concept of 'the region' in geography as meaning 'an essential mental construct for the organisation of geographic data', and postulated that the concept served as a classification system rather than a form of explanation. Further to this, he contended that 'geographic notions about space are ... embedded in some wider cultural experience' (1973:228). How we perceive space is central to our being in the world and our notions of reality (Shields 1991). Postmodernism recognises the 'internal social and cultural complexion and heterogeneity of the rural space and the rural experience' (Marsden 1996:247).

For Simonsen (1996:495), notions of space are linked together as 'social spatiality', 'material environment' and 'space as difference'. The politicisation of the notion of 'space as difference' is extended by Lefebvre's contention that
'the homogenising tendency of transparent space is always threatened by the persistent presence of difference' (in Blunt & Rose 1994:15).

Especially that difference which inscribes the marginalised or ex-centric.

The notion of the fluidity of boundaries is a move away from the modernist idea of concrete and fixed spatialisation. Moreover, Surap (1996:7), talking about the home, the journey and the border, stated that 'the borderline is always ambivalent; sometimes ... inside ... at other times ... part of the chaotic wilderness outside'.

The idea of an in-between space is one which Southwick (personal conversation 1998a) describes as the margins in her research with Pacific Islands women nurses. For her there is the centre and chaos, and the movement between these two points is the space/place of the marginalised.

In this research, however, the in-between was not only a place of movement but also one of rest, of being outside both the centre and the margin. The margin was chaos at times. Betweenness was paradoxically related to both the centre and the margin.

It was being situated in-between that eventually allowed the centre to be traversed and the chaos of the margin to be lived and celebrated. The positionality of betweenness forged a third space both
subjectively and physically. The resident of the third space inhabited an actual geographically identifiable area. Rather than being out of place (in that it was neither the centre or the margin), it was the space/place that ruptured the hegemony of the centre and the chaos of the margin.

McDowell (1996:5) viewed this as a 'hybrid ... interstitial' space.

To some extent I find some resonance with this biological metaphor. Both notions imply the formation of a third space distinct from the first (central) and second (marginal) spaces — hybrid, 'interstitial' space which bathes and supports the cells (the cells being central and marginal).

There is an implication of nurturance and sustainability contained within the conceptualisation of the third space. It is characterised as a space of self-reflection, self-reflectivity and, therefore inter-
textuality. It encouraged a conversation which allowed the uncovering of that which was hidden.

Being on the margins and working with the marginalised are entirely interwoven, and it is difficult to separate these as different conceptual positions – which is the reason I have chosen not to separate them into two different chapters. What follows now is an exploration of the participants' notions of working with the marginalised while feeling marginalised themselves professionally and spatially.

**Working with the marginalised**

*When people are marginalised, they are stripped of their voice, their power, and their rights to resources (Meleis 1996:4).*

While the basis of Primary Health Care, as stated earlier, is social justice, it is also clear that rural health policy historically, at both state and federal levels, had also reflected this idea. The main principle was that of equity, including equity of access, resources, human rights, and participation (Hegney 1996). However, the lack of explanation concerning these concepts, differing interpretations, and also a lack of clear strategies to achieve them created a
'myth of social justice' (Hegney 1996:81) — or, in postmodern terms, a virtual reality of social justice. That is, while social justice was seen to underpin health policy, for Indigenous people, for example, this has been far from reality.

By 1994, according to Hegney (1996), the rhetoric had shifted.

The guiding principles inherent in the discursive statements about social justice were concerned with accessibility to a sufficient and appropriate service. Further to this, a contradictory rhetoric of individual and community control and responsibility for health was juxtaposed with overt statements which placed control with the health service (Hegney 1996). This has especially been so for Indigenous people. The slogan of 'Aboriginal health in Aboriginal hands' has been the rhetorical device which has, on the one hand, indicated recognition of Aboriginal rights to self-determination while at the same time allowing a cut in the financial pipeline to achieve this.

My own story

Although I did not work with any Aboriginal people during this research, their position on the margins was clearly demonstrated by a series of events that preceded a conversation with one of the nurse participants. Before agreeing to talk to me Rachel said she would like to take me for a drive to the Aboriginal cemetery a couple of kilometres from the community
health centre. My experience is documented in the following extract from my field notes.

"When we arrived she showed me through the gate and suggested that I wander for a while and that she would wait in the car. And so I wandered, a little unsure of what to take in. The cemetery was set in an open field surrounded by bushland. As I wandered, I noticed that many of the same family names kept reappearing. There seemed to be more older women, but the men who died were younger. I noticed fond parting words. On my return to the car Rachel interviewed me. She asked me what I had noticed, and I told her my thoughts and feelings. She asked me if I had noticed the age of those who had died, I replied that I had noticed that the men who died were younger by far. Then she said, 'But didn't you notice the average age of those who had died? It was about forty eight years'. I replied that that particular point had escaped me. She also showed me the track through the bush that local Aborigines used to access the cemetery'.

Rachel then suggested that we go to the old Aboriginal mission so that I could gain a sense of the context of her work.

She asked me if I had ever been there. I had to say, that although I lived only
about twenty kilometres away, I had never been.

Still unwilling to engage me in any conversation about primary health care, Rachel drove and told me about her own and her families marginalised background. The reflections from my journal recorded the following.

'We arrived at the old mission. A week before there had been a riot. There was still debris around and nobody in sight. It appeared desolate and without life. I was struck by the fact that this settlement was only within a couple of kilometres of the hospital, and I observed the track that led in that direction. We stopped and called at a few houses but nobody was around. We returned to the car a sat for a while and Rachel told me of the networks in the community. The people who trusted her, the years that it had taken to build that trust, how open people were with her and what and how much they would tell her. She stressed how important this was in maintaining her acceptance in the community. While we were talking, a young man approached us and asked if we could give him a lift if we were going into town; unfortunately, we weren’t'.

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As we were driving away Rachel said she was willing to talk to me as she felt I now had some idea of the context of her practice. I was reminded of Peter Jackson’s words and, later that evening, wrote them in my field notes.

Many of these issues involve a directly spatial dimension where the control of space is a crucial element in the maintenance of social order and the transformation of existing social relations (Jackson 1989:101).

This particular mission has had a history of riots and a reputation as a 'black hole'. And, as I reread this conversation some time after, the feeling of desolation and bareness returned. I was so overwhelmed with a need to represent the 'feeling' of the place that I decided again to paint the images. These are represent in the following photograph of the old mission (see Photograph two).
Photograph two: A photograph of the painting representing the old mission.
Participants' stories

My conversation with Rachel followed our return to the community health centre. Having just experienced talking to the young man who has wanted a lift, I therefore began the conversation with a question related to transport and isolation.

Kierrynn: Well, transport is one of the major problems out in an area like this, isn’t it?

Rachel: ‘Yes, but you’re talking low socio-economic. There’s a bus. It leaves in the morning and comes back in the afternoon. But if you’re unwell, or you’ve got a plaster on you arm or leg or whatever the case may be, you don’t want to spend a whole day’.

Rachel goes on to say:

‘There is [a bus] ... [but it] depends on what colour you are. If you’re Aboriginal, you can’t go on [the bus]. That’s how racist the community is ... racism is alive and well'.
I ask her how she would change things if she could. Rachel's reply begins to construct the idea of holism and reciprocity; however, it is intertwined with the oppositional construct of powerless/powerful. She says:

'I don't even know where to start. It's something that I get really frustrated [about]. Like yesterday ... I guess you feel so powerless ... It's not one problem. It's not one thing that's causing the problem. Attached to it is history, is the geographics ... it's everything. And, being ... a full-time worker here over a period of years ... you come here, you're enthusiastic, you can identify the problems together [through your networks] ... if you're interested. You try... I mean, it's not through the want of trying by a vast number of people. But you're so powerless. You end up ... band-aiding. And even band-aiding depends on your own mood, your own self-esteem. Even that sometimes is useless. And that in itself builds up a lot of frustration, because you have to walk away'.

A further oppositional construct — seeing/not seeing and the movement between is articulated by Rachel. This in-between state is contextualised by
knowledge of, acceptance by, and commitment to the community. Seeing means action and taking responsibility for advocacy.

'You can go out to the settlement and drive around ... or go out with one referral in your hand, do that one referral and leave. So one day ... you may go and do one person, the next day you might go, and this all depends on the person, whether you’re known, whether the people know you, whether you know how to speak, whether you know how to get into the situation. You might go and think this will take me 20 minutes, and you’re still there two hours later, and you’ve got DOCS and the police, and everybody else coming. But at the same time ... back to the first example where you go one day for 10 minutes, you mightn’t subconsciously or consciously... choose not to see it, because you haven’t got the time to see it, whereas [an] other day, you can’t help but see it, because you walk in on something or, you know, it’s pretty obvious, and you think Oh, I can’t not see this today... I’ve got to do something, even though there might be 10 other people or something on your list'.

Rachel spoke of what happens in Yarraville concerning Aboriginal people living in the area serviced by Yarraville but
experiencing marginalisation. She identified clearly some of the tensions within the service in the following conversation.

"They don’t … as far as I’m aware … have involvement in Aboriginal Health … I find it extremely limiting. I can’t understand … there is a big Aboriginal population in Yarraville, and yet, out of the Yarraville community nurses … there’s not one on a team of 9 or 12 or whatever [that] has found their way into that Aboriginal community. The Aboriginal community, to me, would be like an ethnic group … and … they’re not excluded. I’m not trying to say that they’re deliberately excluded. But clients that I have here in Sunville find their way to Yarraville. Down here they’ll get Community Nurse treatment. In Yarraville they get followed up by an Aboriginal Health Worker who isn’t a Registered Nurse'.

Rachel outlined how she worked with the Aboriginal community, the importance of friendship networks, realising limitations, and implicit understanding of cultural awareness and sensitivity. Furthermore, the need for education and preparation of nurses to ensure cultural safety was
implicit within the conversation. The lack of formal education in Indigenous studies for rural nurses also began to emerge.

'Now, relating it to the Aboriginal community, I wouldn't expect anybody, nor would I ask anybody, to go out to [the old mission] or to anywhere in the community, really, without knowing how they feel and what their capacity is [if they don't have the capacity] ... relating it directly to the Aboriginal community... [they] can destroy it ... beyond repair in some places. So, when someone comes here ... and there are times when they have to go ... then before that time arrives, if it's me, I endeavour to go with them. I endeavour to give them a little bit of an explanation of ... how to deal with things. [I say] "If you meet something that you're unsure about, stay on the edge, don't go in. Until you build up your own contacts. Like the people that I have contacts [with] aren't going to be who you have contacts [with]."

Further on the role of language and the need to ensure cultural safety, Rachel says:

'I mean, everyone's a beginner at some time. I used to make some real boobies to start off with, but you learn. In Western language you ... have sayings [that] sometimes [are]
enough to destroy the situation. You offer a cup of tea, and then you say "Do you want it black or white?" I mean, that [is] a basic little example, but at the wrong time, in the wrong situation ... it can be the wrong thing to say'.

Elenore, who had over twenty years' experience working in community health in the area and who worked at Yarraville replied to my question concerning the context of involvement of the service with the Indigenous people of the area. She raised the idea of diversity and difference in Aboriginal identity. Elenore said:

'[There is] more a focus on Aboriginal health, and Aboriginal health workers. And that is a necessity. I've had dealings through my [work] with Aboriginals, and you have to be able to get their trust. Not everyone can get their trust. The white people they don't always trust. This is something that [has] concerned me greatly and now they're starting to get the Aboriginal workers, but not every Aboriginal worker can go into an Aboriginal's home, because they have their [own] tribes. They won't allow some in ... because they don't belong to their group. This is something that has not really been looked at very greatly. But that's a side of the health issue that really needs a lot more work on it ... and they're starting to work that way now, which is good'.

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I then asked Elenore to explain her role with the Aboriginal health workers further.

She replied:

'We had been, in the past, the educators, but now the centre for education and development [in] nursing up at the hospital ... take[s] on the role, and they do the education for Aboriginal health workers. We may go and assist in their screenings and their promotions – things like that – and they assist me. Because, they may need the confidence of one of the workers that knows. Depending on how stretched our staffing is, and how soon they let us know'.

I then suggested that their role was to act as a resource person. Elenore confirmed this and replied:

'Yes. And just observing them and seeing that they are doing it correctly. [For example] their blood sugar screenings and dietary info. So, they need to know the background information to give to the people with the results that they get. So, we're working very hard, and you're trying very hard, which is great'.

The message here is 'Aboriginal health in Aboriginal hands'. This was also a clear
message from Sonia who worked at Mustville. Sonia said:

'I do feel that it’s Aboriginal people that need to be working in Aboriginal health'.

I asked Jay, who was working at Karaville at the time, what changes could be made to improve the service.

'Overall things were working well except for Aboriginal health. This system completely fails ... Aboriginal communities, it is a token effort by the health service ... [they] don't even come close to it'.

I also asked if there was a large Indigenous community in Karaville.

'There are Aboriginal communities here but we see very little of the Aboriginal community here'.

Jay clarified the situation for the Yarraville service.

'There is a big Aboriginal community there. We had the community health centre in Rainville and I saw very few Aboriginal people go past that door'.

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There is obvious tension between owning the need for Aboriginal health to be in Aboriginal hands and providing appropriate, culturally sensitive assistance where necessary. None of the nurses that I interviewed spoke about the need for more Aboriginal people in the nursing profession or the ways in which this could be encouraged. There were, however, several tensions concerning turning away from what was observed and knowing that anyone with a conscience could not help but 'see'. This is explored in a conversation with Rachel, who stated:

'I mean, you have to switch off, you can’t change everything in the world. I had a child say to me once "Hey Rachel, you know where I sleep? I sleep in a drawer". And it upset me no end, to think that this child slept in a drawer. If she didn’t sleep in the drawer, she was going to sleep in the dirt. So where would you sleep? You’d sleep in the drawer'.
I asked about social justice and she moved on to speak about cultural safety. Rachel said:

'I was using that, though, as an example ... you have to walk away. Things like, you can’t project your values on what you’re seeing'.

The tensions of cultural awareness, social justice and advocacy emerge in the following conversation. Rachel said:

'You can’t project your values onto where you’re going, and to what you’re doing. But at the same time, you need ... there will come a time when you know that what you’re seeing isn’t acceptable. And therefore, you have to make the stand, and I’m not going to give up the fight. That’s when you then become the patient advocate ... There’s a difference between walking away and not dealing with what you know, not progressing with what you’re seeing, but a [point] when you have to make a stand, and then [you] go for it. You know in your heart when it’s time. I can’t overlook this, I can’t ignore this. And it usually comes if the person’s detrimental to themselves, those they’re living with, or whatever. You know when it’s time, that the Aged Care Assessment Team needs to be called in, because this person needs to be assessed, and then let the debate start, of do we remove this person? Would they be physically
better off in a nursing home and being cared for, or whatever? And that’s a hard line. But usually you come to that in your head, before anything else. But sometimes you come to the bottom line, and you can’t do anything about it’.

I then asked Rachel how she worked in this situation, and she replied:

'As a Community Nurse in the work situation at the present I’m extremely lucky. I’ve got colleagues that think along the same wavelength. We come back and debate'.

I continue the exploration by asking:

Kierrynn: 'So you’re able to talk it through'.
Rachel: 'You’d say more than talk, you’d say debate. Because we say, each individual that goes into a house sees different things, and picks up different things, and you’ll find there’s only two of us here most of the time. We debate things like, how ‘bout this, how ‘bout that. It’s probably quite frequent, in that, each afternoon we tell each other what we’ve been doing, and therefore you build up overall a complete picture of the patient. We don’t look at somebody by his leg ulcer. You look at somebody that lives in such and such a street, and you know [that] the wife lives there [as well]. You’re looking at everything else while you’re there. Sometimes it’s subconscious, and sometimes it’s most definite that’s what you’re going there for'.
The predominant ideas identified above include the importance of the nursing team, the contribution to a holistic approach and a deterritorialising of both the client and the nurses. There is a mutuality or co-creation in the nurses’ construction. In other words, there is, in the conversation, an intersubjective construction of the patient and their world. Although intersubjective is a phenomenological concept, I will attend to this seeming contradiction in Chapter six. What follows now is a realist, oppositional analysis and a postmodern reconstruction.

The hegemony of feminism and racism: A realist analysis

I have utilised the above title for the following conversation, to locate the contribution postmodernism can make to the ethnocentricism of feminism. Hence this discussion further justifies the choice
of methodology. The main themes arising include overt examples of racism, advocacy, social justice, reciprocity, holism, cultural safety and sensitivity, lack of formal preparation for working with Indigenous people, Aboriginal health worker education, role marginalisation of services, and Aboriginal health in Aboriginal hands.

Therefore, working with the marginalised was contextualised socially, politically, culturally, physically and structurally.

It is relevant to note that for over a decade many women of colour have written of the ethnocentrism within feminism, both in Australia and overseas (Hood 1984; hooks 1986, 1990; Blunt & Rose 1994; Murdolo 1996). For example, Joseph and Lewis’s edited book Common Differences (1981) explored conflicts in black and white feminist perspectives. In the ‘Introduction ’, Joseph (1981) concluded that white women in the women’s movement predominantly dealt with issues that arose as part of their everyday life. These issues were different to those which arose for women of colour.

While Southwick (1998b) was dissatisfied with feminisms’ ethnocentrism, she did, on the other hand, acknowledge the value of critical feminism in the deconstruction of the oppression narrative. Furthermore, she recognised the value of postmodernism’s contribution to a reconstructed post-colonial subjectivity and agency. In her research with Pacific Islands women nurses,
Southwick (1998b) identified several positions of New Zealand nurses to the notion of racism. Firstly, there were those who ignored racism for fear of rocking the boat. Secondly, there was a discounting of the experiences of racism. Thirdly, there was the notion that there were those who would build their career on the status afforded those who 'name and explain the "exotic other"'. Furthermore, Southwick (1998b) acknowledged that voicing concerns about racism has been hindered by a professional community who had not been prepared to listen. Moreover, Southwick (1998b:6) challenged her 'white colleagues' to 'shed this un-useful burden and look ... freshly at the concepts of racism and responsibility', and to do so in a manner which was non-paternalistic.

In the closing days of writing this text I attended the Critical Theory and Feminist Perspectives in Nursing Conference and listened to Margaret Southwick speak of her research. As a consequence I spent much time in a process of self-reflection. I asked myself questions concerning my position in relation to the 'other'. Was the inclusion of these conversations from my research building my career on the back of the 'other'? Or was this a case of the politics of caring – the gift of desire, a mutually positive and compassionate relationship
with the participants which sought to bring 
about a 'good' outcome in relation to their 
advocacy for Indigenous people?

Within this research the dialogue 
concerning the role of Aboriginal health 
workers noted the transformation in the 
relationship between this group and rural 
community nurses.

And although Fuller (1995) was speaking about the primary health care role of the ethnic health worker in his research, he alluded to the notion that there had been an expectation that the ethnic community would change in order to access health services rather than have the health service change to assist the ethnic community.

Mcmasters (1996) also supported the notion that Aboriginal people found it difficult to talk to family about medical problems, and found it even more difficult to talk to Aboriginal people who were not part of their identified group. He called for a move away from what he referred to as the 'taxi driver' approach, where the Aboriginal health worker is the 'go-between' for the Aboriginal community and the health service (Mcmasters 1996:320). Both McMasters (1996) and Hecker (1997) reiterated the need for Aboriginal health workers to be appropriately educated to undertake the responsibilities of the position. Problems with a low level of training, literacy, numeracy and lack of involvement in decision making by remote area Aboriginal health workers were identified in Hecker's (1997) participatory action research. The rhetoric of government policy, however, names the implementation of the Aboriginal health worker program as a key strategy in Aboriginal health (NRHA 1998c).
While it is recognised that the problems cited above apply to the remote rather than the rural setting, recent personal conversations at a local women's forum confirmed Hecker's (1997) findings.

The problems identified above, however, resulted in a preoccupation with continuity of care and an inability of the Aboriginal health worker to be a key deliverer of primary health care (Hecker 1997).

Furthermore, while some participants in this present research spoke from a marginalised position themselves, none spoke of the need to increase the numbers of Aborigines and Torres Strait Islanders in nursing.

While this may be discouraging it is important to view this standpoint contextually. Firstly, the impetus to establish a national network of Indigenous nurses did not arise until 1995. Secondly, a national forum to develop effective strategies to increase the numbers of Indigenous nurses did not take place until August, 1997. Thirdly, it was at this forum that the Council of Aboriginal and Torres Strait Islander Nurses (CATSIN) was formed. As a group they were committed to the
implementations of the strategies formulated by the National Aboriginal and Torres Strait Islanders Nursing Forum (1997).

All of these events took place either during or after the completion of the fieldwork, providing little opportunity to identify any transformations in thinking concerning these issues.

On the other hand, an examination of the NRHA (1998c) issues paper has indicated that part of their policy includes the need to enhance the enrolment and retention of Indigenous students in medicine and other health professional organisations.

In Australia there have been extensive calls in recent nursing literature for nurses to take an overt stand against racism (Venamore 1997; Ramsay & Kermode 1997), to be committed to an educationally informed position concerning Indigenous studies and reconciliation (Ramsay & Kermode 1997; Winch 1989), and to be committed to cultural awareness in nursing practice and health care organisation (Russell 1996; Carberry 1998).

While Johnson's (1992) discussion of PHC and Aboriginal health was sited in the context of remote area nursing, she clearly related the principles of PHC to the fundamental principles of Aboriginal empowerment, community participation and development. These ideas of Johnson (1992) are implied in
notions of cultural danger and cultural safety (Dowd & Eckermann 1992) evident in this research. On this point, Dowd and Eckermann (1992:12) stated:

Cultural safety in health, then, is dependent on the philosophies, aims, objectives and practice of primary health care development/community empowerment which focus on the whole person, the whole community.

For Carberry (1998), cultural safety encompassed both client rights and nursing responsibilities, where the type of care delivered was respectful of human dignity and was of the highest quality. The lack of standards related to cultural competency was said by Carberry (1998:11) to constitute 'professional ethnocentrism'. Furthermore, Carberry (1998) was critical of the notion of cultural sensitivity, as she believed that this position enhanced ethnocentrism by constructing the self-other relationship. Cultural sensitivity is a process that enables us to examine our own ethnocentrism (Baker 1997), to decentre our own perspective and deliberately place ourselves in an in-between place of 'uncertainty' (Carberry 1998:11) requiring a negotiated, reciprocal and receptive space.

While it is not the case in Australia as yet, cultural safety is a major influence in nursing and health care delivery in New Zealand (Polaschek 1998).

Cultural safety is also an exemplary of a 'marginal discourse' critiquing the official voices. Polaschek differentiated between cultural safety and sensitivity (1998). The safety in this concept is similar to safety standards of any nursing care; however, it relates holistically to physical, emotional, spiritual and mental health. This concept supports diversity of identity within particular cultural groups and rejects homogenicity. Transcultural nursing is rejected in this model. For while transcultural nursing relies on respect for multicultural
care and sensitivity, it fails to realise the subjective nature of care and the political context of that care. Cultural safety is based on biculturalism rather than transculturalism or multiculturalism, as both transculturalism and multiculturalism ignore the inherent differential power relations of various groups in society.

Polaschek (1998:453) was critical of the label 'biculturalism' within the notion of cultural safety, and asserted: '[w]hile an oppressive inter-ethnic relationship will always be bicultural ... such a relationship will not always involve oppression of the Indigenous people'.

While culturally unsafe practice is constructed individually, safety also refers to notions of collectivity. Therefore, there is possible confusion between the societal and personal in biculturalism, as biculturalism ignores the situation where both people are from the same group.

In other words it is a failure of the concept to differentiate individual and structural issues.

According to Polaschek (1998), both biculturalism and transculturalism place an emphasis on individual nurses and false consciousness or colonisation, and view racism in a moral context, without dealing with institutional racism within organisations such as health care services. Meleis (1995) spoke of the urgent need to develop competency standards for cultural care.

However, Carberry (1998) has thoroughly critiqued the competency approach to culturally aware nursing care,
and has identified the reductionist nature of such an approach.

Meleis (1995,1996) suggested, however, that knowledge base development in this area of nursing practice is hindered by substantive and methodological issues. These include such aspects as a limited view of culture and a lack of models for understanding the complex and interrelated nature of particular cultural experiences (Meleis 1995).


Meleis (1995) called for the formulation and implementation of organisational policies which support culturally competent care. Furthermore, there is an emphasis on holistic considerations of care, where giving preference to cultural issues only is seen as being just as reductionist as considering only a person's physical illness.

A concentration on cultural populations denies diversity and complexity within such populations and encourages cultural relativism, leading to stereotyping. Moreover, by ignoring institutional racism, the status quo is supported and maintained.

Culture is a unit of analysis in anthropology but, as holism is a concept that has been appropriated by nursing, culture in the context of nursing, therefore, takes into account discourses, structures and power relations (Meleis 1995).

Dowd and Eckermann (1992) are in agreement with Meleis (1995) and Polaschek (1998), and see cultural
safety to be more than just providing another 'black face' to assist in the negotiation of the health service.

It is the provision of a health service that reflects a positive Indigenous self-image and recognises the cultural ties to family groups and tribal lands (Dowd & Eckermann 1992). Linking this idea to that of nurses' involvement with the education and practice of Aboriginal health workers, raised earlier, both Hecker (1997) and Tsey (1997) have been critical of this practice. The health system practice of providing only the 'black face' of an Aboriginal health worker is one which may contribute to an increase in the morbidity and mortality of Aboriginal people.

Further on this point, there is an implicit understanding of 'difference' by participants in this research. Clearly there is a deconstruction of the homogenisation and fixity of Aboriginal identity (Johnson 1994) and a recognition of difference and multiple positional subjectivities (Cully 1996). Jacobs (1994:190) referred to the essentialising of Indigenous identity as a belief in a 'nonexistent premodern identity' that continues the process of colonisation. Furthermore, the participants in Jacobs' (1994) research voiced a rejection of the idea of a single state health service for Aboriginal people that could be structured successfully to meet the health needs of the multi-situated Indigenous population of the area.

I am reminded of the difficulties of Indigenous students from other tribal/land groups who come to study in this geographical area. They often felt lonely, alienated and non-accepted by the original keepers of the land, for they were
from a different tribal group. It was difficult for these students to feel comfortable and often they returned to their own tribal areas. When I became aware of this problem for some of our Indigenous students, I also became aware of my own essentialising of Aboriginal identity and subjectivity.

Connolly (1997) in a chapter entitled 'Racism and Postmodernism: Towards a Theory of Practice', problematised the essentialist notions of a 'black' identity and offered a different framework for the resituating of notions of racism. Expanding on Bourdieu's (1990) ideas concerning the 'context-specific and contingent nature of racism' (Connolly 1997:71). Connolly's ethnographic study of racism was framed within the concepts of 'habitus', 'capital' and the 'field'. 'Habitus' is the internalised, habitual way we think about our world, 'capital' refers to our access to the scarcity within material and cultural life; and 'the field', or various spaces, is composed of a number of forces within a social situation which determine our access to cultural or material capital (Connolly 1997).

Being on the margins, decentered or seen as 'other', an Indigenous person who has certain health needs is habitually conceptualised by different stakeholders in different ways — by different community nurses and by health bureaucrats. The difference between the micro (community nurses) and macro (politicians/policy) levels adds further complexity. How Indigenous people access the material capital of a health service is shaped by the forces of government policy which reduce or withhold the material capital necessary for the provision of appropriate housing and transport (macro politics).
Furthermore, the lack of infrastructural support for an Indigenous Health Service (macro politics) is hidden behind a rhetoric of waiting for the those with a lack of cultural capital to empower themselves and articulate their needs.

In the participants' conversations there are notions of 'rituals of resistance' (Jackson 1989:3) in attempting to do anything else other than band-aiding.

Racism is not dependent on specific localities or particular times, or the changing nature of space, history or geographical circumstances. In an uneasy relationship, those who occupy the edges of space are essential to the powerful centre; however, while they are ignored by the spatial gaze they are also resited and given their own place, (such as the mission, the reserve, the settlement, or the community health centre) in the borderlands. The deconstruction of these contradictions and the recognition of tensions by the nurses working on the margins help to rupture transparent space and deterritorialise and reinscribe place (Katz & Monk 1993, Rose 1993; McDowell 1996) as inhabited by those living in the margins. Nurses in this research have been given voice and have spoken of their frustration, not with missionary zeal but in relation to being on the margins themselves.

There is also a difference in those localities where nurses have not historically worked within a large Indigenous groups in a settlement situation. This finding supports the work of Hegney (1996), who found a similar situation with the nurses in her research.
In respect, and in recognition of reconciliation, Aboriginal health is seen as Aboriginal business.

This attitude of respect, however, should not ignore the possible eventuality that the respect can lead to neglect and lack of funding and infrastructural support. Jackson spoke about the way culture can cover political tensions and stated:

[D]ebates about racism and anti-racism, for example, can be defined if they are presented as debates about ‘multi-culturalism’ where attitudes are less polarised and where the liberal demand for tolerance and fair play obscures deeper questions of inequality and racism (Jackson 1989:7).

Coincidental support of Jackson’s concerns was realised when I recently attended a Rural Nursing Summit which was launched by the NSW Minister for Health. During question time at the end of the speech I enquired of the Minister concerning the support for Aboriginal Health Services and the possibility of increasing the numbers of Indigenous people in the health
professions, particularly nursing. He replied that the Department was waiting for Aboriginal people to articulate their needs and that it was attempting to avoid being paternalistic. I could not help but feel, at the time, that the government was saving a tremendous amount of money while they waited. There was no talk of advocacy or implementing the recommendations of CATSIN. Here I believed Aboriginal health in Aboriginal hands was nothing more than a slogan which hid a lack of commitment to maintaining a standard of Indigenous health that was above that of the third world.

Support and advocacy for CATSIN and the implementation of the recommendations (National Aboriginal & Torres Strait Islanders Nursing Forum 1997) would assist in rupturing the rhetorical euphemisms of liberal ideology. It would, furthermore rupture the marginalised geographical locations that maintained colonised identities while at the same time encouraging self-determination by Indigenous people.
Tsey (1997) has also identified the extensive lack of formal education of Indigenous staff within Aboriginal community-based organisations as a major stumbling block to Aboriginal self-determination in health care. Tsey (1997) also has challenged non-Aboriginal health practitioners and policymakers to support an increase in Aboriginal formal education which is culturally appropriate. Furthermore, Tsey (1997) is of the view that, while culturally appropriate education is important, Indigenous people themselves need to be supported and encouraged to internalise the desire for a level of education which provides the skills to be self-determining.

The tension of working with the marginalised: An oppositional analysis

The two main oppositional constructs that were uncovered were power/powerless and seeing/not seeing. There was a need for positive investment in seeing what is obviously 'staring us in the face'. There was also a positive investment in the esteem of feeling that something beneficial could be done, thereby, offering new possibilities for action and resistance.

It is not only the invisibility of the state of Aboriginal health in this country but also the lack of support given to those who speak out that is problematic.
It is viewed a little like whistle-blowing. As Fahy (1992) so accurately attested, advocacy is a risky business, although it may also have its rewards. Nurses working with the marginalised need to be able to speak from a position of power which is supported both by health policy and service. Rather than being expelled to the margins and decentred, nurses who speak out require a culture of safety to allow what is taken in within the gaze, to be clearly and powerfully articulated.

The notion of the hybrid or in-between geographical space can be further be further elaborated by taking account of these two oppositional contexts. Spaces are complex; multidimensional; real; and imagined.

In this research, not only is the physical aspects of landscape and location (real) uncovered but there is also imagined or metaphorical spaces.

This in-between space contains the backwards and forwards movement and a restless gaze. In this space, rural community nurses are simultaneously inside and outside positions of power and voice; and are possessed of a restless gaze that both focuses and defocuses. They, therefore, have the potential to rupture the hegemony of transparent exclusionary space by naming their experiences with all the richness of emotionality that is portrayed in these stories. When nurses are mapped as powerless scanners of the landscape they are no more than figures — or shadows on the landscape. They are restricted by powerful others who define what it is that nurses will see, and respond to, therefore, territorialising nursing knowledge. While restriction is present, it is also resisted by naming, focusing, and troubling hegemonic discourses that seek to delimit the growth of nursing knowledge. Rural community nurses, who are without cultural capital within the health service, find within 'hybrid' space, a position to contest both the centre, and the margins.
Desire and postmodern reconstruction: The gift of compassion

Advocacy, cultural awareness, the non-essentialising of Aboriginal identity, and the recognition of the multiple and diverse health needs of Indigenous people in different locations characterise the gift of compassion in this research. Here, the 'politics of care' (Fox 1994:94) is framed as compassion. There is a refusal to collude in the oppression of the 'other'. Where you know 'in your heart' that you have to act.

The gift relationship of compassion also entails commitment and involvement. This relationship has a desire for a positive outcome for Indigenous people's health. The movement between seeing and not seeing is compassion. The movement between power and powerlessness is commitment and involvement. Compassion, commitment and involvement inscribe the relationship between nurses and the Indigenous people in the community they serve. This relationship exposes the virtual reality of social justice. Therefore the gift acts as a site of resistance (Fox 1993). It moves away from the repetition of acts of oppression and territorialisation which inscribes relationships with the decentred or marginalised. The gift relationship will be discussed more fully in a later chapter. Suffice to say at this point that the gift relationship is a relationship contextualised within a commitment to achieving 'good'.

While the notion of 'good' is a problematic one and while it is possible to further theorise this section, I wish at this point to leave a more exhaustive analysis to Chapter five where I will explore desire and the gift in terms of postmodern feminism.
Concluding thoughts

Different spaces that those on the margin occupy are constituted by different subjectivities and different intertextualities, with different access to material and/or cultural capital which is shaped in turn by different forces. There is no essentialised rural community nurse in the same way that there is no essentialised Indigenous identity. Living and working on the margins or in the centre is constituted differently. Neither can just be added onto the other. Rather, consideration needs to be given to meeting unique multiple needs in terms of the nature and structure of the health service, those that deliver the care and those that receive the care.

There is difference and diversity of women’s voices echoed in this study; however, these discontinuities are matched by continuities. The question of nurses as (re)producers of primary health care raises the point that we are of not just ‘passive carriers of culture, rather [our] culture is something that [we] not only learn, but also sustain, defend, reset and even create or reject’ (Duncan 1992:38). Therefore we can see the working out of culture in what is done and said. We can see the way culture is inscribed by, and inscribes, notions of spatiality and marginalisation.

The next chapter explores the realist and oppositional analysis of the subject. As I have reiterated earlier, most postmodernists would reject the notion of the subject. I have chosen to follow Rosenau’s (1992) idea of the death of the old modernist conception that is replaced by the return of the new postmodern
subject. This new subject is both the nurse, and client participants. Following this, in a separate chapter, is the a postmodern reconstruction of the subject.
Chapter Four

The Return of the New Subject:
Realist and Oppositional Perspectives
What vitalises this context... [of space, place location] ... are relationships and it is from the nature range and intensity of relationships that community building takes its life'. . . Relationship is connection (Kelly & Sewell 1988:55).

Introduction
To reiterate the position of the more affirmative postmodernists is to state that it is not the death of the subject with which they are preoccupied, but the return of the new subject.

The postmodern subject in this research are those community nurses and clients who participated and told stories of their experiences concerning the implementation and experience of PHC. The majority of those nurses who participated were women. Of the clients who were interviewed, again, the majority were women. What was interesting was that, while I observed interactions mainly between women nurses and women clients, one woman nurse selected a male client and the male nurses selected male clients. The significance of this is difficult to
determine and was predominantly linked, I believe, to the logistics of the situation. By this I mean, in order to maintain the naturalness of the interaction, privacy and confidentiality and to fit in with the clients' schedules I tended to be present at whatever client situations occurred on a particular day that suited everybody.

As suggested earlier, gender is a focus of feminist research, and the original study design included women's health nurses as a participant group. However, I was prevented from including this group in the ethnography. After this particular development and the consequences it had for the research design, I made the decision that I would respond to suggestions from the managers of the service to accept into the study any nurse, regardless of gender, who were willing to be involved. Kelly Burton and Regan (1994) validate the inclusion of men in
feminist research. What they viewed to be important was to avoid merging the male and female voices into one homogeneous voice, and to avoid linking what men have said with hegemonic practices.

The number of male nurses who consented to being involved was small in proportion to the number of women nurses. However, that was a consequence of the fact that the overall number of male nurses in that particular part of the service was small.

As I stated earlier, confidentiality was of prime concern to the participants. Therefore, in order to avoid identification, I have allocated pseudonyms in such a way that it is difficult to differentiate gender. While I am not convinced that this is completely protective, it does contribute to anonymity. The other alternative was to exclude the male voices. The close and respectful relationships that I had developed with the nurse
participants prevented me from taking this action. I have in places, however, de-emphasised the gendered nature of the voice where possible.

Telling the stories of subjectivity and the relationships of the subjects to each other, and the physical, cultural and political environments, of sites of resistance and transformation of rural community nursing is the next part of the story.

As in previous chapters, this analysis will proceed by way of a realist representation. An oppositional analysis to draw out the tensions inherent within the culture of rural community nurses as they seek to accommodate PHC initiatives in their working lives will follow the realist analysis. Finally, a postmodern feminist reconstruction of the I-You-We-It will be provided in Chapter five.
Mapping the new subject: A realist perspective and analysis

From a modernist interpretive perspective, Kelly and Sewell (1988:57) conceptualised the above in the form of 'I-You-We-It'. 'It' represented the physical context and 'I' the sense of self and identity. Partnerships and dialogue were represented by 'I-You'. 'I-You-We' was the diadic relationship where no one person is in control. 'I-You-We-It' represented the four-fold interrelationships within the human and environmental contexts.

While this conceptualisation is reminiscent of phenomenological constructs of Buber's 'I-Thou' (Crossley 1996:1), it is also similar to Fox's (1993) Nietzschean construct of the body without organs in his work on postmodernism, sociology and health.

While it is possible to view these concepts as static, a dynamic approach which represents movement between, as well as back and forth, is more appropriate to this analysis.

Several concepts I have referred to earlier are relevant at this point. As I suggested earlier, the nature of the lived experience in the postmodern world is fragmentary and nomadic, where human subjects are always in the process of movement (Fox 1993). Also relevant is the notion that
individuals become subjects through power, discourse and desire, which frames our social being. Furthermore, Kelly and Sewell's (1988) conceptualisation of I-You-We-It is widened to account for the way in which bureaucratic structures and policies contribute to this discursive field which frames our social being.

While this is so, subjects also resist powerful discourses and desires. Further to this, the concept of material life as embedded in and inseparable from history contextualises this part of the narrative. Therefore, the changes in the structure of the service, the health policy and the subject are conceptualised as transformations. The sameness/difference in subjectivities is presented as continuities and discontinuities.
The Aspects of I: The subject nurse

The sense of self and self-identity within the professional role is related in terms of nurses' own constructions. The clients perceptions of nurses are presented in Chapter five.

There were several aspects of themselves and their roles that community nurses spoke about which were contextualised in their geographical location. These aspects were therefore spatially determined within the 'It'. Nurses in the research talked about being multi-skilled, flexible, adaptable, autonomous, independent, resilient and welcoming of diversity and difference. Furthermore, an appropriate level of decision-making and problem-solving skills were viewed as important, along with the ability to act as a resource person to their clients. The principles which underpinned practice were advocacy, social justice and equity. While these
have been discussed at some length in relation to Indigenous health, they will also be highlighted in this chapter in reference to the degree of influence these principles had on all clients in the service. While the tensions between centre Yarraville and the margin Sunville in terms of the types and number of activities implemented are obvious in the following dialogue, the 'I' was diversely and spatially constructed. This is exemplified by Rachel, who begins by identifying the types of continuities of care and health promotion/education activities.

'Well from here, it operates like normal community nursing ... you have your immunisation clinics, ... we go to the Schools and do the school screenings. We have [our] clinical [where we do] ... dressings, ... showers. We have health promotion, we have a lot of visiting services that come down, ... just the usual sort of community [work]'.

Kierryyn: 'So do you think there's any difficulty with community nurses defining a role for themselves?'
Rachel: 'To be an effective community nurse, you have to be very adaptable, and flexible. Like, a community nurse at Sunville isn’t the same. The basic foundations are the same, but the day-to-day functioning [isn't]. If you really want to know your community, the mechanisms of that are vastly different. Community nurses across the board could virtually write a criteria ... like a job description. But that criteria [would have] to be very flexible, and take on board so many things. In a rurally isolated area like ours, you are everything. In Yarraville ... they don’t have the diverse area like we have ... they don’t do palliative care nursing or they don’t do school screenings [or] immunisation. For me as an individual ... the key word is ... community. So therefore, you should be in all of the community'.

The unique features of spatiality is further explored.

Kierrynn: 'Some people have spoken to me about having a community centre where people actually come into the centre. What do you think of that idea?'

Rachel: 'To be a true community nurse the home environment, or the home situation, is so very important. I mean, when you bring patients into hospitals, you strip them of their identity... [then] ... you discharge them. They’re out the door. You never see where the person comes from, how they live, how they actually operate. You ask them a question “Who
do you live with?", and they answer "My wife". It's not explored any further. "Does your wife have two arms, and two legs? Is she able?". That thought never even enters your head [in a hospital]. So when you actually enter someone's home, you're entering their environment. It's their terms, they can, in effect, indicate to you, by their surroundings, how they live. So therefore you have to work in their environment'.

Exploring further the different perceptions of care within the home situation. I asked:

'So what do you think are important qualities that a community nurse should have if they're going to work in the home with people?'

Rachel: 'flexibility and adaptability'.

Rachel elaborates:

'We can both [have] gone there and done the dressing ... We've dressed your ulcer... You can come out of the house and found out [about] the marriage circumstances, and why there's this, and why there's that. I don't even touch upon that. I come out and find out that she's an avid gardener, and she's given me some cuttings. You can go to somebody's house ... you do the ADL's, ... but there's houses that we've both been in, and
you come out with two totally ... socially different pictures'.

In answer to my question concerning the placement of students in community nursing, Anne reinforces the above ideas.

Anne: 'No, you need that experience ... You need to stand on your own, make decisions, and you wouldn’t have that ... straight out of college I don’t think'.

Kierrynn: 'So you’re fairly autonomous, is that right?'

Anne: 'You’re very autonomous'.

Kierrynn: 'Right, so you have to make decisions without being able to refer to anybody, and on that basis, you need to have good decision-making skills, and probably good problem-solving skills'.

Anne: 'Yes, assessment is your big [area] ... I mean, your nursing care plan is really community nursing. You really start with assessment, and then ... you’re out there on your own. In a ward, you’ve got people around you all the time to discuss assessment, discuss decisions, all of that type of thing. You’ve got doctors doing rounds all the time, you’ve got people on call. In community nursing you don’t have that'.

Kierrynn: 'So you’re ... independent?'

Anne: 'That’s an advantage... that’s not necessarily a disadvantage'.
Kierryynn: 'Is the advantage that ... it makes you feel autonomous?'

Anne: '[Yes], you feel good about doing it yourself ... You haven't got that boss breathing down your ... You haven't got that worry of 'Oh Matron's doing a round today' ... You haven't got to worry about the nonsense side of it. You get in there, you do your work. If you see something that you think needs doing ... you do it. You don't have to put in a request, "can I do this?"

Kierryynn: 'One of the things I noticed is the amazing resilience of some of the people I've spoken to ... People, who've been in the service for quite a number of years keep coming back, even though they sometimes feel like they make very little headway'.

Anne: 'They're not ... it far outweighs working in a hospital.'

The diversity of roles and the associated tension is further identified by Mikalia.

Kierryynn: 'So in fact you have a fairly diverse role, and that diverse role really appeals to you?'

Mikalia: 'I guess it does. But I think ... it's really hard changing'.

Kierryynn: 'Swapping hats, so to speak?'

Mikalia: 'But I do enjoy it ... I like the change, but sometimes it does become a bit difficult changing hats'.
The above ideas are also elaborated by Marshia:

Kierrynn: 'It seems to me [that] you feel fairly independent and have a fair amount of control over what you do and how you do it'.

Marshia: '[Yes] ... but I am accountable too'.

Kierrynn: 'The sorts of things that people ... identify that they enjoy about doing community nursing is this sense of control and independence, and autonomy'.

Marshia: '[Yes]. I like that. I think it's more satisfying out in the community. For me it is anyway'.

I also explored this notion with Gayle, who was talking about the difference between hospital and community nursing. I asked, her how much control over what happened in her work she actually thought she had. She replied:

'Lots of control. And that's one of the ... reasons why I'm still doing this job after 10, 12 years. I have heaps of control'.
We then discussed whether things had changed over that period of time and she replied:

'It's always been that way. I think there's probably more accountability now, than there was, say, 10 years ago'.

Aspects of I-You

The primary health care nurse will have a cluster of attitudes and attributes including the simple belief that those being cared for are of worth. She will have the ability to relate to patients in a way which facilitates, encourages and supports self-determination by the patient. This nurse will be able to establish and maintain effective relationships with patients/families/groups over an extended period. She will be an effective advocate in the patient's cause (Cowan 1996:5).

This aspect refers to the relationships with clients, the community and the service. It was characterised by relationships which were viewed as educative, situated within a network and holistic. The nature of the relationships were intertwined and dynamic.
An educative relationship with clients

Kierryyn: 'Yes, of course. So there’s a bit of role confusion'.

Marshia: 'Yes. With the [aged], I think our main job is to maintain their independence at home, as long as possible'.

Kierryyn: 'Yes, of course, and that would involve some sort of physical care?'

Marshia: 'Physical care as well'.

Kierryyn: 'And teaching them to take over that physical care if that’s possible?'.

Marshia: 'Yes, I think that’s really important'.

The educative role is woven in with networking which supports that role, and is articulated in the following comment by Marshia.

Situated within a network of relationships

Marshia: 'We have an At risk meeting once a month ... but it’s more than just an At risk meeting, it is networking'

Kierryyn: 'So can you explain that a bit more?'

Marshia: 'Well, that’s with all the health professionals, like ACAT ... the OT, Community OT ... Meals on Wheels... Home Care, ... Community Options ... that’s [the] Alzheimers and Dementia [group]'.

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Marshia: 'So we have a lot of involvement with them ... and especially [we are] involved with the carer'.

Kierrynn: 'You were in Yarraville before... That's set up a little bit differently, now isn't it? You do a lot of the things here that they have separate services for over there'.

Marshia: 'Yes, and we've got Early Childhood here too, in this building'.

Kierrynn: 'But you don't do any Early Childhood work except for immunisation?'

Marshia: 'No, but I liaise with the Early Childhood Nurse'.

Kierrynn: 'So if you're in the situation where you notice something?'

Marshia: 'Well ... being in the schools, I often have a home visit to do for the school'.

Kierrynn: 'How would that come about'?  

Marshia: 'Through the school councillor, teacher/principal ... because they can't do home visits, but we can ... For example, on Wednesday, I'm going to meet the psychologist from Child and Family at a client's house ... a client who's at risk'.

I asked about the process and Marshia replied:

'The schools phone. They're free to phone here if they need me for any reason. And with the Kids at Risk it's really important, because the school has meetings with the
councillor, and I'm invited to those meetings. And if there's a child that has problems, well they usually call on me to do the vision and hearing first, to see if there's a problem there, and if there's no problem there, they can look elsewhere. It might be articulation or language or something like that. And I will refer them to the speech pathologist, or physio or OT at the Child and Family Health'.

Again, the idea of multiple roles is explored and the tension between the centre and the margin becomes obvious again. Also, the tension between medicine and nursing is beginning to emerge. I suggest:

'It seems to me that you've had ... years or so to establish sort of fairly good networks and contacts and liaison with people here, and that you have many more multiple roles that you fulfil compared to when you were in Yarraville when they have other services that might step in'.

Marshia: 'Yes, I guess ... I think that's the community nurse. I always liaise with other health agencies'.

Kierrynn: '[Do] you think that's a characteristic of community nurses?'

Marshia: 'Well, yes and no. But I think it's up to you to liaise with the doctors. I guess ... it just comes naturally'.
The 'I-You' is further elaborated on as a holistic relationship. I was exploring the importance of establishing relationships with clients and Marshia replied:

Holistic relationships

Marshia: 'It is holistic ... with both people ... both the carer and the client. And they do get [support] ... through Community Options. They get very good respite, and they have people to come and take them for drives, or take them down to the centre, or to do something [to] give respite for the carer'.

These ideas were supported by Gayle, who was comparing the different perspectives of hospital and community nurses. She stated:

'But, we are looking at the, the big picture ... the whole patient. We're looking holistically. So we're looking at family dynamics, the home environment, their self-care ability. We're looking for deficits, and we're liaising with other community groups to try and meet, get those needs met'.

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The community is explored as the multiple 'you' in relation to Kelly and Sewell's (1988) model. Marshia talks about responding to community needs:

Community needs

Marshia: 'I think it is important to know what the community needs are. And I think that's somewhere that we should really get more and more into. It's easier out here, because it's such a little community'.

I begin to explore this idea and ask:

'You need [a] Needs Assessment, to clearly identify appropriate programs?'
Marshia: 'Programs, yes. But ... I think more for people in their 50's probably. And adolescents [are] important. [so] adolescents and people in middle age'.
Kierryn: 'If we look at the life span, that's an area that you'd like to take ... somewhere?'
Marshia: 'It's just that I think as a community, the [aged] are really looked after here. Community Transport [are very supportive], once every week ... every Friday. And that's helpful'.
Kierryn: 'I know that when I've been out around the rest of the service talking to people, that's one of the things that
they've identified, is that lack of transport ... especially for the older age group, who perhaps can't drive any more but would like to be able to get out'.

Marshia: 'Well, they can be taken ... with our transport ... the rules are that they can be taken to a doctor, or a medical appointment. But they do have trouble getting ... say their spouse is in the nursing home in Holliville, for instance. Well, they have to get a bus or something. That's where they cut it. And I think that's a shame, because a lot of them are in homes, and the other one's living alone'.

Kierrynn: 'So [there is difficulty] meeting the client's emotional needs of being able to have contact with their spouse'.

Marshia: 'But they're aware of that, and we're working on that one'.

I then asked Marshia to explain what was being done about this matter. She replied:

'Well liaising with the Community Transport, and they're aware of what we think the needs are'.

The diversity or discontinuity between communities is recognised and the concomitant discontinuities in service
provision are articulated. While staff in other communities work the weekends, where Marshia is, nurses from other areas cover her community at the weekends. I ask:

'And have you found that [to be] a good arrangement, has that been positive?'

Marshia: 'Oh yes, we can’t fault [it] ... They do weekends for us, if there’s any private [patients] ...because we’ve never worked weekends [here]. But of course now, if we have anything that has to be done ... the girls in Yarraville do it. We send them in to the dressing clinic, or they come out'.

Kierrynn: 'Right. Is there any historical reason why that hasn’t happened here?'

Marshia: 'No, It’s probably because ... [for] the diabetic[s] [people] with their poor vision ... we’ve always educated a relative or a neighbour'.

However, the intracommunity diversity is also recognised. This is seen in my conversation with Gayle.

Gayle: 'And as far as the client’s concerned, well, it's the usual mixture of people who catch on very quickly and learn,
and have a lot of support within their family, to support them in their decision to change what they’re doing. [There are] people who have absolutely no skills, and very little ability to learn, and no support in the community, and [there are] those who are ... at risk, and often they can’t be discharged from our books. If we can’t set up something in the community to deal with those problems, then we have to monitor on an ongoing basis'.

**Kierryyn:** 'So, would you say that tends to affect mainly the older age group?'

**Gayle:** 'It depends on their intellectual capacity. Some young people have also no ability to deal with their problems. But what we mostly deal with is the aged'.

While heavily involved with overt and covert resistance, the nurses involved in the study demonstrated a high degree of resilience. As part of a discussion of proposed structural changes in the service (that is, a move towards early discharge programs), I commented:

Resilience

**Kierryyn:** 'Just given a lack of funding, and a lack of infrastructural support, for people [in the early discharge program]... nurses in the service seem exposed to a certain
degree of change, and then pick themselves up and come back again'.

And Sally replied:

'I certainly see us as being a resilient group. And with the support of each other, we've been able to move with changes and keep on. I mean, because we've got this basic core belief of caring for clients ... that's what ... is within nurses, that desire to consider the clients' needs as paramount'.

In a discussion of the principles that underpinned the practice of rural community nurses, the following conversation captures the main themes of advocacy, empowerment, resourcefulness.

Kierrynn: 'You and others have raised this idea of advocacy. Do you see that to be a fundamental principle that underlies your practice?'

Sally: 'Yes, definitely'.

Kierrynn: 'Implied in what you have said earlier, you have a belief in social justice and equity, and advocacy. Are there other things that perhaps you could identify that ... characterise you as a community nurse?'
Sally: 'Well, I suppose they’re all ... interlinked with those concepts, and that’s ... the empowering of the clients and giving them control. Allowing them to make decisions. Giving them the information ... so they’re better informed. Letting them know the processes that they can take if they have an issue or a grievance, or want to make complaints, and the community are slowly getting more control over their care'.

Kierrynn: 'So, being a resource person in a lot of ways?'

Sally: 'Definitely a resource person'.

Kierrynn: 'It seems to me that, again, it’s one of the things that came out of my client interview the other day, is the way in which the client perceives the community nurse as resource people that they can contact if they’re unsure about people, ... where to go. I see it as a very important role'.

Sally: 'Yes, you’re an advocate, you’re a liaison between services, you’re often the only person that they are seeing the whole ... day. So you are a companion at times, you’re a basically a person that they can just run ideas by. You keep them ... orientated to society. Often, they’re very isolated, in a little rural cottage, and they’ve got nobody... It’s a very challenging and rewarding job, though, to see somebody grow and come and be able to change, and be able to care for themselves, and then the feeling that they get when they realise that they are quite capable of doing things for themselves, and making decisions'.
While the main philosophical principles of social justice, advocacy and equity have been clearly articulated, involvement in community development was a major activity for some of the nurses in the study. I am exploring this issue with Elenore. I have summarised a previous conversation and say:

Community development

'It seems to me that you have a deep interest and understanding of community needs and community involvement, and perhaps even community development. What other sorts of programs have you been involved in?'

Elenore: 'I'm involved in the Access Committee in the town, which is a Council Committee. I have been to the NRMA rural transport workshop for future planning. And that was collecting information from this area, [including] the needs that we felt were there. Then there was a Department of Urban Affairs and Planning ... what future do you want for the region? That was another workshop I only recently went to that and I was able to put a lot of our things forward. Then there was the Pilot Study on Ageing. And I went to that workshop, and again I was able to put a lot of things forward. I tend to get involved in those things, because they are for
future planning, and I have an idea about what is here now. I feel that a lot of the aged things ... have ... not been looked at [when] ... planning's been done'.

**Kierrynn:** 'The two things that come out of that for me is that you obviously have a deep interest in community development, and that, also, you can see the need for future planning'.

**Elenore:** 'Absolutely. And, taking into consideration, any developments that are going to be [considered] have to be projected twenty, thirty years time, not just now. Not a bandaid. They've got to be developed for the future'.

*Elenore also outlined work that she'd done in the 1980s as a result of meetings with Senator Grimes concerning the need to establish prescription assistance for people with diabetes mellitus and epilepsy.*

**Kierrynn:** 'So tell me whether you did this in your own time, or was/is it part of your job?.

**Elenore:** 'Sometimes in my own time, sometimes in work time'.

**Kierrynn:** 'But is that encouraged and supported, for you to be involved in those projects?'

**Elenore:** 'Yes. [It] was offered [to me] ... to go to the NRMA workshop, and I was selected to go to the others. I go to the Access Meeting, which is once a month, [the] weekly community nursing review, a weekly team meeting, and a monthly
district team; we have CHASP meetings which are on a Thursday and I’m the assistant secretary of the Community Nurses Association. I am also the Secretary of the Diabetes Educators Association [for the region]. Discharge Planning Meetings, [I am also] CPR accredited ... so, I help the other girls ... Run the CPR drill for primary health staff, immunisation once a month, the diabetes screening for the World Diabetes Day, Hep B injections and blood-taking at the linen service, which is a couple of hours, and I’ve done that on two occasions. I attend the disaster committee. I’ve been in the CHASP review as the person being interviewed and then the interviewee. I take on reading [reports] when X doesn’t get a chance to do it, and I’ve just done a review of the aged care report. With the Access committee ... we have just been able to get a drive-through letterbox in X park. And that means that people in wheelchairs don’t have to get out, they just drive up and there they are. And that’s one of our projects. That was one of my suggestions, actually’.

Exploring Elenore’s involvement in community development further, she identified the main characteristics of the I-You, which were, the role of specialised education in community health and, arising out of that, skills in networking. She stated:
'I think it basically comes back to the course that I did. Because this was the focus that you saw... you looked at your community, you went around and you spoke to.....ministers, government officers, doctors, chemists ... to let them know who you were, and let them know that you were working in the community. Now that isn’t done so much these days'.

Finally, Elenore talked about a recent major community project.

'Now when I was out in the ... area, I slipped into my generalist role again, and decided that, looking at the community as a whole ... it’s a low socio-economic group, because there’s no covenants on the land and the land is fairly cheap. So therefore, low cost housing, low socio-economic group. Dad might go to work with the car, Mum’s isolated out there ... no bus services except the school bus service ... in the morning and the afternoon. How do they get to town? A taxi costs too much. Income is very low. So what happens to the kids on the holidays? No sporting facilities out there. They’ve got a bowling club. They’re going to get a tennis court ... that’s four years ago - it still hasn’t got there. But not very many kids are interested in that. They want to go swimming, they want to have some other fun. So what I did was do a survey of the school. First of all I went to Sport and Recreation ... and they said OK, you have to get the school’s permission if you want to use their ground. So I went to the Education Department. The Cluster Manager gave me
permission to go the school. I went to the headmaster, and organised a circular to go out to the parents with all the kids [asking] "Would they like a Vacation Activity Centre out there". I think it was more than two thirds came back, saying yes. We organised a two-day Vacation Activity Centre. All I had to do was to set it into motion.

Then Sport and Rec took it over. They had two days there, and they had 55 the first day, and 35 the second day... Then what we were taught in the course is you set these things up, then you back out and allow the community to continue, and that's what happened with the senior citizens ... That's what happened with this, I then passed it over to the P & C'.

Aspects of I-You-We

The nature of the relationship between I-You is contextualised as I-You-We.

The I-You or nurse-client context discussed above was considered from several perspectives. Firstly, where the emphasis is placed on the nurse's relationship with individuals and, secondly, where the emphasis is placed on the nurse's relationship with the community and the service. The I-You-
We context represents the nature of these relationships with clients and colleagues.

Empowering client relationships

The nature of the relationships was predominantly seen to be empowering for the through the development of skills in self-care which provided a level of independence for the client, allowing the client to remain in the community rather than having to seek hospital care.

Kierrynn: 'So in other words, it seems to me that really what you're talking ... about is community development where the nurses develop [programs] in the community ... orientated towards preventing illness'.

Gayle: 'Yes, and certainly there's a role for the clinical aspects of a community nurse's job, too. There's no disputing that ... but, I see assessing people in their homes ... referring on to relevant agencies, just generalist work for a community health nurse is enough without trying to make everybody an expert in a very narrow field. But I see that [the] clinical aspect of our work should be something we move in and out of as quickly as we possibly can, and don't develop any dependency'.
Kierrynn: 'So client independency is ... important?'

Gayle: 'Absolutely vital ... I try not to have the clients thinking of me as a necessary ingredient in their life. I'm there for a limited amount of time to teach them ... what they need to know to manage their own health problem, and then to withdraw as soon as I possibly can ... I don't think it's fair to anybody. It's not fair to the patient, and it's not fair to our service to be making unnecessary visits to people because our time is precious'.

Kierrynn: 'Would you see that the time problem is one of the major features in limiting what you can achieve?'

Gayle: 'It certainly is a significant contributing factor. However, I think morally, even if we had all the time in the world, it's not the most efficient way to work ... to encourage dependency. The most efficient way to use your time is to teach and withdraw. And empower people. A lot of people don't want to, they don't want to be dependent, but there are some people who ... are much more likely... to want to have you coming all the time'.

Kierrynn: 'Yes, it certainly seemed to me that on some of the visits we made together that ... maybe we were the only people they were going to see for the day, so our visit was important in terms of company, and in terms of having somebody to ... interact with'.

Gayle: 'That's right, and I feel-sorry that there are people, lots of people in our community, who have that need. But I don't see myself as a paid companion. I don't see myself as a person who is there to jolly up their day. I'm a health
professional who is there to educate them about their health problems, and then to redirect them, so that they can maybe join a group of some kind, and get their socialisation that way'.

Aspects of I-You-We-It

The I-You-We-It contextualises the nature of the relationships with the environment and the service.

Relationship of accountability and responsibility to the service

One of the major issues for the nurses was the fact that the service was undergoing a CHASP evaluation while the research was being conducted. This increased the workloads because of the increased number of preparatory meetings. Here I have identified the role of the evaluation in terms of accountability, responsibility and education. Sally stated:
'In all the standards of CHASP, I see we meet them in part. That it is OK to spend time on these things, that we will develop them further. And, because we've been part of the process, we'll own it, and we feel that it is OK to spend time developing philosophies, and developing policies on particular things. And start accounting for what we do, and not just saying, "Well, I've got this gut feeling that this is what I should do". But saying there is a standard there, saying that this is the best practice, and this is the benchmark on which I'm going to base my practice'.

This is picked up by Mikalia, who utilises an interesting metaphor:

'I think, where we're probably up to at the moment, is actually having a policy for each group. Which may not come from the same heart. So, I guess, the CHASP gets you all singing from the same song sheet, where we are coming from the moment ... We've come from being very specialised services ... For example ... My early discharging planning policy should be very similar to D & A's, because we're in the same building, we're under the same team. We should have the same one, even though they're dealing with this sort of client. So, I think that there only needs to be one policy. This idea is starting to come'.

Kierrynn 'How do you think, at this point in time, the service [is] shaping up?'}
Mikalia: 'They have looked at it from the point that we have to envelop the concept. It is a learning tool to get people to look at the principles of Community Health, and how it should be run. The questions just are a learning tool to get people to refocus their thinking, and to review and ask themselves [questions] [and then] we can gauge where we are up to against a set of standards'.

Transformations in structure, policies and nursing focus

'About two thirds of the way through the fieldwork I noted the following reflections.

'My overall impression is that some nurses (individuals) are very pro-active. While they seem extremely overloaded they have accomplished a great deal. They have undergone major changes since March - reorganisation, new management structure, and an increasing emphasis on PHC rather than continuity of care. However, they are faced with CHASP, and are also undergoing individual clinical review. They are also dealing with early discharge programs or hospital in the home, and the battle over turf and who will be responsible - hospital nurses who go out into the community or community nurses.

They seem to be getting multiple messages about directions and responsibilities. Full time staff numbers are down, they are utilising a lot of casual staff and it seems like this could be problematic. It also seems, like any job, there is scope for full commitment or only putting in what you need to. They
are asked to wear a lot of hats. Some terms which come to mind to describe this are: fractured identities, ruptured identities. The service is in the process of evolving - it is typically fragmentary, always in the process of movement. There is, however, individual agency/resistance. Questions at this point are: What is the nature of representation? What is the nature of subjectivity? What would a service be like if it was able to respond to all these issues? Can a model for this be developed?'

One of the major destabilising elements was change. Change in both policy and structure of the service. A transformation directed towards a seamless service, increased accountability and responsibility, multi-disciplinary teams and the potential for an early discharge programme managed by the present community nursing service was articulated.

Mikalia: 'We've gone from a model of [a] specialised community health service, where community nurses looked after everybody anyone else didn't want. [But] people could tear into them, [at] any part they want to, whereas a D & A person
knew exactly where they sat. Well, those services have been very much blended in together now, and [it's] not so obvious where one starts and the other one finishes'.

**Kierrynn:** 'Yes. That seems to indicate to me ... that there needs to be a level of autonomy available as well. And I suppose with that comes responsibility and accountability.

**Mikalina:** 'That is accountability within documentation, rather than accountability [which says] "Hey, ... you can't do that". Accountability and documentation, whether it's within where we're going with our team, [as well as] asking ourselves: "Is it within our limits?" "Could someone else have done it?" "Are we duplicating services?" "Was that the best possible thing to do?"'

_I discuss this issue further with Gayle:_

**Kierrynn:** 'Would you say that, in a way, given the changes that are happening, that perhaps this service is evolving, and the culture is evolving? That things are different to what they were a year ago?'

**Gayle:** 'Oh yes, they're different all the time. It changes, and grows and matures I guess, all the time. We are focussed on CHASP, that's where we're headed. I think that it's what we should be aiming for. Goals need to be 'up there' with the stars, and whether we achieve that standard or not is [unknown] but you've got to have the ideal situation somewhere to aim towards'.
My concern that the contribution that nurses make to the seamless service is hidden or invisible is answered by Gayle:

Gayle: 'What CHASP does is look at the whole service, and I don’t think they specify any particular profession, so we would fit into that multi-disciplinary team, just as a podiatrist, or an occupational therapist, or a physiotherapist'.

Kierrynn: 'Right. So in other words, it doesn’t matter who does it as long as somebody does it?'

Gayle: 'Yes'.

This is accentuated by a perceived lack of defined role.

Kierrynn: 'So do you think that that makes it hard for community nurses to set their own goals?'

Gayle: 'Yes, it does, because I think nurses as a whole, especially in primary health, have not clearly defined their role. For example ... a podiatrist knows exactly what his job is and what he has to do, what’s expected of him. And I think this has been why there has been a lot of conflict in our team, and I guess in other teams as well. Because our goal is not clearly defined, each person has the opportunity to put their own stamp [on it], if you like, or interpret the role of a community health nurse in their own unique way. And of course, then you have to defend your stance, and so everyone’s
fiercely defending their own perspective, and there's conflict'.

Historically, transformations in nursing focus and the influence this has had on nursing practice and relationships is articulated further by Gayle.

'We had conflict resolution a few years ago, and we had two psychologists come and work with our team. And we separated ourselves into two distinct groups. The Florence Nightingales, and the Evangelists. You know, even within those sub-groups there were sub-groups. Like some Florence Nightingales were much more Florence Nightingale than others'.

Kierrynn: 'And when you say Florence Nightingale, you are talking [about] those who were typically the ward nurse transferred into the community'.

Gayle: '[It was] pat, pat, "never mind I'm here. I'll look after you ... Just you relax, and don't worry, I'm the Mother and you're the Child", and they foster dependency. They take on board responsibility for the outcomes of the intervention. They disempower, to a certain extent, the patients or clients, I think to meet their own needs in some ways. That they're rescuers or whatever. And I can be a rescuer, too, in a big way, but I try not to be. I try to think "The fairest thing to do for this person is to empower them"'.

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Kierry: 'So do you think that [what] was characteristic of the Evangelicals [was] that they tended to empower people?'

Gayle: 'Yes, and also ... Well, there were only two of us. There were about twelve nurses, and I think only two of us were Evangelicals, and the rest were all Florence Nightingales. [We] also looked at community development and health promotion ... looked at things in a much broader [way]. Probably, as far as this organisation is concerned ... the Florence Nightingale approach from my colleagues [made] that a difficulty. Though, I must say now, with our new team leader, she has the same kind of approach [as the Evangelicals], and that makes it much easier, and I feel validated there. But it has created conflict in the past, where we have been coming from different perspectives, from within the team'.

I pursued this further and spoke to Gayle in relation to the proposed new early discharge program.

Kierry: 'So, this idea that community nurses need to define their role ... What sorts of things do you think would help to achieve that?'

Gayle: 'I think that it has to be written down, and I also think that we can't take on every dog-fight that comes along, you know, we just can't. And all the time, requests are coming in for us to do all this stuff, and we need for us as a team to sit down and say what we're going to do and what we're
not going to do, because we can't cover everything. Though I think in community nurse training they also have to fit into the system, as it is in that particular area, and so they have to [be] broadly skilled, and they also have to have the confidence to move into a team, and adapt to that teams adaptations. Nurses are multi-skilled, they can pick up almost anything. You know, physiotherapy, occupational therapy, podiatry, counselling, hands-on clinical stuff ... They can do the lot. And we're going to have to say "No, we don't do that. We will get the person who does that to do it". And I think possibly once we have the opportunity to work in a multi-disciplinary team, then what we do will be narrowed down, and we'll do it better. But at the moment, because we're fragmented, because of our geographical fragmentation, we tend to not have that multi-disciplinary approach [and] try and take on the whole problem [ourselves].

Politics of resistance

A realist analysis also requires an examination of the way power is exerted and resisted. There were two major areas that were involved: the areas of policy and structure. Nurses resisted both through non-compliance and secrecy.

'Dropping into the "in-between" space and being unable to comply with service
demands was something that Rachel spoke about in depth, and this was a measure of her deep sense of frustration at being on the margin. I will not reiterate the conversation here, but point to it as an example of non-compliance as resistance. There was a definite aged care focus that was central to the funding base and therefore to the work of rural community nurses. Nurses resisted a preoccupation with this group and clearly identified and worked with other groups in the community. This is exemplified in my discussion with Marshia. She stated:

'Well, I think that the old people are well looked after here in Karaville. Because we have the golden years [group], walking for pleasure, aqua aerobics, CWS, GPs, senior citizens, church groups, community transport, meals on wheels, community options, home care.'

In another conversation, I am talking with Lee concerning personal philosophy and its evolution. Again, non-compliance
is a feature of resistance; however so too is secrecy.

Lee: ' [It developed] over a lifetime. My model of community is the client. I've had problems with the service ... with accountability and time sheets and I say "Look, I'm No. 1 accountable to my community ... Because that's my job. No. 2, I'm accountable to me ... because it's my job, and No. 3, I'm accountable to the service that pays me. But you guys get third bite of the apple ... The first two bites are myself and the community". And they have trouble with that. Most services like you to be accountable to them, first and primarily ... Whereas I have a very different view ... I think that if I feel confident within my community, then I'm doing a good job, and the people I can see around ... have gained from what I have done ... Then that's my accountability sewn up'.

Kierrynn: 'And does that cause you a lot of problems ?'
Lee: 'Not if I put my green form in every month and don't tell them'.

Kierrynn: 'Would it be fair to say that there is a certain policy that's dictated within the bureaucracy, about the priorities?'
Lee: 'Yes'

Kierrynn: 'Which was, you were saying, that men's health was down the bottom and it wasn't a priority. Therefore it seems to me that you're saying that there is either an articulated
message, overtly articulated or covertly, that there are some priorities and that's where your attention should go'.

Lee: 'Yes'.

Kierrynn: 'And that's determined by policies?'

Lee: 'Yes. I think the two words you used there that are very pertinent are 'overt' and 'covert'. Overtly we follow all the priorities and statistics and all the rest of it. But covertly ... I'm a lone practitioner in an isolated area, and I do what I want. You know that's basically the bottom line. I don't know how the others go but I don't tell them what I do. In a lot of ways, if you're one of the new generation of nurses ... that are coming out, then you really have to lie a lot about what you do to maintain the status quo, because our funding bodies are so varied. We have HACC funding, we have NSW Government funding. There[are] people that are funded through all sorts of pockets of money that have been left-overs and add-ons ... from around the place, that you're pulled from pillar to post. I mean, even the Area Health Service's hands are tied to a degree. They say eighty percent HACC funding, therefore you do eighty percent HACC work. And HACC is frail aged and chronically ill.

With a five or ten percent component outside of that. Now, if that's not your client group statistically, you can be cutting your own throat by not showing that that's what you do. I've found that over the three and a half years that management is tickled pink if they get what they want. If they don't get what they want, then they're very unhappy, and they make your life very difficult.
So, if you continue to give them what they want, and do what you want to do, then they, although they know you're not doing what you're supposed to be doing ... they're happy, because on a piece of blue paper every month it says that you are. But in reality, you're not, but they don't care. So long as you put on that blue paper that you are, then there is no problem'.

Dealing with the stress, frustration and tension, Mikalia spoke about creating times to be frivolous, which could be viewed as a form of resistance.

Mikalia: 'We had the Melbourne Cup day, and everyone was frivolous ... but there's not been a lot of opportunity just to do that prior to this. Because there's no National holiday, there's no OK day, even if you say "Let's take the afternoon off and have a picnic together". It happens, but it doesn't happen with that frivolity'.

Kierryn: There's no real excuse?

Mikalia: Frivolity, yes, so the Melbourne Cup Day was a great excuse. [Then] we move to a Christmas party with the staff, and we'll move then on to Christmas, and I wonder [if] they see this vision that "O, God, this year's behind us, we have survived this!"

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Summary

The worklife of rural community nurses was framed by spatialisation. They clearly differentiated between hospital practice and community practice, both in the home and in the larger community. They identified diversity or discontinuity within and between the service sites and the communities serviced by those sites. Multiple roles, individuality, difference and diversity and the tension that was created also featured in their conversations. Accountability, responsibility, flexibility, problem solving and decision making were features of their practice. Responses to historical, present and future transformations, in both the structure and policies of the health service together with myths created by the policy rhetoric, were also identified. The nature of the relationships with individual clients and the larger community, the problematic
nature of accessing educational needs and
an appropriate career structure, together
with resistances to structure and policy,
were also a feature of the conversations.

Rural community nurses and the rhetorical spaces of PHC

*Rural nurses themselves often take their complex
practice for granted ... nurses ... in rural ...
communities face a number of unique issues that
stem from the geographical, social and cultural
character [of the community] * (MacLeod Browne

Rural nursing practice as described by the nurse participants and reinforced by
the clients in this study, reflects that described by rural nursing research in
Australia (Kreger 1991a, b; Thorton 1992a, b; Hegney 1996, 1997; Keyzer 1998).

Furthermore Macleod et al. (1998) have identified
similar features of rural community nursing practice in
Canada.

I was, however, dismayed to find a
continual confounding of rural hospital
and community practice (Keyzer 1998;
NSW Health Department 1998a), but
also heartened to find a balanced approach
by those who recognised the differences
Keyzer (1998) has called for a research-based exploration of rural nursing, with the aim of more clearly defining the nature of nursing care in this context. Clearly, however, when rural nursing practice is discussed, hospital practice is easily identified but community practice has a type of taken-for-grantedness around it.

Furthermore, while there are discussions in the literature concerning individual- vs population- focussed programs in PHC, very little is discussed in relation to the spatialisation of the concepts. Sheils and Lindsey (1998:24) have raised the issue, and differentiate between 'community as context and/or community as resource'. They contended that the 'community as context' perspective have been strongly influenced by structural geography, and implied that the 'community as resource' perspective has arisen from the reconceptualisation of health within the Ottawa Charter (Sheils & Lindsey 1998:24).

It is unfortunate that 'community as resource' has a tendency to conjure up images of economic rationalism and the 'mining' of the community. Sheils and Lindsay (1998), however, disagree and view this perspective as enhancing the integrative aspects of both human and service resources. Furthermore they identify community as client and community as a relational experience (Sheils & Lindsey 1998).

What I would reiterate here is that space is relational.

Liaschenko (1994:23) stated that '[t]he social construction of space structures what we see and therefore what we confront'.
Nurses in the present research identified diversity and difference within the home space, service contexts, and the nature of the communities they work in. The features of advanced practice are clearly identified, such as autonomy, advanced decision making, accountability, and responsibility. However, they have clearly identified that much of the continuity of care practices were not 'new', but something that they had always carried out.

Nurse participants did not relate stories concerning the carrying out of sophisticated diagnostic screening such as radiology. I believe that this was related to their geographical location being sufficiently close to such services. They did, however, clearly differentiate these aspects of their practice from rural hospital nursing. While they were satisfied with the educational up-dating
sessions they were able to attend, easy access to tertiary education was seen as problematic. Those who experienced the benefit of such programmes clearly indicated their value and the contribution that knowledge derived from them had made to their practice of PHC. Interestingly, it was further education in PHC rather than rural nursing that was seen to be deficient.

The following conversation draws heavily on Desley Hegney's ground breaking Foucauldian discourse analysis of rural nursing which was submitted in 1996 just after I had completed my own fieldwork. It has been the only work on rural nursing which I could locate that was in a similar paradigm to the present study.

In a later work, which discussed the practice of rural nursing Hegney (1997) viewed it as example of advanced practice.
Nurse participants in the present study spoke about community rural nursing as a generalist role.

MacLeod et al. (1998:75) contended that rural nurses were in need of 'generalist knowledge' (however, they preferred the term 'multispecialist knowledge'), by way of acknowledging their diversity of practice.

On the other hand, Hegney (1997) argued coherently for the title 'advanced nursing practice'.

Nurses in the present research clearly saw a need for a satisfactory career pathway linked to advanced educational requirements.

Recent moves in NSW to legally and professionally establish the role of the nurse practitioner (NSW Health Department 1998b) will enable rural community nurses in NSW to take up this title once they have been accredited. Moreover, NSW has just established two advanced nursing practice postgraduate programs. One is in rural nursing and the other in remote area nursing (NSW Health Department 1998b).

Nurses in this study had a 'fill the gap' approach in terms of continuity of care and also in health promotion and
education. This was balanced, however, by a clear understanding of the role these two concepts played in PHC.

Given the constant change, and discourses of seamless service and early discharge combined with the myths of intersectorial support and multidisciplinary teams, nurse participants responded with resistant activities of non-compliance, dropping out and secrecy, with collegiality contributing to resilience. Evaluative discourses such as CHASP acted to discipline nurses, creating lack of recognition and lack of legitimisation of their advanced practice role.

Hegney (1996) referred to the problem of deskillling in relation to rural hospital nurses, indicating that although education was available, most of the funding was directed to the medical profession.

Furthermore the following findings from Hegney's (1996) research are well supported by the Rural and Remote Nursing Summit Report (NSW Health Department 1998b).
For example, access to education and training was limited and 'ad hoc' (Hegney 1996:260) with inconsistencies and lack of government policy in the various states, a lack of appropriately designed courses, and lack of relief staff contributed to the problem (Hegney 1996; NSW Health Department 1998a,b). Hegney (1996:268) also stated that 'sixty percent of nurses preferred to have education and training delivered on-site'.

While Hegney (1996) and others (NSW Health Department 1998a,b) have identified local shortages of nurses in rural areas, this was not, and never has been, the case in the health service area where this research was conducted.

Even so, at least one participant believed that the possible shedding of jobs was affecting people's behaviour. This was due to the fact that downsizing of the nursing workforce was very new phenomenon for a regional area where there was extensive competition for employment in all nursing fields.

Furthermore, in her research, Hegney (1996) found rural community nurses felt prepared for their role; however, rural midwives experienced deskilling.
The importance of the above finding is recognised in two initiatives of the NSW Midwives Association, which saw the establishment of 'Refresher and Skill Update Programs' and a 'Midwifery Emergencies Survival Package for Non-midwives' (NSW Health Department 1998b).

Moreover other findings referred to the disciplinary power of medicine; the often inappropriate level of education for rural nurses; the control of knowledge in academic hands; a lack of legislative change; the lack of career structure; the disciplinary power of the state in terms of discourses of multiskilling in policy; the fact that current practice was seen as 'normal' due to its so-called cost effectiveness; and the lack of legislative support for some aspects of rural nurses practice (Hegney 1996:282). Tactics of control included 'lack of funding' (Hegney 1996:282), the supremacy of the medical model, and multiskilling presented as 'new', and a non-legitimated part of the extended role.

Resistances and the discursive formation of rural community nursing
Writing on power and knowledge production, Foucault, explored the notion of political resistance. For Foucault, resistance was an inherent part of power relations, and neither could exist without the other (Fillingham 1993). Power is everywhere. It is localised and patterned within the social body and institutions, such as the family and the state.

However, power relations are not static and change in accordance with conditions of resistance. Therefore, according to Foucault we all have some degree of power and therefore some degree of resistance.
Hegney (1996) linked the practice of rural community nursing with spatio-temporal notions when she contended that:

*Regardless of their level of experience, rural nurses are required to make autonomous decisions as they have reduced opportunities for consultation with nursing colleagues and other support staff. The level of independent decision making increases proportionally to the isolation of the nurse* (Hegney 1996:196).

In reference to the difference of rural nursing practice, Hegney suggested that the community in which the rural nurse practises is different in that the 'scope of nursing practice reflects the diversity of rural settlement' (1996:197). She goes on to say, however, that '[t]he majority of authors who promote the uniqueness of rural nursing practice do not provide a clear picture of what aspects of rural nursing practice are unique or different' (Hegney 1996:197). She goes on to identify 'The "Womb to Tomb Care" ... the Diversity of Role ... Education and Training requirements ... [and the ] [r]ecognition of speciality Role[s]' which reflected a different context and scope of practice to that of metropolitan nurses (Hegney 1996:198,199).

Differentiating rural hospital and community nurses Hegney's (1996) research identified that hospital nurses were satisfied with their role and did not indicate a need to move away from the medical model and adopt a primary health care approach. However, she stated '[r]ural community nurses also know their place, but are more likely than hospital nurses to deliver health services which have a primary health care focus' (Hegney 1996:202). Further to this, hospital nurses who changed to community required an orientation to their new role in the promotion of health rather than illness. In terms of scope of practice, Hegney also suggested that it is dependent on the type of support services available, the 'smaller the community, the more likely the nurse to provide an illness -orientated service' (1996:207).
Hegney also suggested that there was control of rural community and mental health nurses by rural hospital nurses insofar as rural community nurses did not feel valued and the acute context was considered more important. In a discourse analysis of policy documents Hegney (1996) identified the importance these documents placed on the delivery of primary health care in rural areas. Specifically emphasised was, the importance of community involvement, responsive to community needs, and mechanisms for local residents' input into services.

However, still in the realms of rhetoric, a wellness rhetoric health service was still dominated by the medical model and illness services.

Thornton (1992a) cited his earlier research (1989) concerning the members of the community and their perceptions of the role of rural nurses in the community. Rural nurses were considered to be well known, good communicators, and very responsible community members; they believed in a good level of basic care, and were hard working, and were a 'trusted and respected ally of town doctor' (1992a:123); they were more caring than their city equivalents, always had time, made good decisions in hard situations, and made 'a good cuppa' (1992b:67).

While Thornton (1992b) suggested that education would provide some of the above attributes, others he considered were personality traits. Further to this, he stated that rural nurses needed to be flexible and be independent socially.

The difficulty with Thornton's work was that at times he did not differentiate between rural community nursing and rural hospital nursing (1992a); and rural practice and rural nursing practice (Thornton 1992b).
Thorton (1992b) drew attention to the establishment of two bureaucratic structures: Rural Health Policy Units and the Rural Health Education Training and Research Network. He further stated that it continued to be difficult to determine the complex nature of this type of nursing. He illustrated this by a very large quote from his earlier (1989) research and at the end of it, stressed the diversity of the nurse’s role and the degree to which nurses are pushed in their professional roles, including 'assuming some of functions of the medical practitioners and other health professionals' (1992b:68).

Policy and structural transformations
'The health system is in a state of continuous change and development' (NSW Department of Health (1998a:6). The influence of state government change on health policy and the organisation of services is of some relevance in a discussion of these issues. In 1995, just after commencement of this research the Labor government came to power in NSW, replacing the previous Liberal/National Party government, which had been in government for many years. There were widespread changes, with a major reorganisation of the structure of the health service, which moved from districts to area health services.

Middle management was disbanded and new positions were created, for example, the Manager of Extended and Primary Care was established, and a new health agenda was set. The major decentralised group, the Indigenous people of the area, were targeted, a 'whole of government' approach contextualised the thrust of the policy and a new document on Community Health was published, the major theme of which was equity of access.

Nursing transformations
A nursing summit was called for February 19-20, 1998, in Northern NSW. The background paper for this summit and the final report (NSW Health Department 1998a,b) clearly outlined the issues facing rural and remote area nurses. Strategies and initiatives of Commonwealth and State government
and Area Health Services, together with professional and industrial organisations were clearly identified. The issues covered included the need:

- to recognise professionally rural and remote area nursing as a speciality nursing practice area
- to support this recognition with appropriate professional, clinical and educational support
- to recognise the depth and breadth of the role of the rural and remote area nurse
- for rural and remote area nurses, employers and community members to be educated concerning the legislative constraints on the scope of nurses' practice
- the problems of geographical isolation and the link between geographical isolation and recruitment and retention
- for strong support for collaborative practice
- for postgraduate and continuing education
- for state health and nursing partnerships to improve the situation.

The background paper also outlined new initiatives in NSW Health, identifying what had happened in relation to the recommendations of the Nursing Recruitment and Retention Task Force Report (NSW Health Department 1996). These initiatives had focussed on involving area health services in the problems, especially as related to the specific functioning of each service; involving professional nursing bodies with issues related to staff development, staff relationships and discrimination and harassment problems; the development of human resource policies and nursing workloads for individual area health services; guidelines concerning partnerships with universities; award negotiations with industrial bodies; the encouragement of Indigenous people and NESP into rural/remote nursing; an improvement in staff counselling services; supporting the development of professional networks; giving priority to safety issues for nursing staff; equity
policy on staff leave; a review of flexible work practices; support of innovative nursing strategies; and incentives to increase recruitment and retention of nursing staff (NSW Health Department 1998a).

Further the paper briefly mentioned the progress of the Framework for the Nurse Practitioner Services in NSW, a feasibility study of a proposed locum relief pool for rural and remote nurses, the establishment of a Professorial Chair in Rural and Remote Nursing, funding provision for education programs, area health service initiatives in education and training partnerships, professional and industrial nursing organisation initiatives in education, research and the establishment of competency standards for practice, and Federal budget initiatives.

Rural health policy and rural health conferences

The National Rural Health Strategy (NRHS) was developed in 1991 and arose out of the Australian Health Ministers' Advisory Council (AHMAC) Rural Health Taskforce deliberations (Humphreys & Murray 1994). Reviews took place between 1992 and 1993, and a major health initiative was released in March, 1994. The goals were underpinned by 'principles of equity, access and social justice' (Humphreys & Murray 1994:26). The implementation of this strategic plan, therefore, took place the year before the commencement of the fieldwork for this research. While four National Rural Health Conferences have provided insightful recommendations aimed at supporting the revision of the NRHS, Gregory and Humphreys (1997:172) reported, however, that 'to date, progress in the implementation of many of these recommendations has been tragically slow'.

Professional organisations

The Rural Doctors' Association of Australia (RDAA), The Association for Australian Rural Nurses (AARA), The Council of Remote Area Nurses of Australia (CRANA) and various other organisations such as the National Rural Health Alliance (NRHA) have all been instrumental in attempting put
forward a cohesive and consistent approach to solving the problems in rural health in Australia. Of particular relevance to this research are the areas of Aboriginal health, aged services, transport, and the widening gap in health status between rural and city people, especially in relation to the level of service delivery. On this point, and arising from the 4th National Rural Health Conference on Health for All by the Year 2000; the NHRA has stated:

> The problems in rural and remote health, and the way to fix them, have been know for years. Instead of ducking the issues and hiding behind artificial arguments about who is responsible, governments and others with responsibilities such as universities and professional organisations should declare 1997-1999 the triennium in which they will rejuvenate country health services (Gregory and Humphreys 1997:171-172).

Watson (1990) called for structural change in the HCS, and for nurses be instrumental in challenging the dominant values in society that continued to perpetuate the present system.

> Further to this, she asked for caring to be considered a core value in the formulation of health policy. And she viewed this lack of caring, as a moral failure (Watson 1990).

Her argument was that women’s work, and therefore nurses work, can only be assessed in relationship to ‘brilliant men’ (1990:62). In an exploration of this world view, Watson (1990) contended that, while some nurses worked hard to dispel this view, and effect change, women remained invisible. This is compounded by some a fear of losing power. Having drawn out the links between nursing and feminism, and the idea that the personal is political,
Watson (1990) further called for a peaceful, nonviolent revolutionary approach.

These ideas of Watson (1990) are echoed, to some extent, in the following section. The next section explores oppositional constructs, and the notion of an emerging resistance postmodernism.

Deconstructive perspective and analysis

Oppositional constructs identify the subordinate and the dominate terms. Grosz (1994) has commented on the value of an oppositional analysis. Moreover, she has linked this analytical strategy to a type of 'postmodern resistance' (Giroux 1990:31) in her statement that:

... risking rethinking global oppositions and macroscopic hierarchies in order to have more optimistic prospects for effecting transformations and realignments of these global relations, and moreover, seeing their capacity to infiltrate microscopic recesses which may appear immune or outside their influence (Grosz 1994:173).

In conversations with the participants it was evident that tension arising from the oppositional constructs were part of their working lives.
Rather than these being fixed positions, there is movement and rest between the two position. This in-between space, however, is filled with tension.

*So, while there is constant tension within and between these constructs, there is also movement and rest. This is continually reflected in the following conversations which highlight the oppositional.*

*One of the oppositional constructs which emerged was skilled/deskilled.*

**Mikalia:** 'Yes. I’m looking at this person having such a generalist base, but, the other thing about community nurses they problem-solve every day of their lives. As I said out there, at that meeting, community nurses already practise all those problem-solving skills that they teach them to do in University, and have to write down. They’ve been doing it. You don’t give a drug you don’t know in the community, because you don’t have somebody else to ask. Unless you go and you look up your MIMS, and you check that because you’re not going to get back to that person until tomorrow. And there’s this problem-solving sort of mentality, and I don’t mean that to demean them, I think its wonderful'.

Another oppositional construct that created tension was see/not seen. I asked:
Kierrynn: 'Can I just follow on your point of community nurses not being visible, because they’re out on the road ... and in peoples homes. Do you think it's always been that way?'.

Elenore: 'Oh, absolutely'.

Kierrynn: 'Do you think it's improved?'

Elenore: 'Well, there used to be Registered Nurses meetings each week, and we used to try and present ourselves there, but we had a different uniform then, and we were in uniform. So that’s another change ... everyday clothes. So we used to attend and people would identify us ... and at one stage we had pale blue, which is the same as the Nurse Aids. And they treated us like Nurse Aids. And there is a class system ... so we asked for a change in uniform, because they were both in pale blue, [but a] different style'.

A third construct concerned the tension between delivery of health promotion programs and continuity of care. This is exemplified in the following discussion, where I ask Gayle to tell me about some of her clients.

Gayle: 'I think where I’m coming from is ... an educational point of view. I see myself as a person who moves into a situation, teaches people how to deal with their health problems and withdraws. [Or] we might have a child who needs catheterising at school. I might go and do Health Promotion in
the workplace, so my clients would be the factory manager and his staff. Immunisation clinics, so I would be immunising babies, and talking to their mothers'.

This tension is exemplified by a fieldnote entry made after some conversations in the tea room about half way into the fieldwork.

Kierrynn: 'Some [nurses] are very cynical, perhaps burnt out. Whereas others are excited and enthusiastic about the new falls prevention program that will run. Management have just identified about five hundred dollars in funds which will allow four groups of twelve to be organised. There is a lot of rhetoric about things related to PHC, but very little money around to run the types of programs that would be appropriate. People are often elated when they find out there are funds available'.

Furthermore, the tension between community/hospital nursing emerged, with the movement between being the early discharge program. This was an elaboration on the previous health promotion/continuity of care opposition.
Gayle: 'You have a hospital nurse ... someone coming from a hospital nurse perspective moving into the community, and they don’t know about primary health care. It’s a completely different field and you’re coming from a completely different perspective. And I don’t think hospital nurses make good community health nurses. They haven’t got the background training, and I think a post-graduate course is absolutely essential'.

Kierrynn: 'So in a way you’re saying that the values and the beliefs are a little bit different?'

Gayle: 'Yes, I guess so ... I think that the nurses in the wards are looking at the physical problems that are presented to them, and that’s what the role of a hospital nurse is. I’m not saying that ... we’re superior in any way, but that’s what you focus on. Though that is decreasing with time ... they do have discharge planning now, which is a big improvement ... And that’s why the patient has been separated from his home, because he’s got something physically wrong with him. But we are looking at the big picture ... the whole patient. We’re looking holistically. So we’re looking at family dynamics ... the home environment, their self-care ability...we’re looking for deficits, and we’re liaising with other community groups to try get those needs met'.

Finding voice and being heard and living in the tension was a theme that was evident in some earlier work that involved research with novice nurse academics.'
1993b). The tension between the oppositions voice/voiceless is filled with fear of the consequences of being heard and speaking too loudly. Elenore begins with a reference to a professional organisation, and then moves to commenting on the actual work situation.

**Kierrynn:** 'Just a couple of points on that, because ... my personal belief is that specialist associations of nurses are really very important in the professional development of ... particular types of nursing groups. Do you think it plays a very large role in directing the development of community nursing?'

**Elenore:** 'Well, this has only been in the last month, so I can’t give you much of an idea. I’ll reserve my judgement on that'.

**Kierrynn:** 'I think it's interesting, because I used to be President of the Neuro Nurses' Association myself ... I [was] wondering if there is a Community Nurses' Association'.

**Elenore:** 'We used to have one ... in the 80’s, we had meetings, but people found it very difficult to go to meetings, and this is a big change ... so many meetings'.

**Kierrynn:** 'Yes. So has it actually been a resurgence and a sort of re-interest in the Association?'

**Elenore:** 'Only because of the direction that nursing is taking now'.
Kierrynn: 'Could, could you just maybe elaborate on that?'

Elenore: 'Yes... Number one, [it] is assumed, and I’ll only say assumed, that there’s lack of consultation'.

Kierrynn: 'With community nurses?'

Elenore: 'Yes. About their future, and about their future directions. It is assumed that the managers are organising all of this without actual ground roots consultation. This is a fear by the staff, and it’s a fear [about] lack of a job. This fear was brought about by the situation in the hospital where people were made redundant. And that fear has come down the line ... to us. Now, some of it may be quite unfounded, but the fear is still there and needs to be addressed. So, I think that that’s one reason why ... It may give them a voice, but they have to be careful that their voice is not overpowering because that will do the opposite of what it is needed to do'.

Another oppositional construct, Knowing/not knowing, was related to education and involved the power of knowledge to control the agenda which depended a little on whose knowledge was seen to be the most powerful in controlling and setting that agenda. I am discussing Elenore’s qualifications with her, and she says:
Elenore: "Yes, a three-months course, and I also included as electives rehabilitation and diabetes education, so I’m a qualified diabetes educator as well'.

Kierrynn: 'Did you find that [the] course helped you consolidate your knowledge?'

Elenore: 'Absolutely. That course is only now being put into practice, basically. When X came here... (she brought us all in to have a talk about what we thought) ... and I said “Well, at this course, this, this, this and this [was included]... it has never been done here”, [she] had the same vision ... direction, and it is now just being done, and that is becoming holistic - looking at everything. Looking at the town, looking at the resources ... and this is another area of my, work here. I’m the resource person. And it came from that course, that we need to know what resources are in the town, to be able to direct our clients to those resources. And if you don’t know the resources, you can’t direct them'.

Kierrynn: 'So, in fact, that course was ahead of its time in a lot of ways'.

Elenore: 'Absolutely. Yes'.

The same issue arose in a conversation with Sally. However she draws out the expectation to know and the lack of incentive to know.

Kierrynn: 'So there’s a lot more money coming through, and a lot more opportunity for these [educative]occasions?'
Sally: 'Yes, there is, but then, on the other hand, there isn’t a lot of opportunity. It’s an expectation that nurses these days have tertiary qualifications, and there is no incentive'.

Kierrynn: 'No incentive from the health service?'

Sally: No, and well, it’s an expectation. They’d like to have the image that all the nurses have tertiary qualifications but there’s no study leave given ... the financial reward is minuscule. Many of the nurses [have] being nursing for twenty years, and they might already have a CNS status, and graduate wages are no different... there’s ... no reward; really. No recognition'.

Marshia also continues the conversation, as I had raised this issue with her. And, as I had been invited by the research group to attend a wound seminar with them, I asked:

'Do you find that you get enough time to update yourself on things ... that there’s enough educational provision? [For example] they had the big wound[care seminar] the other day'.

Marshia: 'It was excellent, yes ... we’re going to have more ... we used to always have updates in schools. For school screenings and school issues. We’re going to start that again'.

Kierrynn: 'Who would usually do that? ... Would it be the school?'
Marshia: 'No, the consultant. ... [is] supposed to do that for the district ... well, she organises it anyway. It's just more or less to really identify any problem that a child may be experiencing so ... Early Intervention'

Kierrynn: 'So [for] those sort of issues [do] you think [you need] some more time and being updated?'

Marshia: 'Well, I go yearly to an Audiology Conference, and that's wonderful, because we liaise with everyone in Australia. So I've got no complaints there. Probably, just at a district level, we need to do a bit more with that and Immunisation, but they're working on that'.

A discussion of the diversity of the work space raised issues concerning the spatial organisation. The oppositional constructs, homogeneity/heterogeneity, emerges in the working life of several of the nurses. The discussion is centred on the difference in various parts of the service.

Kierrynn: 'If you were to compare the two of them, would you find that you have [a] preference [for] ... one more than the other? For example, would you prefer to be in a more diverse situation, or would you prefer to be here where you seem to have ... other backup services available to you?'

Elenore: 'Well, diversity is something that you work with yourself. And it's your choice whether to be diverse or not.'
You can be diverse in an urban area, you can be diverse in a remote area. And you can choose to do many other things within your unit. Certainly they'd be different things in this urban area compared to remote, but I have no preference for either'.

**Kierryyn:** 'So, in other words, you're saying in terms of diversity, there is just as much in the present service given your clientele and the type of projects that you're able to undertake, and diversity is present in both, but they're just different'.

**Elenore:** 'They are different, because the numbers of staffing in the smaller areas restrict how much diversity you can have. Because they've got the blood taking, and they've got the palliative care, and not as much home care. So, I mean, their time would be taken more with those, than ours are. They still do health promotion. But not to the degree ... that we do ... Because of the small number of staffing, you just can't do it'.

The sheer demand on the service in terms of client load, continuity of care, health promotion, individual vs population programs, education up-dating, and paperwork all created inroads into the working day and week. There was tension between the oppositions having time and having no time. Each person dealt with this tension in different ways.
Kierrynn: 'People have said to me as I’ve spoken to them that there’s an increase in paperwork'.

Elenore: 'Yes, absolutely'.

Kierrynn: 'Is that manageable? Are you finding it does get overwhelming at times?'

Elenore: 'It depends on your attitude to it ... If you say, why have we got to do this?... it will inundate you. If you say ... well we’ve got to do this, it’s manageable'.

Kierrynn: 'You organise your time and you prioritise it, and you get it done?

Elenore: 'Absolutely. And that depends on your management of your time during the day. If you don’t manage your time very well you won’t get it done very well. As I said, it’s your attitude to what you have to do'.

*Sally has a different perspective. She is considering the context of an outcomes-driven nursing service and says:

Sally: 'A lot of Hospital work is driven on 'occasions of service' ... and that’s frustrating'.

Kierrynn: 'Yes. In fact it’s difficult to compare doing a dressing that might take 15 minutes compared with setting up some sort of home education programme [in the home]'.

Sally: 'Exactly, that’s right. Where as at home we’re talking about educating them. We’re giving them the power of their care, and that’s the explanation of that process of me looking at them holistically ... is far more time consuming'.
And further on in the conversation she says:

'That's what worries me when there's talk of case mix funding related to community nursing. I would like to investigate that further before that is even considered a possibility'.

Adaptation to the constant restructuring which was a major feature of the health service raised ideas of being flexible or fixed. My conversation with Sally reflects this opposition.

Kierrynn: 'One of the things that I have noticed that people have spoken to me about is that ... as change occurs, and there is restructuring, there seems that there is an increased amount of paperwork to be done'.

Sally: 'It's enormous'.

Kierrynn: 'And this seems to be detracting from one of the other things that they mentioned ... that there is a need to be flexible to respond to situations as they change'.

Sally: Yes, generalist nurses community nurses are very flexible people. We're used to planning a day, and quite often they don't go the way you planned, because we aren't in a controlled hospital environment, we're in a person's home. We're in the community where nothing is stable. Nothing's static and circumstances change all the time, so we're very
flexible. We learn to adapt to those things and [are] good decision makers, and good problem solvers. I think we have to take stock and not keep responding to all the demands and look at why we’re doing it and base it on research, base it on evaluation of the process'.

Cohesion/fragmentation concerning role definition was a feature of my conversation with Elenore. While it had been problematic in the past, one of the benefits of the restructuring had been to clarify roles. This opposition is exemplified in the following exploration of the issue.

Kierrynn: 'If I can just explore that idea a little bit with you, Elenore, Do you find that there is the problem of duplication, and you don’t want to duplicate services? That’s obvious [from what you are saying]. Do you feel though that it tends to fragment your role a little bit?'

Elenore: 'No'

Kierrynn: 'Do you feel that there is a clearly defined role for you, and a clearly defined role for the other service?'

Elenore: 'Yes, [but] that has been more defined recently and that’s why I have no problem with it'.
Kierrynn: 'So, in other words, earlier there may have been a problem?'
Elenore: 'Yes, earlier there was, because there was no definition of what each other did. Now there's a definition of what we do. So that's clear now.'

While this was so for the nurse's role, it was not so for every nurse's relationships with other members of the health team, as Gayle indicated when she responded briefly to our exploration of the issue. Fragmentation produced by spatiation supported the myth of intersectorial support, and traced the visibility vs invisibility oppositional tension.

Kierrynn: 'I was just interested in [you] working with other members of the team, and what that was like, and we talked about an intersectorial support. It seems that perhaps one of the goals that you could have in the service [would be] a better facility where you could all be accommodated. Do you think it's the fact that you are fragmented, and you're in different sections that prevent you from coming together?'
Gayle: 'Yes'.
This is confirmed by Anne, who stated:

"Yes, I mean, I don’t think the Health Promotion Officer has ever been to Sunville, and that’s nothing against him, he’s a very busy man, but that’s an example that the service doesn’t get out to ... the country areas'.

While medical dominance is a theme that accounts for the tension between a comprehensive and selective implementation of primary health care, nurses' own attitudes are also viewed as problematic. It also raises the visible/invisible, heard/not heard oppositional tension, as well as the injustices that befall nurses. The following is an extract from that conversation with Gayle which began as frustration with inadequate equipment and priorities and then moved on to explore the context of primary health care.
Kierrynn: 'So do you think that ... community nursing particularly in the context of primary health care is a bit like the poor relation?'

Gayle: 'Yes, I think that community nurses are lowly regarded in the system. [An example is] what has happened recently to a colleague who will probably be sacked for neglecting to report on some patients. And yet, there was a doctor just recently who infected 5 patients with the AIDs virus, [and] all that happened to him was that he was sent to a class to teach him about infection control. In this building, just recently, there's a Doctor coming into the place ... and furniture was bought for him to sit on, and we're still needing equipment to use on patients'.

Kierrynn: 'Nurses are regarded [as] the poor relation. Not just in terms of facilities that are provided, but do you think that perhaps some members of the health team don't believe that Nurses have a role in primary health care. That they are seen as, like, the ward nurse transferred into the community, and they're there to do the dressings and the ulcers?'.

Gayle: 'Yes, I think that's what they think. And until nurses can take pride in themselves and take responsibility for having a high standard, we will continue to be [treated that way]. There are a lot of Nurses who [are] still caught up in that Florence Nightingale way of looking at things'.

In the following conversation, Jay also identifies the choices nurses make to
see/ or not see and anticipate problems.

Jay has been discussing a client's relative who was responsible for the client's care and who was stressed. Jay felt she was a bomb waiting to explode. The conversation begins:

'I could have gone in there, Kierrynn, [and] I could have handled it in a less positive way. I could have gone in there and thought "Well, all I have to do is make sure this thing is getting changed as often as it needs to be. This women is standing here and she will learn how to do it if I just teach her once". I could have taught her and said "Right, I will come back on Monday and you can have a go". And I would have gone back today and she would have done it and I would have said "Well, right, see you later", and there would have been all that dynamic stuff which is for my money a kind of bomb waiting to go off. She would have sort of carried on, and maybe that's going to happen anyway, I don't know. I am just saying that I perceive that potential problem and that was also part of my work'.

Kierrynn: 'In other words, that she could get so sick and tired of it and blow up and then you're left with the situation'.

Jay: 'He would be in the hospital and then a nursing home'.
While it is admitted that walking into anyone's home places you at risk, the tension between safety and risk in other areas away from the centre is clear in the story that Rachel told. While the story is fairly long, I have included it all as it clearly portrays the oppositional construct.

Kierrynn: 'You were saying that one of the really good things about your service down here is that you actually have the mobile phone'.

Rachel: 'We haven't always had a mobile phone. That came about because ... I ended up in a situation where I had a gun pointed at me, and though it wasn't threatening, I wasn't scared, but it was a gun. It wasn't loaded. When I first came here there were two community nurses, and once we left in the morning there was no way anybody knew where we were, and how we were to be contacted, and it was actually my mother that said to me one day "Aren't you frightened?" and I said "Frightened of what?" And she said "Aren't you frightened, what if you don't come back, does somebody go looking for you?" And that of course started to make me think'.

Rachel related a story behind the provision of phones and pagers which ironically was
really about the oppositional tension of control/non-control of nurses' working life in the context of a crisis. Rachel, however, was a great story teller and this particular incident was related with a twinkle in the eye and very 'tongue in cheek'.

'So I raised the question with the other community nurse, and she didn't seem to be too worried. All her answer was "Well, I've been here for ten years, and nothing's happened to me". But then, she didn't go far afield, in the manner that I tend to find myself. Which made me start to think, and we raised the question again, and of course, money is always thrown up at you in the health system. Anyway, we came to an agreement with the Director of Nursing that they would give us two pagers. In between the time when she said that she'd get us two pagers, and they actually arrived, an incident happened where Dr ... had been to a house in Lightville, and he needed oxygen urgently. A women was dying in that situation, and they couldn't find a community nurse. The hospital was busy, there had been a car accident or something at the same time, so nobody from the hospital could go, (it was when we were under the hospital structure). So the Director of Nursing hooked one of the maintenance men out of his whatever he was doing. They grabbed an oxygen cylinder, they drove down to Lightville, they're crossing the bridge at Lightville and here I was, I
even had my legs sitting up on the dashboard, the only time I'd ever pulled up on the side of the riverbank, I was so hot. And they just pulled up beside me. "What are you doing?" [they asked] ... I said "I'm having lunch, what does it look like I'm doing". Anyway, the crisis was dealt with. Then the pagers appeared real quick. We had pagers for a couple of years, only one pager ever eventuated, and I used to wear it. The other nurse wasn't ever keen on wearing it. So I wore the pager for a few years, didn't really ever work effectively, because they never knew if I got the message or not.

Then this incident [occurred where] I was asked to go and visit this eccentric man on [his] property out the back of X. I'd built up contacts with the ambulance man at Zaraville, and I was leaving ... I went there and I said "If you haven't heard from me within an hour, this is where I'm going", and I drew him a map. "I want you to come looking for me". Told him the circumstances of why I was going there. He said "Yes rightio, I'll do it". So I went out to this place, anyway ... [the man] was quite an eccentric. Anyway, the incident with the gun occurred. It wasn't loaded, I wasn't frightened at all. But as I was driving away from the place, it then occurred to me that, yes, what if the gun had been loaded? What if this, what if that? And I thought "Oh look, I need to raise this", but I didn't know who to raise it with. The other community nurse wasn't much interested in anything, really. I came back and it was a little while later after the incident ... we used to have meetings with the Director of Nursing, and the big boss person used to come down from Yarraville, and I was in one of these
meetings this day, and ... I used it as an example for some story that I was trying to relate and all the antennas went up, and I thought I'd done the wrong thing and said the wrong thing. Anyway, during this same meeting, I had to go out and photostat something, and while I was at the photostat machine someone else came along and [made a comment] and I said "Yeah, well, give me a shoe phone and I could deal with all this". Anyway, I went back into this meeting, and one of the Managers moved straight away that we get not "shoe phones", because they'd obviously heard what I'd said. "We won't be getting you 'shoe phones', but we will be getting you car phones", and that's how the car phones eventuated, and they arrived very quickly, and they were installed. So yes, they are an asset, and yes, it is a big relief. I mean, we've had them for a couple of years because of the rural isolation ... It makes life a lot easier [because] you can be at a house without a phone, or, just things like if you need to ring an ambulance, if you need to ring the hospital'.

The historical transformations in the shape of the service and the tensions between formulating the most integrated and least fragmented service is exemplified in the following conversation with Makalia, especially about the structure at Yarraville, the centre for service provision.
Kierrynn: 'Now it seems to me, up here, in Yarraville, that you have discrete services like palliative care team, early childhood and the school nurses'.

Mikalia: 'We do. Unfortunately'.

Kierrynn: 'Now how does that sit with you? Does that feel comfortable? You said "Unfortunately so"'.

Mikalia: 'Well, yes. I think this happened historically years ago. And in a community health service ... if you were at Holliville, or if you were at X or Y, they’re all in together. But we’ve got big. There was a lot of preciousness. I think there was too many positions, probably, and people didn’t quite know where to sit. So they ... separated. The community nurses used to do all the schools and everything. And I think there was empire building ... somewhere. I’m not quite sure what happened. But everybody got sort of separated off. Now, when I came here there was early childhood staff and the community nurses as well [but not] school nurses. But when we’ve split this time, early childhood has gone towards the child and family, which sits much better with them'.

Kierrynn: 'I could probably say that the ideal, for you, would be to be lot more integrated'.

Mikalia: 'I think at least the ACAT team, which is now still connected to Yarraville, but it still comes under primary health care, I think that needs to come into us. I think it’s a good idea, because we’re talking about 200 staff. So in actual fact, child and family sits fairly well with early childhood and school nursing. I mean, some of the staff cross over and go and work for them, and I think that’s a nice little
healthy swap. And so the skills are kept up when someone's off sick, or [when] someone's away on holidays. However, I think the way it's been split up is healthy. [We've] got an adult team which is about adult [care].

The tension created by the oppositions stability/instability with restructuring is evident in Mikalia's conversation. The past changes are tracked and then the looming new change to early discharge or hospital in the home is discussed.

'If we could stay stable ... it's our instability I see as our handicap. If we could stay stable for another two years, we will go way ahead. But we're having a new re-structure. So, it would be hoped that there's not too many people change positions, because we've all come along with this philosophy, and certainly been, and certainly the primary health care have certainly had a lot of training and a lot of input from our Director about the seamless service, continuity of care. I mean, we're all saying it, but he actually translates it into action, and when we get a bit off track, he heads us back on. So we've actually enveloped that, and we've been able to pass that down, through our papers we've written and any service development things we've done. I see change, I see the re-structure as being able to make or break our vision'.
Kierrynn: 'With the restructuring of the service, and [if] the hospital in the home comes out of the [this] department, [what will happen]?'

Mikalai: 'We [are] working with the DON. We’re building bridges ... we don’t all smoothly flow together at some of the smaller hospitals, but certainly here we’re building bridges, and [the managers] and I are tending to come from ... the nursing-type focus, or primary health care focus. I see that if one of us changed, there may not be that same vision for the community nurses. I’m not just saying the nurses - I’m meaning our whole service'.

However, the tensions became too much and the whole new tentative change appeared to be put on hold as one of the group became frustrated by the process which had implications for the service the clients received. Mikali says:

'We’ve changed foot on the early discharge program, let the hospital take it over. We either keep bandying it about until we all decide what we’re going to do, or we just let them do it, and we’ll back them. We’ll get on and do another project. I guess that’s where we have to actually step back and say “Who are we really talking about?” “Are we talking about our service, or are we talking about giving the clients a service?"
Kierrynn: 'If I could just explore that a little bit. What motivated you take that stance? Was it the thought that there was a restructuring that might happen?'

Mikalia: 'No, just the fact that it’s been on the table long enough'.

Kierrynn: 'And it was going nowhere?'

Mikalia: 'Well, it was going places slowly. We’ll sort it out later on. Otherwise, we can’t move on to anything else'.

Kierrynn: 'Do you suspect that you might end up with it in the end? I mean, do you suspect that it will get too hard [for the hospital service]?'

Mikalia: 'Basically, I think it's an easier concept for a community-based person, ... and the hospital would have a totally different idea, I would say. I think it is much easier for a community-based person, it’s cheaper, easier, and with not much philosophy change, for a community-based person to give any kind of service. I think you can make a patient dependent. And there’s a long track, and it's a [takes a certain] philosophy to make a person independent'.

Kierrynn: 'Can I ask a little bit more [concerning] the things I suspect will happen when those who are not used to acting to empower people, implement an early discharge program? Now, the carers in the home will take over a lot of the responsibility, in much the same way as what has happened in mental health with the Richmond [plan].'

Mikalia: 'Well, say we’ve got a [woman] that’s come out with the baby. The husband might take over a lot of the things, I suspect, depending on the personality of the wife. The nurse
could still make the patients dependent on them. And the patient could stay a patient, instead of a person who's had a baby [and gone] home to their environment. And I think that’s my anxiety, my concern, even though that’s not what the people who have set up the program have envisaged.

*Mikalia* further differentiates community nursing and hospital based nursing and the dependence/independence oppositional tension is articulated.

*Mikalia*: 'Their philosophical way of delivering care, is already there. They’re already walking into a room, checking if there’s any mats in the room. They’re already talking to people about their diet. The weather’s hot, their talking to them about their fluid levels. They’re checking, they’re looking to see what tablets did you get from doctor. To actually talk people through health problems they’re doing ... health promotion. But a hospital-based nurse doesn’t. Because ... they’ve got dependent, acute clients that they need to have these extremely high skills [for, but it's] a dependency model. They’re looking after clients that are dependent, and well they should. However, the community nurse is actually empowering people to take more control over their life. To change their whole status for down the track'.
The question of medical dominance and the oppositional tension between an allopathic vs a complementary medicine approach is exemplified in the following conversation with Sonia. It could also be called a tension between selective and comprehensive PHC. In exploring this, I say:

'You mentioned that community nursing is really where you’d like to be, and you’d like to see things move where there’s more balance between clinical and health promotion, and ... because you like being in people’s homes. I mean, what is it about community nursing that you think that you were attracted to, apart from an obvious commitment to health education and health promotion, and community development. Is there something about the nature of community nursing that makes it different to say working in an intensive care unit?'

Sonia: 'Well, it’s just the holistic aspect of being in somebody’s home, seeing how they live, what they eat. Just everything about the client you can pick up that can help in their homes, and ... For me, nursing in a hospital is very hard. I put a lot of emphasis on diet, and environment as a healing thing, and to me, hospitals aren’t conducive at all to that. So it is totally different'.
Kierrynn: 'So community nursing in a way tends to reflect some personal beliefs that you have?'

Sonia: 'That's right. I think [diet's] an important aspect of healing. I think it's very underrated by the medical system. So [while] I am in their homes, I suppose I exert a bit of influence as far as their diet [is concerned]. I think one can be a little bit more natural at the home. Therefore that's more conducive to people listening, as far as education goes'.

This is further explored in a conversation with Lee. We are discussing the tension created by being informed through education and the position the service takes. This notion could be reframed as the oppositional construct, nurses' knowledge/policy rhetoric.

Kierrynn: 'How well do you think the ideology that you've come to understand about community health [through] the program that you did, fits with the ideology of the present situation that people are working in? Is there a bit of tension there?'

Lee: 'Yes, lots'.

Kierrynn: 'Can you identify the sorts of areas where the tension sits?'

Lee: 'The main areas are your overlaps. You've got ... the model under which we work is a community-based wellness model ... Yet it's dominated by a medical model driven by economics
... and New South Wales/Federal Government protocols and priority listings. As an example, I was doing some men's health and was at one stage was told that I would basically be sacked if I continued, because ... men's health was not even on a priority listing, yet it was proven that there was a huge issue there ... And, I was skilled in that area, and had done some training, but was not allowed to do that. Now, those sorts of things I found fairly frustrating, I find that sort of medical model of community health, pretty hard'.

Kierrynn: 'So there's a level of subservience?'

Lee: 'The covertness, and overtly there's a lot of lip services given to the Ottawa Charter and health promotion. People still think that health promotion and health education are the same thing. And that taking someone's blood pressure is health promotion. Or immunising children is health promotion. Which they are, in a very, very narrow sense. But in the broader sense of health promotion, it's looking at holism and people within communities and setting up networks and driving forces behind communities.

I find that they don't like change, and NSW Health Department priorities generally have not changed since Adam and Eve were running around. It's still cardiovascular ... You know, cerebral vascular and those types of issues that have never changed'.

Kierrynn: 'So, could I say that one of the frustrations around doing your job here is that the needs of the community are quite different to the sorts of priorities that the Health Department has?'
Lee: 'That's true, and it's not. The needs of the community very often fall within those things ... But it depends on how you stretch the truth. I mean, cardiovascular to me can be counselling somebody. Because, if I counsel somebody and discuss their issues and perhaps fix them up with a better lifestyle and discuss alternate therapies ... then what I may be doing is preventing that person having a stroke or a heart attack in 10 years' time. To me, I'm working within the Health Department priorities, but I don't think they would see it that way. They would see that cardiovascular health promotion for community nurses, equals blood pressure screening once a year. That would be their concept. My concept would be totally different to that'.

Kierryynn: 'So, in other words, they're working on an outcomes [model]'.

Lee: 'Medical model'.

Kierryynn: 'A medical model [in] that the blood pressure is being controlled. Whereas your approach is much more holistic, looking at the social factors, environmental factors that might be operating'.

Lee: 'Exactly. It can be fairly medical. I have a real suspicion of our Western-style medicine ... which [is] just fill people with pills and they're going to be OK. I really don't go along with that philosophy. My philosophy is you take control of your own needs and wants and then, if you really need to add ... chemicals, then that's OK. But you really try everything else first. Not, "Alright, I've got this huge weight problem, I've got this huge blood pressure problem, I'll go to
my doctor and give all the power to my doctor and let him run my life ... for the next 20 years". So I look from the framework of community empowerment'.

This theme is continued by Sally, who also draws out the underlying principles of social justice, equity and advocacy.

Sally: 'No, I actually feel on my own when it comes to those issues. I'm all enthused, I go to do my degree and I'm doing issues relat[ed] to social justice and looking at social planning in the Yarraville area and always incorporating looking at ethics ... We're evolving, and becoming more autonomous, and recognised as professionals, and it will take time for those that have worked in the system of being rather subservient in the medical model ... But in time, others will think on similar lines to me, and think, when they see somebody, they won't just look at why they're not getting a treatment, but looking at how the community can be more responsive to their needs. Just making sure that they've all got access to services, and that the lower socio-economic groups aren't disadvantaged'.

Summary
A deconstruction of the nurse participants' conversations revealed multiple interwoven tensions within the oppositional constructs skilled/deskilled, seen/not seen, health promotion/continuity of care, voice/voiceless, heard/not heard, expectation to know/lack of incentive to know, homogeneity/heterogeneity, time/no time, fixed/flexible,
cohesion/fragmentation, selective/comprehensive PHC, safety/risk,
control/non-control, stability/instability, powerful/powerless,
allopathy/complementary medicine.

Therefore, it was the negative aspect of the above oppositional constructs which clearly defined the marginalised positions of the nurses in this study. In this study the negative aspects are deskilled, not seen, exclusive focus on continuity of care, voicelessness, not heard, lack of incentive to know, homogeneity, no time, fixed, virtual cohesion, selective PHC, virtual safety, non-control, powerless, and an allopathic medical emphasis in nursing.

I have utilised the term 'virtual' in cases where the assumption of the reality of a construct, by the health service, creates the negative aspect. For example, while safety cannot be absolutely guaranteed, and a certain amount of risk is inherent in life, assumptions of safety can be extremely risky. The example I have just provided also leads onto the notion discussed in Chapter three. This is the notion of the inter-relationship of the negative and positive aspects, the movement between and the degree to which both can be occupied simultaneously.
In other words, it is difficult to imagine safety without risk, or risk without safety. The two terms are dependent on each other.

The rhetorical and paradoxical space of the new subject

The policy rhetoric of PHC created a complexity of tensions for these nurses as they attempted to implement the principles as espoused by those in management. It was evident that the tension created by the oppositions also created movement between the two. Arguably, this movement was strategic in that it enhanced a resistance to the policy rhetoric and created opportunities for a vital, dynamic and advanced nursing practice. The in-between space, therefore, contained a movement which crossed a rural community nursing rather than medical terrain and viewed a landscape within a nursing rather than a medical gaze (Liaschenko 1994).

Rose (1993) has named this space paradoxical. In paradoxical space our points of departure and arrival are constant interruptions of the centre and the margin.

On this point Rose (1993:140) stated:

*This space is multidimensional, shifting and contingent. It is also paradoxical, by which I mean that space that would be mutually exclusive if charted on a two-dimensional map - centre and margin, inside and outside - are occupied simultaneously.*

Paradoxical space is constituted by tensions and resistances (Rose 1993).
The tensions in the present research were lived and felt. Resistances to the status quo attempted to subvert the power of the dominant discourses of medicine, selective PHC, and policy rhetoric.

Transparent space acts to confine, constrain, disempower, and rename who we are as nurses, and what we do, as nurses. The metaphorical in-between space seeks to disrupt the confines of what is mapped by policy rhetoric and dominant discourses. Furthermore, it seeks to redefine both the territory of knowledge and create an 'elsewhere' (Rose 1993) or space of our own.

The question to ask is: What would be the characteristics of rural community nursing within such a nursing gaze? I suggest they would be:

Skills to practise in a fragmented, heterogenous, unstable health service which has created you and your community as marginalised. That practice would require skills that sharpened the nursing gaze for a relational practice within the home and the community, a practice which can be fragmented, heterogeneous and risky. Moreover, the space of the new subject would require skills that enabled resistance to the discourses which construct the rural community nurses as deskilled, voiceless, unknowing, powerless and not in control of their own practice.

The nursing gaze would construct an educationally well-prepared nurse whose practice was based on knowledge and understanding of community needs, with an emphasis on complementary approaches to 'cure' and without a neglect of the role of best practice medicine.
In other words, nurses with the cultural capital to create a space of their own.

Concluding Thoughts

A realist and oppositional analysis revealed the spatialisation of rural community nursing, both in terms of spatio-temporal locations, and metaphorical spaces. The spatio-temporal coordinates contextualised a nursing practise situated at the geographical centre or margin. Marginalisation, for these nurses, was further constructed as a transparent, rhetorical and paradoxical space. Even so, this space contained a resistant movement which allowed simultaneous occupation of the centre and the margin. Furthermore, the movement created the another metaphorical space - the space of desire. Interpersonal relationships with people in the community were a major aspect of the conversations with nurses in this study. Chapter five
explores these relationships as a postmodern reconstructed desiring subject.
Chapter Five

Mapping Desire: A Postmodern Feminist Reconstruction
Spatiality, the space surrounding and within the subject’s body, is thus crucial for defining the limits and shape of the body image: the lived spatiality of endogenous sensations, the social space of interpersonal relations, and the ‘objective’ or ‘scientific’ space of cultural (including scientific and artistic) representations all play their role (Grosz 1994:80).

A postmodern reconstruction of the social space of interpersonal relations

The metaphorical ‘in-between’ space to be discussed represents the movement between the centre and the margins. This movement also contains both the centre and the margin and is not composed of spatio-temporal co-ordinates. Rather, this metaphorical space concerns social relations. It is also feminist postmodern reconstructive movement.

Deleuze and Guattari (1991) contended that movement is in everything.

They further elaborated on this notion of movement, and claimed that it resembled a biological fractural. The movement is described as passing:
through the whole of the plane by immediately turning back on and folding itself and also folding other movements or allowing itself to be folded by the, giving rise to retroactions, connections, and proliferations in the fractionalization of this infinitely folded up infinity (Deleuze & Guattari 1991:37).

Rose (1993:141) referred to this metaphorical in-between space as a reconstructed 'undecidable'.

"My early reflections on the nature of the relationships established between the rural community nurses, and their clients in this study, exemplified my struggle to conceptualise what it was that I was observing, and experiencing. I noted:

'My observations are that community nurses bridged the gap in service and acted like a community web which held the client, their family, medical, paramedical, and other community members together in a coherent manner, providing a sense of consistency that the clients could trust. For some, the community nurse was the one dependable factor in their life, "like a sister ... [brother] ... I never had"'.
The in-between space and the desiring, becoming subject

As suggested previously, the in-between metaphorical space concerns social relations, and in particular, in this research, it also emphasises the desiring subject.

There are three major framings of the conversations and participant observations with nurses and those they cared for which will now be explored. These are, the subject and intersubjectivity, the gift of desire, and becoming. A short overview of the major ideas of scholars who have contributed to this theoretical work on the subject and intersubjectivity will be presented first. Then the 'data' will be presented, without reference to these scholar's work, in order to enhance the flow of the conversations. Following that, the major theoretical concepts of the gift of Desire and becoming will be utilised to frame the 'data'. I have chosen this
approach in order to frame the ‘data’ so that sense making by the reader is enhanced by making visible the lens through which the ‘data’ is finally viewed.

Overview of theoretical framings concerning the subject

Reference has been made in Chapters three and four to the work of Deleuze and Guattari (1983, 1988, 1991), and a further exploration of their work now follows.

In regard to theorising the subject, Grosz (1994:161) is of the opinion that, out of all of the male writers ‘Deleuze and Guattari’s status in feminist evaluations seems rather more shaky than others’. In fact, when one considers the attention given to Foucault, Derrida and Lacan, they have been largely ignored.

Although Deleuze and Guattari’s work is complex and covers a huge conceptual terrain, I like others (Fox 1993, Game and Metcalfe 1996), believe that a selective use of their work has much to offer the more pragmatic, affirmative and
Watson and Jowers (1997:185) have spoken with concern about a 'Deleuzian paradigm' shift. While this is so, Watson and Jowers (1997:185) also believed that Deleuze and Guattari have moved away from the post-structuralist 'language/Body interface', towards neurophysiological, cybernetics, physics and artificial intelligence, especially in their discussion of rhizomatics. On this point, Watson and Jowers (1997) saw the post-structuralist concern with language as a denial of affectivity, and were concerned with the tendency to ignore affectivity in favour of an emphasis on creativity, hybridity and fragmentation.

They saw within the postmodern conceptualisation of Deleuze and Guattari, an accommodation of the humanist accounts and a shift away from post-structuralists preoccupations with language.

However, Watson and Jowers' (1997:185-6) critique of Deleuze and Guattari's (1977) earlier work is contradictory. While they believed Deleuze and Guattari rejected 'disciplinary state[s]' in the form of capitalism and fascism (which tended to re-territorialise individuals) they also identified an emphasis on affectivity as the core of social process (Watson & Jowers 1997).

It is Deleuze and Guattari's accommodation of social relations and emotion and the rejection of the post-structuralists preoccupation with
intertextuality that is appealing about their work. In addition, it provides a postmodern frame for making meaning of everyday life, especially in the context of suffering and caring.

Best and Kellner (1991:76) proposed that Deleuze and Guattari have attempted to 'create new forms of thought, writing, subjectivity, and politics'. Although Best and Kellner (1991:76) proposed that Guattari (1986) believed postmodernism to be cynical and conservative, they also see both Deleuze and Guattari as exemplifying 'postmodern position, which is exemplified in their critique of modern assumptions concerning unity, hierarchy, identity, foundations, subjectivity and representation while celebrating counter principles of difference and multiplicity in theory, politics and everyday life.

**Deleuze and Guattari, like Foucault, have critiqued modernism's tendency to produce dominant normalising discourses which control all aspects of everyday life interactions.**

However, Deleuze and Guattari have tended to appropriate aspects of modernity, for example, linking libidinal energy and capitalism. Rather than a critique of knowledge production theirs is a critique of capitalism, therefore, recognising the importance of macrostructures of control.

All three (Deleuze, Guattari and Foucault) seek to decentre the 'humanist subject', however, for Foucault the subject is 'effect of discourse and disciplinary practices' and for Deleuze and Guattari, the subject is a reflection of a 'dynamic unconscious' (Best & Kellner 1991:78).
All three theorise the decentred subject freed of fixity and unity.

In addition, Foucault and Deleuze have worked together to reconceptualise theory as 'always-already practice' and 'local and regional' in character (Best & Kellner 1991:79).

Before introducing the conversations with nurses and their clients I wish to explore two concepts that are interwoven with the subject, and that are relevant to making sense of the 'data'. These are intersubjectivity and the web of social relations.

Overview of theoretical framings concerning intersubjectivity (the subject-in-relations)
The self can be understood as self-in-relations — in other words, intersubjectively (Benhabib 1992; Griffiths 1995; Habermas 1991). It is a notion that most postmodernists have failed to conceptualise in relation to subjectivity, mainly because this is a notion derived from the work of the phenomenological philosophers such as Merleau-Ponty and Husserl (Kearney 1989; Crossley 1994) who are rejected by the postmodernists. While there are those, like Brodribb (1992), who would argue that Foucault would deny he is a postmodernist, Brodribb does recognise the huge contribution that he has made to postmodern thinking, and as such critiques his work.
Furthermore, Guattari has clearly articulated his dislike of postmodernism. Even so, there is also much contradiction. Deleuze and Guattari's work (1983, 1988, 1991) has supported the anti-realist and anti-foundationalism of postmodernism; however, they have also argued for the place of 'phenomenological - philosophy' as opposed to 'scientifico-logico' approaches to conceptual development (Deleuze & Guattari 1991:143). And, this is evident in their conceptualisation of affectivity referred to earlier.

Given this, it is worthwhile to take note of Crossley's (1994) contention that in a discussion of Foucault's notions of power and resistance, intersubjectivity, plays an implicit major role. The main line of Foucault's argument, as Crossley (1994) suggested, is as follows:

1. freedom is always situated in relation to power and control
2. to think of resistance, one must think of power
3. both these concepts exist relationally
4. acts of power and resistance are situated within the mutual recognition of players in the game
5. as players in the game one anticipates the other's actions
6. therefore, power relations are created intersubjectively
7. discourses are situated struggles suggesting a shared partial understanding at some level
8. therefore, discourses are contextualised intersubjectively.

While Crossley (1994:121) is careful to note that articulating the implicit in Foucault's writing may be 'translating without warrant ... it is by no means incompatible with the notions of subjectivity and intersubjectivity posited by Merleau-Ponty'.

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Based on this I wish to take these ideas and extend the argument and contend that relations of care and love in this research are also created interrelationally, therefore, intersubjectively.

Game and Metcalfe (1996), in an exploration of teacher-student relations and knowing, draw out the relationships between the ideas of the postmodern feminists Cixous, Irigaray, and the phenomenologist, Merleau-Ponty. Postmodernists generally will argue against the notion of the subject and speak instead about subjectivity. We are all constituted as discourse, and that discourse becomes embodied and can be read as text. The notion of intersubjectivity is not referred to by postmodernists, rather, the notion is one of intertextuality.

Game and Metcalfe (1996:154), however, have argued that 'meaning resides in neither the text nor the reader but in the in-between of the relation between reader and text'. Meaning, therefore, is created in the in-between space.

Grosz (1994) raised the question of feminist phenomenology. While on the one hand she suggested that there is much in Merleau-Ponty's work that is significant for feminists, she also questioned:

whether phenomenological descriptions are appropriate for women's experience and, if they are not, whether it is desirable that they should be or whether instead, altogether new and different
theoretical terms are necessary - and how such terms may be developed (Grosz 1994:111).

Overview of theoretical framings concerning the web of social relations

Intersubjectivity can be further contextualised metaphorically. The value of metaphoric knowledge is reflected in the words of Game and Metcalfe.

Instead of seeing the world mechanically, as a finitude of things connected by measurable forces, metaphoric knowledge understands it as the movement of creation, as potentialities of existence blossoming forth (Game and Metcalfe 1996:51).

I have chosen to reject Deleuze and Guattari's (1988) metaphor of the rhizome, replace it with the metaphor of the web, but retain the principles in their most general form. The rhizome is a plant root system which lives underground. This is a useful metaphor for Deleuze and Guattari as they are concerned with the unconscious. As I have not taken a psychoanalytical approach, the web is more appropriate.
In summary the principles of Rhizomatics (Deleuze & Guattari 1988:7-12) are: '1 and 2. Principles of connection and heterogeneity'. Both these principles implied that any point can be connected to anything else and that there is constant diversity of contexts for that connection.

'3. Principle of multiplicity’. This notion concerned the changing multiple dimensions of a person in relation to varying life, and feeling contexts. Furthermore, it implies transformation.

'4. Principle of asignifying rupture’. Here, the notion is one where rupture results, not in death, but proliferation.

'5 and 6. Principle of cartography and decalcomania’. These notions concern mapping and the tracing which construct and connect the unconscious to the events of life.

Mapping the self-in-relations

Nurse client interactions

The following exploration of conversations and participant observations weaves the 'data' as voices, rather than collapsing the 'data' into homogenous themes.

The metaphor of the web is one where relationships are set in time, space, and place and made in relationship to everything in the environment. The web possesses multiple strands, webs can be multiple and diverse, can be mapped and
traced, can be ruptured, modified and transformed. So too, are the relationships of rural community nurses.

Watching a spider weave its web, the very fragility and delicateness is a beauty in and of its own. The painstaking attention to joining the different, somewhat disconnected and fragmentary strands, the constant movement is a metaphor for rural community nursing.

Gentleness

Nikalia's words contextualise these images as she reiterates a typical conversation that might occur in an health education falls prevention programme. The tone is tentative and questioning.

She said:

"In the community, it's a slowness, it's a gentleness. "It's let's talk about the mat". "I know you love it there [on the floor] and I know your Mother gave it [to you] and [your] Mother had it since 1904. But do you think if we moved it to
the right, just when you're coming along there, you mightn't trip on it"'.

   Sonia spoke about the particular characteristics of the community she worked with, and her treading carefully and gently. I began by asking:

   'How do you find those community people out there? Do you find that they respond positively towards you and the projects that you do?'

   Sonia: 'Generally, Mustville is a hard place in that there is a general non-acceptance of ... the system. We've got the old settlers and the new. I consider myself to be kind of bridging the gap. And it is hard to just zoom in there and say well "We'll, do this" or "We'll do that". We have to tread carefully in order to be accepted and respected and so, I think that if you aren't too pushy, you will be listened to'.

   I then commented on the need for time and for everything to develop organically and she confirmed this. For Beth being a community nurse was a way of life that was evolving. She saw herself on a journey with the community, rather than just a job.

   She said:
'It's a life'.

Nurses and the cared-for as friends/family

*I also explored with Sonia the idea of friendship as it had been raised in a previous conversation with another participant.*

**Kierrynn:** 'I've spoken to ... [who suggested] ... that you're more of a friend. You're invited into the home and you feel more like an informed friend that has knowledge that you're capable of handing on'.

*Sonia explained the friendship in terms of trust and rapport.*

'That's right. I never feel that I can pass any knowledge on until I have gained their friendship and their trust. I don't like to, as I said before, to just go in and say, "you do this and that". I like to go for a couple of visits before I start educating, so that I know that they will listen after a while. They won't listen the first time, or the second, until I've gained that trust'.

**Kierrynn:** 'It seems to be a very common theme that keeps coming through. People say "I like to be in people's homes
because I have a much deeper understanding of their situation — how their marriage is going... and those things'.

**Sonia:** 'Their social issues ... their personal issues and just their whole being, really'.

I explored these notions further with Beth and said:

'You’ve just been saying that perhaps you see that other people [view] your practice as a little different. Could you outline [for] me the sorts of things you mean?'

**She replied:**

Closeness

'I like to operate in a very close way with people. I like to have [a] close relationship. It means a lot of time, usually; that doesn’t happen overnight, and you build up a rapport and a trust with people. I know that I step outside the clinical role many, many times, and I don’t see that as a problem, and it actually enhances my practice, and it actually enhances the achievements. I believe it enhances what happens in the interaction, and the quality of the interaction for these people. Quite often the community nurse is their only communication outside the home, or is a big part of the communication outside the home. A lot of the conversations I
have with them has very little to do with what I’m there for. It’s about my life, it’s about their family, it’s about what’s happening in the world. It’s their connection with the outside world. And I still see that as a valid thing, and a valuable thing’.

Exploring this further, she says:

‘You become adopted into their family. Some people don’t want that level of interaction, and you have to respect that, too. They will run at the level that they’re happy with. Whereas some people want you to be very close. They want you to be part of their life, their friend as well as their community nurse. Which makes some demands on you, too. Sometimes you have to know when you’re a friend and when you’re a nurse and be able to draw the line – and that can be tricky to do. But that’s your role, that’s what you’ve got to do’.

I then asked if it could be called a collaborative or participatory type of role between the person and family. She replied:

‘The demands and what you can realistically provide, and what sort of services you can or can’t provide ... Yes’.
The uniqueness of interpersonal connections

I then explored the individualised nature of the relationship and suggested that not everybody wants the closeness, although some people do. Beth affirmed this.

Beth then continued to draw on notions of respect of diversity and difference, integrity, credibility and trust. I asked:

'So, some would be open to the health education, health promotion, and some would be quite closed to it?'

Beth: 'Yes, whatever you find, wherever they're at, that's what you respect. You get no prizes for ramming anything down anyone's neck and it doesn't work anyway. So, you have to accept that some people won't accept anything you are going to offer. And it's not a failure. It's them, and you've allowed them to be themselves'.

Kierrynn: 'Their response to individualised programs would be better than their response to more global health education programmes'.

Beth: 'Much more likely, and also depending on how they see you, whether they think you're a credible person, whether they think you have integrity, whether they trust what you're saying to them'.

Kierrynn: 'You said [earlier that] honesty was very important'.
Beth: 'Probably the most important factor. If I say I'm going to come to see you, I come to see you. If I let you down once, I've undermined your trust in what I'm going to tell you, and it goes across the board. And I've your trust in whether I know how to manage your wound, whether I think that's a nice colour that you're going to paint the kitchen. I mean, if they value your judgement they will want you to be involved in lots of other decisions in their life, not just their wound, or the support, or their caring for their family. They value lots of opinions, and some people don't want to give that much, and I think that's OK. You've got to know where your limitations begin and end'.

I then explored the time-consuming nature of the relationship. She replied:

'Very time consuming sometimes. I tend to make sacrifices. I sacrifice the paperwork for the people work'.

I attempted to summarise some of the features of our conversation and suggested:

'So it gives you an area that you enjoy, working with a base of good experiential knowledge, but it gives you a degree of flexibility that allows you to be autonomous'.

Beth: 'Yes'.

Kierrynn: 'Have I summarised that OK?'
Beth: 'Perfect. It also allows you to work how you want, to [at] the level you want to, and that’s what I’ve been saying all along. I like to get in close. I like to have that kind of relationship with my clients. I really know my clients. I can ring them up and I know that what I suggest, or offer to them, when we’ve discussed it, and when I’ve laid it on the table and we’ve chewed the fat and decided what’s going on ... I know that they will be receptive to what I’m saying to them because we’ve got the background, we’ve got the foundations. And often, I’ll ask them to do horrendous things, and they’ll do them. Because they want to do them'.

Therapeutic friendship, body space and touch

We then begin to explore the idea of a therapeutic friendship. Beth says:

'It’s something I’ve discovered, the power of touch, the power of being. I’ve learned not to underestimate the benefits of that. I know that some people can’t cope, don’t like to be touched. They don’t like people to get in too close, and you have to respect that with some people. And when I touch you, if you flinch, I’ve got to realise that you don’t like that very much, and I don’t get close. I must leave you ... leave your space. But I never underestimate the therapeutic effect of having warmth and interaction and caring and touch'.

Kierrynn: 'It seems to me, though, that you’re talking about touch at another level. That in a way, when you talk about
touch physically, it seems to me there's a psychic and a intuitive touch about that as well. An understanding of their total person, not just a physical touch'.

Beth: 'It's not your leg ulcer, it's not just your sore shoulder, it's not just your hand, it's the total you, and your total environment'.

Kierryn: 'So there's an emotional touch. There's the warmth, and perhaps the psychic and emotional understanding and touching'.

Beth: 'And the tolerance and the respect'.

I then explored the temptation to hang on to people.

Kierryn: 'Given your personal involvement, and the grassroots way that you like to operate, do you sometimes have difficulty in letting go? Getting people off your books?'

Beth: 'Probably. But sometimes I discharge people from service and keep them as friends'.

Complexity and the unexplainable nature of the interaction is explored.

Beth: 'I adopt them instead, and discharge them. When I say I like to get in close, I like to have a personal relationship. I like to have that sort of a relationship of action. I'm still a nurse, and I still only have eight hours a day in which
I've got to operate, and it's no good to create a dependency. When I realise that's happening I have to start backing away and giving them space. A lot of it's instinctive. I can't put my finger [on it] ... I'm finding it very difficult to express in words how I feel, but a lot of it is very instinctive and I don't believe it's good to create dependencies for people. I can't be all things to all people. I can't be there for them for everything, and I very much try to let them know exactly what I'm able and not able to do'.

Mutuality in relationships

*Mutuality is implied in the following conversation with Beth.*

**Beth:** 'I try to set the barriers for them. I try to let them know that I'm not being adopted for life. I am a community nurse. I am there for a specific reason, but along the way, if we can do a few things as well, then, then I'm more than happy to go along that road. But I'm not there to be there for life ... Although, many times we are there in long-term relationships'.

**Kierrynn:** 'Therefore, it's very much dependent upon whether both you and the family mutually feel that. So you discharge them, and you may keep in contact with them, if that's mutually agreeable with them?'

**Beth:** 'Yes. So you can discharge from care, but stay on as a friend'.
Kierrynn: 'Do you often get drained, a little bit?'

Beth: 'Sometimes, but I also get a lot back. It comes back threefold. Then it always blows me away. I never expect to get back what I often get back. Emotionally, support-wise. It's just amazing. Once they take you into the larger role, they give back on that scale as well. They don't just take, take, take, and it's like any sort of relationship'.

The importance of love and empowerment

Lee also talked about friendship along with love and empowerment.

Lee: 'Love, if you don't have that then you don't get anything else. It's such a primary need. If we teach people more about the running of their own body ... and more about the life forces that control their body and their mind, then people are able to heal themselves very quickly rather than giving power to us, because we just don't have the power to heal'.

Kierrynn: 'Obviously love is a valuable concept to you. Are there other concepts that are valuable to you that form part of your work?'

Lee: 'I think friendship is probably one of the most important assets for any interactive professional. As the community networkers, if you can befriend somebody, then it automatically changes your attitude. If I run in and run out then I'm not doing my job. And if you are friends with someone, then your obviously going to see them, as therapeutic friend.'
Although sometimes those boundaries are very grey between therapeutic and just friendship. It's difficult to separate those sorts of things. But if you're a friend, then you really care about someone, therefore, you will really care about their needs ... an individual, not as somebody that is my client. If I say to someone in the nursing service, "Look, I've got to go 'cause I've got to catch up with a [friend] of mine" they think "What are you going home early for?" But I'm not, I'm coming back to work again. Because if I think of them that way, then I put them within that framework within my life ... Then I'll really think about, care about, what their needs are, and look at them as an individual, and not as just a group of people that I look after'.

Nurse nurse interactions
Collegiality

Participants' relationships with each other are articulated by Anne, Elenore and Rachel. Collegiality is a common theme.

Anne: 'We do function more as team here, and talk a lot amongst ourselves, but I think you'll find that in any small community. I mean, your bigger places are always the hardest'.
Kierrynn: 'Always more fragmented?'
Anne: 'Yes, and I think that's just the nature of the beast. You're more creative when you're a small team'.

In my conversation with Rachel I attempted to clarify my understanding, and asked:

'So there seems to be a sort of collegial support?'

Rachel: 'Very much so. I haven't seen evidence of it either, anywhere else that I work. Out here we speak on behalf of each other. And it's not just the two full-time workers. It has occurred with our relief staff as well. I say it a number of times a week on the phone: "On behalf of myself and my colleagues, we're not going to do that" or "Yes, I can speak, I won't be working tomorrow, but I feel that my colleague will do that", and you know darn well that they'll do it'.

While relationships are sustained by collegiality, there is a celebratory note and sense of enjoyment in the relative paucity of crisis work in rural community nursing. Anne points this out in the process of describing the different 'hats' she wears. She said:
'It is very stressful [in D&A]. Whereas community nursing with the [aged], and health promotion with the younger [ones], it’s less stressful and it’s more enjoyable'.

**Kierryynn:** 'Do you think there’s a sense of [greater] achievement? Is it harder to have a sense of achievement with drug and alcohol[work]?

**Anne:** 'Drug and alcohol ... is what we call 'low visibility nursing'. But there’s not as much crisis work in community, as there is in drug and alcohol, or psych'.

Sensitivity with each other

*Mikalia spoke about the team and being sensitive and in touch with feelings as part of collegial support.*

'Sensing and feeling, and just checking and working out. You notice I always look down before I look up, to see how you feel at what I’m going to say. I’m extremely direct, which just a couple of people find very difficult to cope with. I’ve been through a long journey to get to here. I’m interested in environment, and the staff are very sensitive. If someone’s having an off day, it’s OK to have an off day. But I think a team is about people, and from the people comes the service, and if you’ve got a team that like to be where they want to be, or feel comfortable to be where they are, they’ll go out and give the service. They’ve chosen that path
to do it. I’m about making them feel comfortable when they come back here and in their team. The client gets the best possible service'.

Recognition and validation

In another conversation, I raised with Elenore her extensive involvement with community development, and how other colleagues responded to that.

Kierrynn: 'How do you find that your involvement is accepted?'

Elenore: 'Great'

Kierrynn: 'You have no problem with people respecting whatever it is you have to say? And there seems to be a genuine acceptance of your input into that?'

Elenore: 'Not a problem. Yes.'

Kierrynn: 'Do you think that it's always been like that, that people recognise that this is happening?'

Elenore: 'Yes, it was. Because there was more continuity of care with the client. If you stay in [an] area too long, you become dependent on that client, and the client becomes dependent on you. And that is not good in my opinion. That’s not what we’re there for. We’re there to make them as independent as possible - not dependent. Optimal independence'.
Importance of client rapport

Initially, in a conversation with Marshia,
I explored the notion of entry into the home
and then moved on to a discussion
concerning the establishment of rapport.

Marshia: 'Well, I just find that going into homes, you have to
have a rapport with the person first. Because you’ve got to
remember that you’re in their home. You’re in their domain,
the approach is holistic'.

Kierrynn: 'So how do you establish rapport? What sorts of
things do you do?'

Marshia: 'Just chatting. It’s amazing the things you do find
out after a few visits'.

Kierrynn: 'Sit [down] over a cup of tea maybe?'

Marshia: 'Sometimes, all depends on the time. I just think
that you’ve got to remember that you’re in their home, but I
think that being honest about why you’re there, and how you can
help, right from day one'.

The power of spatialisation: the home as the place of intersubjectivity
Control in the home is sited with the client/ and or relatives or carer. It is their
territory. It is within this terrain that the intersubjective emerges.
Relationships are inscribed by mutually. They territorialised by control and
dependence and deterritorialised by compassion.
All of the people in the community that I visited with the community nurses, except one, were aged. This group of people made up the majority of the community nurses continuity of care 'load'. Continuity of care was the major nursing focus. Health promotion and health education aimed at creating independence was so intertwined as to appear 'natural'. My observations of clients in this group were that they were consistently fearful of dependence and were resistant to dependence in the extreme. The home, as a place of healing, was characterised by a naturalness and receptivity on the part of all in the home, including the nurse. As I suggested earlier, the clients were unwilling to be tape-recorded, therefore, the following conversations were recorded in my field-notes. The notes were reviewed afterwards, and reflections on the conversations recorded.
As I said, the clients were aged and some had been 'on' and 'off' the 'books', for anywhere between 2 and 6 years. Some clients were either new for that nurse, or in some cases, a significant amount of time had past since the last visit, either by that nurse, or someone else in the service. John explained to me the importance of the nurses visit for him, and his method of initiating a visit.

**John:** '[The] service is really good. The community nurses have been coming for about 5 years. If I need them I can ring up, but I do so only in an emergency. I mainly work through my family doctor ... who calls the nurses if I need them'.

*I further recorded that:*

'The service keeps him out of hospital. This is great as it allows him a good level of independence'.

*My participant observation field notes, recorded after a visit to John's home, also revealed:*
"The community nurse visits for a variety of reasons. Mainly they go once a week, to help organise his medications for the week, or occasionally to attend to skin tears, and do a dressing, if necessary. Jay assessed John concerning his state of health, the working of various pieces of equipment, and how things were going at home. Jay stated that [the] client had his phone number, and can phone him if necessary, which he has done in the past. Jay is aware of John's needs, and past history, and the relationship dynamics between John and his wife. Also, Jay has a very calm approach to managing someone who always needs to 'run the show'. Jay's interactions and actions were thorough, understanding, helpful, very respectful and friendly without being intrusive'.

Affective qualities of rural community nurses

'The interview with Grace revealed that she was aware of differences between nurses who visited, however she stated:

'The community nurses are interested, and try everything to help. They also respond by being happy when my health is improving. They give extra care, [they are] dedicated and knowledgeable. Also they are honest, and tell me exactly what is happening, and I appreciate this – it is genuine and caring. I sometimes ring the nurses, and I feel great about this, and feel confident they will come if needed'.
Empowering nurse client interactions

Furthermore, Grace indicated her ability to have input into her health care, direct the type of assessment, and to alert the nurse to impending problems. By way of example Grace stated:

'I rang, and asked [the] nurse to bring a stethoscope with her on her visit, as I felt my blood pressure was up, and [I] wanted to check it'.

Understanding client needs and social space

Grace revealed the attention given to physical, mental and family concerns, and stated:

'They understand the needs of the family, including the emotional needs. The nurses notice my moods, and provide support. [They are] very supportive to family and friends but not intrusive'.

The importance of independence, and the relationship this has to family dynamics, and her own mood, is revealed by Grace,
(who had a crippling painful illness, was on large doses of medications, and had dressings which needed attention). She said:

'The good thing about the community nurses coming is that someone comes to the home, therefore, I don't have to go out, as I cannot walk. I have a wheelchair, but my husband cannot manage and gets demoralised. Therefore, it is better all round to have the nurses come to the home. I need to be as independent as possible, so I don't get too down'.

After observing Marshia in Grace's home

I noted:

'Marshia seemed to really know the client and understand her situation. She identified the elevation of mood, and she discussed this with the client. She identified that the presence of her grandchildren and daughter-in-law were probably the reason. She also discussed the healing of the wound with the client, openly, and accurately. She commented on Grace's progress, the value of the present treatment, and responded supportively and informatively to Grace's questions. For example, she told Grace her BP when asked, and ensured that she understood what makes BP go up and down.'
Grace introduced Marshia to the rest of family members. The interactions were friendly and open and sincere. I observed that the interactions were supportive and facilitative without creating dependence'.

Much later over a cup of tea in the tearoom I spoke to Marshia about the role of the community nurse, and wrote in my notes:

'Marshia and I were exploring the role that community nurses play in the community today, and in struggling to understand this I suggested, that it was similar to the old style country GP, and she agreed, seeing some similarities'.

Between the time of making the appointment to see Duggal, and that actual date arriving, the client had a fall and was admitted to hospital, for assessment of his mobility. Therefore, Duggal was the only person interviewed and observed outside of the home. Duggal stated that the community nurse came once a week, that his sister helps with his care, (although she has a cardiac problem), and
neighbours do his shopping. Although mobility was a problem, Duggal also required attention to a dressing. As well, the community nurse helped with some grooming that Duggal could not manage himself. He stated

'The nurses ask how I am managing and then do an assessment. The nurse is to take me home this afternoon to see how I am managing with [the] wheeler'.

I noted during the talk with Duggal:

'Duggal is not happy with the wheeler. He thinks it is bit old and worn. But, he will give it a go, although he is not really confident with it, and is afraid of falling on his face'.

However he went on to say:

'The nurses act as advocates, and the Doctor will get the nurse if there are problems, or he rings if there are problems'.
Balancing humour with seriousness

The interactions with Duggal were extremely humorous, with many jokes and much laughter, and a lot of good stories concerning his early life in the area. This is obvious in the notes I made after the participant observation with Ann and Duggal.

'Again, the language was obvious, humour was used frequently, but appropriately. Although, the conversation became serious when required. Ann has an excellent rapport with Duggal. She has known Duggal for several years and this professional rapport was very effective. Anne clearly understood Duggal's needs and was able to identify problems concerning his return home. The interactions were extremely caring and supportive. Ann acted as Duggal's advocate in terms of assisting him to meet his health needs and remain as independent as possible and out of hospital for as long as possible'.

Alleviating concerns

Mary had had an accident and sustained some injuries. She was admitted to the hospital for treatment and once infection
cleared she was able to go home. It was arranged for the community nurses to attend to the dressings. She also had a serious medical problem that effected her ability to receive oxygen into her body. Mary told me that the:

'Nurses first visited about 3 weeks ago, and management has pretty much been trial and error, however, the wounds are healing well. The nurses have been marvellous- worth more money. Having the nurses here makes me feel more confident and I can ring any time if I am worried'.

However, ongoing assessment of Mary's physical, mental and family health was a constant feature of her interactions with Beth. Mary said:

'Beth noticed the problem with my feet and arranged for the podiatrist to come and visit. Community nurses also come and wash my hair'.
Mary confessed herself to be a very private person. While this is so, she also stated:

'Now I feel more comfortable. Home care is not appropriate and cannot do what is needed. The community nurses being here allows me to stay out of hospital. Although I won't need them when the leg is better I will miss them. I feel safe and can ring them at any time'.

Mary told the following story.

'I ran out of oxygen, there was none at the doctor's surgery, so I went to the ambulance station and got an emergency one. Then I rang the community nurses to find out what to do when it happens again. They gave advice, even when it was not their responsibility. They also provided phone numbers and sorted out the problem. I now feel confident to use them as a back up. I have a trust in their ability and willingness to help. They obviously care about what happens to me. They provide a support network and this appears to be working very well'.

For Mary, asking for help from a community nurse was easier than when she was in hospital. Further to this she said:
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Trusting and respecting

'I trust the community nurse and recognised her expertise and this gives me confidence'.

Reflecting on my conversation with Mary

I noted:

'Mary is of a generation who is proud and independent, and not used to asking for help. She has difficulty asking for assistance, and therefore, values a respectful caring attitude when she needs to interact with health care providers. She does not like to feel she is a burden'.

Beth commented that Mary was a relatively new client for her, and that they were just establishing the relationship. I observed the interactions to be:

'Warm, friendly but not inappropriate'.

At one point during the interaction the next door neighbour came in and I observed the interaction. I later stated:
'Beth established warm and friendly interactions enabling trust to be developed with Mary's support networks, she was more like a therapeutic friend'.

Speaking on/with/at the same level

*I further commented that the interactions were:

'Informative. Beth spoke clearly about the nature of the problem and in what way it was improving, therefore, giving Mary the hope of independence as she is fiercely independent'.

*Mary's comments during our conversation were consistent with my observation that Beth was:

'Observant of Mary's other needs as well as her primary problem. She spoke to Mary about these problems with an informed understanding and made arrangements for further help from other practitioners in a way that enabled Mary to remain at home and independent'.

*Like the previous interaction between Ann and Duggal, and Rachel and Connie to follow, one of the most notable features of
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The interaction was the language, both in content and idiom. I recorded in my notes:

'There was much humour, colloquialisms and swear words but it was generationally appropriate, and this made everyone comfortable, and did not set them apart. There was merging of conversational styles and a minimal use of complex medical and nursing language to reduce distance, establish trust and rapport, and ensure understanding of fairly complex health information. By ensuring an understanding of the health problems Beth enabled Mary to be involved in informed decision making concerning her care, and respected her wishes'.

Compassion

I also became aware of space issues as part of the interaction and commented:

'Beth respected the space she was in. It was Mary's home. She always checked first concerning the use of anything in the home, for example, the tap for washing hands, the telephone for ringing a practitioner. The important issue for Mary is that she can ask for help, and maintain respect, dignity and independence'.
I concluded my entry saying that although the interactions were new for both of them:

'Beth's interactions and care demonstrated compassion. She has a good knowledge of Mary's background, medical problems, networks, supports, routines. Mary trusts Beth's knowledge base, and this gives her confidence, and that made her feel safe'.

Rachel and Connie had a six year history together. Connie was the only girl in the family with 10 brothers. She had returned home to care for her mother (aged 93) after her mother had a stroke seven years ago. Connie also cares for one of her brothers who is demented, and is sometimes uncooperative, because Connie is younger than him. Connie described the community nurses in the following way:

'They go out of their way and do extra'.
Nurses as sisters — 'an endless resource'

Connie told the following story about her first contact with the community nursing service.

'When I first arrived home after mother had the stroke the place was in a mess, I didn't know how I would manage. The community nurses came and helped. They arranged everything, and taught me how to organise everything, and helped me get established. They were like the sisters I never had. I could ask about anything, and although different nurses came, they were all the same. I needed support to manage at first... I was taken from a situation of having no confidence (and no nursing background) to a place of feeling I that can deal with most things'.

Rachel also encouraged Connie to ring if there were any problems. Connie said:

'The community nurses are caring and act like a resource person. Also the nature of the [geographical] area, it's sometimes difficult to get help, so having this service is very reassuring'.
The fundamental role that community nurses play in holding families and individual together begins to emerge more fully here. Connie said:

The security of lasting relationships

'I discuss any problems with them. Like a country doctor but not a doctor... I have grown attached to the community nurses as they have been attending the family for about 7 years. Rachel is very intuitive and seems to know when something is wrong with mum ... then acts on the situation'.

I recorded the following field notes after the participant observation of Rachel and Connie:

'The interactions seems like family interactions in a way. There is a lot of joking, laughing and telling of stories. At the same time Rachel was very observant of the family dynamics, and situations, as we sat over a cup of tea. The familial nature is exemplified by Connie giving Rachel some items for her home. There are many "in" jokes and stories which reflect the seven year history of the interactions and care for this family. Trust and rapport have been well established and Rachel drops in for just a yarn and a cuppa. It appears as if the

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community nurse is the glue that holds everything together, the pivot or linchpin'.

Again, the language used in this interaction helps to solidify the relationships.

'The way of speaking to each other was very familiar ... in the same way you would speak to a family member. Their backgrounds are similar in that both Connie and Rachel are from largish families, and they act towards each other in a supportive caring way'.

For Violet the community nurses have been coming on and off for the last couple of years. Just recently it has been every second day to attend to a dressing. However, just this week it has been changed to a daily dressing by her doctor. Violet demonstrated her ease with the community nurse and said:

'I ring the community nurses if they need to come. I was about to ring them as the dressing was changed to daily and no one had arrived as yet'.
Violet's husband had died suddenly three months ago and she was missing him greatly. She had no family in the area, was immobile, but used a walker. However, her neighbour was very supportive. She also has problems with her vision. My reflections of our conversation stated that:

'Violet seems very teary and somewhat down'.

Although the main reason for Elenore's visit was to attend a dressing, she had established a good rapport and has set up a ritual of reading the horoscope together as something to share. Furthermore, Elenore clearly had Violets confidence. I observed that:

'Elenore showed a high level of knowledge about Violet's health problems, and saw it as her responsibility to effect curing. She is extremely knowledgable about Violet's physical and emotional health. She talked openly with Violet about the progress and any changes in the state of the wound. She is
aware of Violet’s mood, and agrees with me that she is a little down and teary'.

_Elenore revealed an excellent knowledge of the client’s history. I noted:_

'However, she indicated that this is understandable as her husband died only 3 months ago and there is no family nearby. She is also aware that the neighbours will be away over Christmas and that Violet will be by herself as family will not be up'.

_Ronnie had a problem with a finger wound and the break down of some post-operative wounds on his back. He has had contact with the community nurses some years ago after his mother had a stroke. However, this is Ronnie’s first contact with the community nurses for his own health problem. Ronnie said in conversation with me, that the:_

'Community nurses are terrific. If they weren’t available I would have to go up to the hospital to have dressings done (this was about five kilometres away). They tell me anything I
want to know. The nurses help with my diabetes as well ... they ring up to see if I'm OK, and will come back if they call when I am out. They also come in to see me if I am in hospital. I am a very independent person and don't like to have things done for me. I feel confident to ring the nurses if have any problems'.

Respect and private spaces

_The nature of the interactions reflected the approach that Lee spoke about earlier._

_I noted:_

'Lee was informal but respectful of the fact that we were entering someone else's private space. The mateship was obvious and Lee was honest about [the] situation and explained [the] nature of the problem well to someone who has little formal education. Furthermore, Lee checked that Ronnie understood the problems. Lee provided helpful advice about managing any problems and checked on drugs ensuring all instructions had been carried out. The interactions were supportive and facilitative in action and speech. Although the surroundings were chaotic in no way did Lee indicated any discomfort'.

_Again, I was struck by the role of humour and particular patterns of speech that_
reflected an effort not to distance the client. I noted:

'Lee joked at lot with Ronnie.'

Lee also indicated when he would return, and appropriate strategies should anything happen, and what to do over the weekend, when there would be no community nurses available.

'Lee took a [lot of] time with the client, and although being very busy, did not rush the client, and spoke in a way that the Ronnie could understand. Time was taken to explain things especially the look of the wound and what was happening'.

My observations on the first day of orientation visits revealed the complexities and diversity of rural community nursing.

'In the morning met we met with continuity of care assessment patients. It was very busy. The clients needed heaps more time than was really available. They had looked forward to the visit. Obviously the needs are more than physical - support, dying, decreased level of activity. There was frustration with the lack of time. Most do not want to depend on others.
However, there is great diversity, and for those with good family support this was invaluable.

There is a 'discourse of caring' - doing more than just what is required. Health education is prominent, as is democratic participatory decision making. The care is holistic not just in terms of clients needs, but also in terms of the family and interpersonal relationships. Also support and direction re contact are provided so that the client isolated and has access to relevant care.

My visit with Gayle was to an industry based health education/promotion project which was her PHC client. I recorded in my field notes:

'In the afternoon I attended a session with Gayle concerning an industry workplace based project on healthy lifestyle education in the workplace. This idea moves beyond safe work practices and is more about using the workplace as a facility for total approach to health.

Gayle plays a facilitator role - encouraging worker and management responsibility in decision making concerning the type of program and how it was to be conducted.

If work can be considered a type of community then there appears to be an element of community development here. Gayle acted as a resource person, also offered to provide some health
assessment activities and 'health in the work place literature' for the group.
There was encouragement of participant decision making and she led participants through to the point where they had enough information to make the decision. This provided a sense of ownership over decisions concerning what projects to undertake.'

I have spoken earlier of the metaphor of the web.

While Deleuze and Guattari (1988) have used the metaphor of the rhizome, their conceptualisations of the subject and subjectivity is helpful in framing the 'data'.

The subject and subjectivity
According to Grosz (1994), the following is important to consider in relation to the work of Deleuze and Guattari in their two major works Anti-Oedipus (1983) and A Thousand Plateaus (1988).
A predominant feature of their work is a negation of the privileging of the social over the psyche. The answer, however, is not in a simple reversal of these two. Rather, they penetrate us and each other.

In other words they are forces that directly interact without the need for mediation or production through various ideological systems.

These forces, however, are required to be codified, or territorialised, and in that process, they will also decodify and deterritorialise.
Deleuze and Guattari (1991:110) describe it as 'deterritorialisation and reterritorialisation [which] meet in a double becoming'.

This is the eternal return or becoming which will be explored further in the chapter.

Further to the above, if the subject's relation to the world is direct, then the need for a real and ideal world is problematised. Moreover, Deleuze and Guattari provide a way to conceptualise the movement between the oppositional elements of deconstruction by posing 'both-and-relation' in a context where 'identifies and stabilities are not fixed' (Grosz 1994: 181). There is a pragmatic turn in their conceptualisation, where relations and materiality are read in terms of what they produce (Grosz 1994).

Deleuze and Guattari's roots in Marxism are obvious in their emphasis on production and materiality.

The products of the nurse client relationships were that clients felt confident, safe, independent and informed decision makers. Nurses were taken into the family, without territorialisation. Furthermore, they, and their relationships were respected and trusted.
Furthermore, desire encourages an exploration of 'possible alternatives, possible modes of entry into and exit from knowledges to be used productively in day-to-day life, in political struggles of various kinds, and in cultural creation' (Grosz 1994:183).

As Grosz (1994:182) further commented, desire is not constructed as seeking an object or something lost. Rather, desire is recoded as a positive, productive force that 'makes things and forges alliances'.

The risk, of course, is that the very act of decoding and deterritorialisation, will lead to codification and territorialisation.
The work of Deleuze and Guattari is complex and extensive, wandering over a huge conceptual terrain.

The intention here is not to be absolutely faithful but rather selective in the appropriation of those aspects which concern the main thrust of this research.

Subject and object are not dualistically related. They are conceived as a series of flows, energies, movements, strata, segments, organs and intensities.

In other words, as fragmentary assemblages.

I had a sense of this in the ease of the relationships.

While this may be so, fragments can be linked or disrupted. Fragments all exist in an ontologically equal plane, therefore without hierarchy. And while this
may be so, Deleuze and Guattari do acknowledge hierarchy; but rather than being a phenomena of the fragments, it is inherent in 'modes of organisation of disparate substances' (Grosz 1994:165). And the processes which produce the links are productive. Assemblages link the fragments provisionally and are always in the process of being made in practice or ontologically. And there is no rule or principle of assemblage. It is, rather, experimental and transformative.

Therefore, assemblages are formed intersubjectively in everyday life.

Desire and the gift

Hinting at the idea of intersubjectivity and therefore linking it to desire, Game and Metcalfe (1996:146) commented that '[d]esire is a relation, an emotional dynamic between the self and other'. Notions of desire are unsettling, moving the text into the terrain of the passionate and sensual.

On the other hand, our common understanding links desire to lack of pleasure and a driving need to find that which we lack.

Both Fox (1993) and Game and Metcalfe (1996) reject the Hegelian notion of desire being situated in the master/slave model. Fox (1993:163) followed Deleuze and Guattari (1991) and drew on Nietzsche's conceptualisation of the 'will-to-power [as] ... the notion of desire as a positive investment in the other'.

While Cixous has rejected a desire where 'the other remains other' and Hegel spoke of proximity and distance (in Game & Metcalfe 1996:153) Game and Metcalfe (1996) suggested that such notions of desire as a positive investment may not be possible in our everyday lives. They have spoken about the movement between the two terms and the strain of two human beings in
constant movement within the 'in-betweeness' (Cixous 1992:70 in Game and Metcalfe 1996:153).

The 'Gift [is] the feminine relation of generosity and trust, opposed to the Proper' which is associated with the masculine and power and control (Fox 1993:162). Cixous was inspired by Clarice Lispector who she believed wrote in a space that was beyond the oppositional. It was a space which was an 'economy of the gift. And of love. Of how to give' (Sellers 1994: xxx).

However, Cixous also questions the sustainability of such a generous relationship as the gift, and clearly anticipates the slide into territorialisation.

About half way through the fieldwork I noted:

'What keeps coming up is the point that community nurses believe that you must establish rapport and trust, before you are welcomed into the lives of clients, and therefore, have the chance to influence them in appropriate health orientated behaviours. Establishing this can take some time. Also, the importance of a long history of association with clients allows helpful insights into problems, needs, and how to appropriately deal with these together'.

What then are some of the characteristics of the mutual Gift relationship in this research?
Nurse client relationship

This relationship was contextualised spatio-temporally and chronologically, predominantly in the home, however, public and work spaces were also the site of intersubjective construction of relationships. The relationships between community nurses and those cared-for were created intersubjectively and were characterised by: Being close, presencing, touch, treading carefully and gently. Friendship, trust and rapport, getting in close, and being like a family member also featured. While there was initial territorialisation and repetition, this was followed by de-territorialisation. Credibility, integrity, honesty, the power of touch, warmth, psychic and emotional understanding was also viewed as important. Relationships were viewed as more personal than strictly professional and they were also action orientated. The eternal return and the power of being is
noticable in discussions about getting something back, mutuality, and organic development over time. Furthermore love, friendship, empowerment, respect, and creativity were all important fundamentally to the care of rural community nurses. Within the relationship that nurses had with each other, collegiality, sensitivity and support and recognition and validation were features of their everyday life.

I am in agreement with Fox (1993), who commented on the ease with which slippage into the possessive can occur. Empowerment could become disempowerment, closeness distance, love hate, honesty dishonesty.

And, as one of the participants commented, some these characteristics of the gift relationship may be deemed to be 'out of place'.

These thoughts are echoed by Fox (1993:92), who commented on this positive investment in the client, saying that 'if applied to the profession, [it] would not only be seen as unusual, but possibly even inappropriate or "unprofessional"'.
In many ways the relationship of the gift is similar to that which characterises the informal carer in the home.

Cixous used the word '[p]ropre' which has been translated as 'proper' (Sellers 1994:27) to describe territorialised relationships. This term contains the idea of ownership, and the desire to possess (Fox 1993; Sellers 1994). The gift relationship ruptures the relationship of control, inscription, repetition and territorialisation.

Cixous (in Sellers 1994:27) explained that what she asked of desire is that:

\[ \text{... it have no relation to the topic which puts desire on the side of possession, of acquisition, or even that of consumption-consummation, which, when pushed to the limits ... links (false) consciousness with death.} \]

Therefore, the gift relationship, or desire, becomes the 'politics of care' (Fox 1993:94), as it resists the slide into a possessive relationship. It is also a 'politics of care' in that it encourages diversity, and difference, welcomes other views of the world, is compassionate, and loving without being self-sacrificing (Cixous and Clement 1986; Sellers 1994).

\[ \text{And, although articulating notions of belonging and family thus far, these community nurses have avoided the oft familiar family power struggles.} \]

Although Game and Metcalfe (1996) do not speak about the gift, they do discuss desire intertextually. They, like Fox (1993), explore Cixous, but draw out her siting of desire within pleasure.
This positive investment is a tangible force rather than an imaginary one, as demonstrated by the clients' words and my own journal entries and observations.

The gift relationship is enhanced, rather than made possible, by the space that it occupies. That space is the client's home. It brings into being the 'politics of care' in the home and community.

It is worthwhile to note, at this point, that the nurse does what the client cannot do at first, and then, by every effort possible, attempts to bring the client to the point where they can do it for themselves or a family member can do it. Now the desire of the gift is relational, and at that point where the relationship is first established, there may be that oppositional construct of power-knowledge. Furthermore, it may continue for those people who are without family support and whose illness or age prevents them from being able to do it for themselves. Therefore, oppositional
constructs exist in a moving relationship with each other. Desire and the gift exist in that 'in-betweenness'. This 'in-between' space is one which negates the relationship of control, inscription and repetition.

Sarup (1993:93) suggested that Deleuze and Guattari (1977) have drawn on the Marxian and Freudian discourses in reference to the three concepts of 'desire', 'production' and 'machine' to construct desiring machines. 'The outward, linguistic manifestation of desire ... [is] de'lier ... [which] is an effect produced by the machinery of desire' (Sarup 1993:93) and it has a collective and social character. Sarup (1993:93) maintained that Deleuze and Guattari have adopted the slogan 'the personal is political', in that, for them, there is 'no separation between the personal and the social, the individual and the collective'.

Therefore, it is possible to conceptualise a politics of desire.

Deleuze and Guattari (1988) conceptualised desire in two forms. Firstly, reactionary states or organisations based on centralised power, hierarchy and authoritarianism. Secondly, small, loose, non-hierarchical, no-bounded organisations — 'a society of nomads' (Sarup 1993:93).

Clearly there are two poles or oppositions in Deleuze and Guattari's conceptualisation of desire.
Furthermore, Deleuze and Guattari's (1983, 1988) theory of desire, according to Sarup (1993), has drawn heavily on Lacan's imaginary, and envisions a politics of the imaginary where the political goal is to reclaim freedom and passion. On this point Sarup (1993:95) stated '[t]hey glorify the pre-symbolic stage of direct, fusional relationships, of spontaneity, of primitive, unmediated desire'.

It was also clear that Deleuze and Guattari saw marginalised groups as being connected with the pre-symbolic. And have drawn heavily on Lacan's theorisation of Oedipalization, which is the process by which society enters the individual.

Deleuze and Guattari (1988) have been critical of discourses of modernity that suppress desire and support fascism. They 'seek to precipitate radical change through liberation of desire' and therefore propose a 'micropolitics of desire' (Best & Kellner 1991:76). They concentrate however on the 'colonisation of desire ... by modern discourses and institutions' (Best & Kellner 1991:78) and unlike Foucault, who treats desire as a subtheme, they give it prime importance.

Desire is linked to the eternal return and becoming.

The eternal return and becoming

In Sarup's (1993:97) view, Deleuze and Guattari are Nietzschean, and that 'the notion of productive desire is none other than ... the will to power'. Deleuze and Guattari have rejected fixed modern forms of identity as repressive. They conceptualise desiring nomads in a 'constant process of becoming and transformation' (Best & Kellner 1991:77).

It is more than mere movement, it involves positive change.
Time is non linear for Deleuze and Guattari (1991), and seems to hold the idea of movement along a curved plane. Again, they have drawn on Nietzsche, and have suggested that the eternity of becoming is similar to Foucault's 'outside-interior' (Deleuze and Guattari 1991:113). Past, present and future become enfolded into one when they posited that the 'actual is the now of our becoming ... and the present is what we are ... and what we are already ceasing to be' (Deleuze and Guattari 1991:112).

Nietzsche had drawn on the stoic philosophy of courage in the face of the ravages of life, where the eternal return was modelled on the evolution of the cosmos. Therefore, being is the will to power in the face of adversity (Sautet 1990).

For Cixous, however, the return is not a repeat of the same, but another or different passing. And like Deleuze and Guattari (1991) the return is, 'between already and not yet' (Sellers 1994:215).

Becoming was a phenomena for both the carer and the cared-for.

Drawing together the subject, desire and becoming Best and Kellner (1991:79) stated that Deleuze and Guattari attempted to theorise a dynamic world of becoming, comprised of desiring 'intensities' and non-totalisable multiplicities'.

There have been those critical of the work of Deleuze and Guattari, for example Jardine, Irigaray and Braidotti (Grosz 1994). Grosz (1994) identified their major issues of concern and these are summarised here.

Firstly, there was Deleuze and Guattari's (1983, 1988) conceptualisation of the subject (which they inherit from Spinoza). Most importantly, in terms of the
subject as a rhizome, there are inadequacies concerning the subject's: doing, performing, transforming, becoming, and its linking with others (Grosz 1994:165).

While I have rejected the metaphor of the rhizome I have appropriated some aspects of Deleuze and Guattari's (1988) subject.

Second was Deleuze and Guattari's 'active, affirmative conceptions of desire' (Grosz 1994:165). The inconsistency is, while there is a positive conceptualisation noted above, desire is also fulfilled by practices of separation (Grosz 1994).

I have maintained the notion of desire as a generous gift of positive mutual investment, rather than separation.

Nurses and their clients in the research spoke about friendship and being like a family member.

McMurray (1993) is one of the few Australian nurses to identify friendship as a feature of rural nursing practise. Although she did not differentiate between rural community and hospital nursing within this comment, she suggested that nurses in country areas 'work patiently becoming accepted as a friend and community member' (McMurray 1993:2).

Fox (1993) has spoken about a 'quasi-familial model' of relationships and warned about territorialisation and the 'oedipalisation of care'. In the family
model articulated by Fox (1993), dependency relations are common, and the medical gaze reframes family life into a more normative style.

On the other hand this present research has described a form of relationship which is created intersubjectively, which resists territorialisation and codification. It has also made visible the invisible, and uncovered both the micro and macro aspects of the politics of relationships. A new conceptualisation of care is put forward which is empowering and facilitative rather than creating dependency. While the expert may be capable of an exploitative, disempowering, controlling and repetitive relationship, this was not the case in this research. Furthermore while policy rhetoric may deny a 'market in care' (Fox 1993:118) the context of care uncovered in this research enabled those cared-for to have the level of health they wish to have inscribed on them. The nurses as subjects wove a web that intertwined continuity of care with PHC in an organic way. This is exemplified in the way time was allowed for trust and rapport to develop.

Walker (1995:161) has argued that nurses have been seduced by a 'mode of desire' which is proper (controlling and disempowering) rather than a gift (empowering and facilitative). Furthermore, it is a 'mode of desire' which invests in the knowledge of the powerful 'other' — medicine and medical scientists (Walker 1995:161). Clearly, nurses in this research have rejected the proper and have sought to rebalance the investments in PHC and allopathic medicine, thus disempowering the knowledge base of the powerful 'other'.

Concluding thoughts

The question to ask is: What meanings can be discerned from the in-between space? The in-between space was contextualised by movement and nodes of rest. It was a metaphorical space that contained the lines of a web that held individuals and the community together. These lines are similar to Deleuze and Guattari's (1988) lines of flight, which are the tracks of wandering nomads. The in-between space also contextualised mutually realised interpersonal relationships which were positively invested for nurses and those they cared
or. This was the gift relationship of compassionate friends. It was also the space of the politics of care and desire which interrupted territorialisation by the power of knowledge and expertise.

The following chapter discusses what shaped the research. It deals with important questions of rigour and ethics. Following that, Chapter seven explores my reflections on methodology, methods, representations, sense making and the fertile ground for further research.
Chapter Six

Shaping the Research
How should interpretive methodologies be judged by readers who share the perspective that how knowledge is acquired, organised, and interpreted is relevant to what the claims are? (Altheide & Johnson 1994:485).

The question of rigour

Answering the above question requires an exploration of what it was that shaped the research, or caused it to be as it is, and the bases on which it can be decided that this research is worth taking note of. Two major areas that shaped the research will therefore be covered in this chapter. Firstly, the limitations concerning questions of rigour. And, secondly, the epistemological and ontological questions of ethics that shaped the research.

As Glass (1994:145) has so aptly stated, 'all research attempts to present credible finding, all methods must ... [undergo]... critical appraisal and be subject to ... [an] ... evaluation of rigour'.

While this may be so, it is worthwhile noting that I have undertaken, in the
writing of this chapter, to assure myself that, within my own frame, this research has met the requirements of an acceptable postmodern feminist ethnography. On the other hand, it is the reader who will ultimately make sense of what the text means.

Before beginning that task, however, it is incumbent on me, in keeping with the methodology, to critique the whole question of rigour in qualitative research.

Deterritorialising research rigour

Working in the postmodern paradigm demands that the notion of rigour itself be critiqued. Such a move would alert us to the notion of the discourse of 'good research', where questions of rigour become framed as dogma. Furthermore, the need to adhere to dogma then becomes the mechanism of power and control by which certain types of research become accepted as contributing to the body of knowledge, while others are excluded. Rigour as dogma, then, becomes the gatekeeper of accepted knowledge.

Should postmodern feminist research therefore be concerned with questions of rigour? In other words, is it inherently contradictory to be interested in such issues?
To answer these questions, I will firstly explore notions of realism and anti-foundationalism and the implications these notions have for the Crisis of Interpretation and the Crisis of Representation (Lather 1993; Denzin 1994b). Then, the question of rigour in post-positivist research will be considered first, followed by a discussion contextualised in the methodology of this research.

Anti-realism

Why do some postmodernists propose that it is difficult to differentiate the 'real' from the 'unreal'?

The answer lies in beliefs concerning reality.

While postmodernists do not deny reality, they do suggest that 'existence is not observed uniformly or identically' (Natoli 1997:21). Reality has to do with representation. What we realise or observe as represented takes place within the context of what it is we attend to; this then frames our reality. Natoli (1997:24) referred to this as 'stories in motion', meaning that reality is within us. We communicate most effectively when we share a common narrative frame. Atkinson (1990:62) refers to this as a 'shared reality'.

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The belief in a common frame, however, can be fabricated just as much by the scientific community as it can by politicians and the media.

Multivocality, as one example, threatens the idea of a common sense of cultural reality and cultural truth.

**Anti-foundationalism**

The move into a post-positivist era was characterised by an anti-foundationalist approach which questioned the stability of knowledge production across varying contexts; researchers; and methodologies. Anti-foundationalism questions truth as it is constructed within a realist framework, as being out there waiting to be discovered. While the more extreme postmodernists would reject any possibility of truth, the less extreme would admit to a possibility of 'local, personal and community forms of truth ... which hold at a specific place and time' (Rosenau 1992:80).

**The crises of interpretation and representation**

Anti-realism and anti-foundationalism are linked to the crises of interpretation and representation. For Denzin (1994b:500), 'nothing speaks for itself ... there is only interpretation' which makes sense of what has been discovered.

*The researcher's role, therefore, is to translate this information in a text which will communicate their own understanding of what has been uncovered.*

This view reflects a 'crisis of interpretation' in which post-structuralists and postmodernists have challenged the positivists' and post-positivists' privileged position in determining the criteria for judging 'good' research.
This challenge is framed by several arguments. Firstly, the recognition that the criteria for judging the adequacy of any interpretation will vary with each community of scholars. Secondly, the need to make room for marginalised voices. Thirdly, the need to accommodate feminist and critical social science criteria. And fourthly, the argument that writing and fieldwork cannot be separated. Therefore, according to Denzin (1994b:501), the evaluation of interpretive validity is 'political, personal, and experiential'.

Denzin (1994b) has suggested that interpretation begins with a field text (notes, documents) which forms the research text which is then recreated as an interpretive text (initial attempts at sense-making) which becomes, in some cases, a 'quasi-public text' by being shared with colleagues and a public text when published in a journal.

Translating the field to text is therefore a complex reflexive process.

'Good' writing, therefore, may be considered to produce 'good' interpretation and hence 'good' sense-making.

On the other hand, the rules for determining what is 'good' are no longer clear within postmodern/post-structural challenges and interrogations of knowledge production.

Denzin (1994b) is insistent that story telling is interpretation but that stories differ depending on the paradigm/perspectives. Each perspective gives the 'writer a public identity' (Denzin 1994b:502) and has its own problematic writing style which imposes order or structure on the account.

Every writing genre therefore has its own laws of truth. Truth for Denzin (1994b) is a textual production.
Furthermore, Lather (1993) contended that we are in an inscriptive era which has challenged narrative realism and, furthermore, has supported alternative forms of presenting and authoring texts.

Denzin (1994b) has identified important representational issues that could be considered as criteria of rigour.

I have represented these issues in the form of questions.

Issues of voice
Are there first and third person statements?
Does one voice talk over the other?
Is multivocality accommodated?

Issues of legitimation
When scholarly work is made into a public text, then this work makes a claim to authority. In foundationalist terms, this claim depends on measures of rigour such as reliability, validity, and generalisablity. However, a 'postmodern sensibility' (Denzin 1994b:504) rejects foundationalist authority and, instead, the claims of rigour depend on asking:
Is this a local account?
Is this a personal account?
Are the micro and macro politics discussed?

Issues of desire
Desire in this context refers to decisions about what will be written. Therefore, is the text:
Vital for the writer and reader?
Pleasurable for the writer and reader?
An act of discovery for both?
(Denzin 1994b:504).

Boring texts are science-based voices from everywhere. However, Denzin (1994b:505), referring to Carver (1989:24), warned that 'experimentation is not an excuse or a "licence to be careless, silly, or imitative"'.

With the above warning, I was brought to the point of asking if this work was trivial, silly or imitative. My panic begins to resurface. And, in an effort to be serious and rigorous, I will now explore rigour in the context of qualitative research.

Qualitative research

Researchers situated within the positivist paradigm have suggested that rigour is difficult to achieve in non-experimental research. Scholarship within qualitative research over the past 15 years, however, has extensively challenged this view (Reason & Rowan 1981; Guba & Lincoln 1989; Dick 1990; Merriam 1990; Lather 1991; Hammersley 1992c; Lather 1993; Wolcott 1994; Appleton 1995; Worrell 1996).

While this may be so, notions of rigour vary extensively with the paradigm in which the research is situated (Lather 1993).
Sandelowski has suggested that the concept of rigour as it is usually used is contradictory to the essence of qualitative research and that there is a need to adhere to the 'spirit of qualitative work' (1993:2). Her view is that validity has been reduced to a set of procedures. It is the social processes that validate and define the work of science, and the worth of scientific endeavour is determined by different groups of researchers. The concept of validity is therefore a theoretical issue rather than a technical one, and the determination of trustworthiness is a matter of judgement as to what constitutes 'good science'. She stated:

\[
\text{The social discourse on reliability ... is better understood as a particular way of warranting validity claims, rather than as a universal or abstract guarantor of truth (Sandelowski 1993:2).}
\]

While Sandelowski (1993) concluded that the need to establish reliability in qualitative research may weaken validity, Altheide and Johnson (1994) saw the move away from positivism and therefore reliability to be a feature of the reflective and reflexive turn in qualitative research during the 1960's and 1970's.

Researchers such as Lather (1993); Altheide and Johnson (1994) and Wolcott (1994) consider validity to be the main conceptual approach to judging the worth of research. For Altheide and Johnson (1994:486), this is based on their view that the 'social world is an interpreted world, not a literal world'; therefore, the possibility for replication is significantly framed by the perspectival lens of the researcher (Denzin 1994b).

In Sandelowski's (1993) case, the emphasis on validity is based on her ideas concerning phenomenology. In particular she believed that one of the main
problems was the assumed relationship between validity, reliability and the notions of reality. While those within positivist paradigms may view reality as 'external, consensual, corroboratory and repeatable', this is not the case when reality is conceptualised within the 'naturalistic/interpretive paradigm' (Sandelowski 1993:3).

In other words, two researchers dealing with the same question will not end up with the same results. This is based in the differing philosophical and theoretical positions that they both may hold.

In support of this, Sandelowski stated:

The idea of empirically validating the information in one story against the information in another for consistency is completely alien to the concept of narrative truth and to the temporality, liminality, and meaning-making function of stories (1993:4).

Further to this Sandelowski (1993) cited Bloor's (1983) warning that the decontextualisation of one story does not constitute a validity test. Hammersley (1992c) has taken a realist view and has spoken of validity in terms of an accurate presentation of what was intended to be put forward. He therefore equates accuracy with truth.

If, however, an anti-foundationalist approach is accepted, then validity depends on the community which interprets or the audience that reads the research.

For Altheide and Johnson (1994:488) this has meant that either the notion of validity be abandoned altogether or that it be radically reconceptualised into what they have referred to as a 'hypentated approach'.
These researchers have reviewed the concept of validity in the literature and have suggested that 'tests' of validity in relation to ethnography can be categorised within the following notions.

1. 'Validity-as-culture (VAC)'. This is the notion that ethnographers should clearly name their own cultural position.

2. 'Validity-as-ideology (VAI)'. In this case, as well as naming the culture, the ethnographer must also clearly emphasise the nature of structure and agency within that culture.

3. 'Validity-as-gender (VAG)'. Power imbalances situated within gender relations should be clearly articulated.

4. 'Validity-as-language/text (VAL)'. This particular criterion cuts across the above and emphasises the role of language as discourse which frames the research.

5. 'Validity-as-relevance/advocacy (VAR)'. Requires that empowerment be a feature of the research.

6. 'Validity-as-standards (VAS)'. In this case there is an emphasis on understanding rather than the theorising of information.

(Altheide & Johnson 1994:488)

However, Altheide and Johnson (1994) have rejected the above approaches and also those which would construct validity as truth. Instead they have offered another hyphenated approach which takes a post-positive but humanist approach.

7. 'Validity-as-reflexive-accounting(VARA)'. In this test of validity everything associated with the research is considered to be framed by interactions. There is a focus on a reflexive account of the ethnographer and the ethnographic processes. It considers a pragmatic, interpreted world, rather than a literal one. There is a rejection of a dualistically constructed real/ideal world with an emphasis on findings produced through communication. Therefore their
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criteria for 'testing' validity are: plausibility; credibility; relevance; and the
importance of the topic. Furthermore, the ethnography should allow for
multiple cultural voices situated in time/space/place/ and cultural experience;
should accommodate tacit knowledge and account for ourselves as researchers;
and should utilise a form of representation that is consistent with the chosen
methodology (Altheide & Johnson 1994).

Although speaking about phenomenology, Rose Beeby
and Parker (1995) considered that the consistent
application of methodology and the avoidance of
method slurring can contribute to the maintenance of
rigour.

Method slurring is considered to mean an inappropriately applied method
which leads to methodological inconsistency. For these researchers, credibility,
consistency and congruence are acceptable measures of rigour.

Jayne Beeby's analysis of her own research
identified her problem with 'method
slurring' (Rose Beeby & Parker 1995),
which has some relevance for this present
research.

Beeby chose to examine caring by in-depth interviews with nurses and
observation of the same nurses at work, and matched what they said with what
they did. However, she concluded that the 'two sources of data [were]
incompatible' (Rose Beeby & Parker 1995:1126). She had in fact been trying to
do methodological triangulation, but found this incompatible with
phenomenology.
In the present research a similar triangulation may appear to be present. That is, the research design included interviews with nurses and clients, and participant observations of these groups both individually and together. However, what I was attempting to create was 'thick' description rather than triangulation.

From another perspective, understanding is validity for Wolcott (1994). However the question for him is, 'How valid is valid enough'? (Wolcott 1994:370). The difficulty in answering this question means that, for Wolcott (1994), validity is not a helpful criterion for judging qualitative research.

Moreover, he contended that it is a fear of inconsistency and 'not getting it wrong', rather than our concern for validity, which causes us to 'stiffen' our ethnographic writing (Wolcott 1994: 338, 347).

Wolcott (1994) echoed Denzin (1994b) when he described moving from description to interpretation as moving to a point of understanding. Therefore, getting it right means:
1. Talk little and listen a lot.
2. Record accurately.
4. Let the readers 'See' for themselves - 'include primary data'.
6. Be candid and include feelings and judgements.
7. Seek feedback - share with colleagues.
8. Try to achieve a balance in what is reported.
9. Write accurately and coherently.
(Wolcott 1994: 348-354)

The most relevant style of qualitative research for this particular study is feminist research. The following conversation explores the characteristics and therefore questions of rigour for this style of research.

Worell and Etaugh (1994:445) have reviewed the feminist research literature and stated:

In the area of feminist thought, the lines are finely drawn in attempting to distinguish where one discipline begins and the other ends ... It should be clear in the list generated below that feminist scholars, while disagreeing on many points, have converged on an interconnected set of viewpoints, beliefs, and values that can transcend any particular discipline.

In a later work Worell (1996) suggested that the following themes characterised feminist research. If these characteristics are accepted, then meeting the
following criteria would be a test of rigour. From this feminist perspective, then, research should:

1. Question the traditional scientific beliefs of objectivity and value free research.

2. Be concerned with the experiences of women which allow diversity within the category 'woman' and explored issues of relevance to women, and be affirming of woman.

3. Deal openly with power imbalances and hierarchy, and seek empowerment of all involved in the research.

4. Recognise gender as socially constructed and therefore accommodate multiple constructions of gender.

5. Deals with language as text.

6. Be orientated 'towards social and gender justice'.

(Worell 1996:476)

Hall and Stevens (1991) are two nurse researchers whose writing on rigour and feminist research has been referred by others in an effort to determine the worth of this style of research (Glass 1994; Walter 1998). They have identified features similar to those identified both by Worell and Etaugh (1994) and Worell (1996). Moreover these researchers collapsed validity and reliability into:

1. A continuous standard of adequacy. The criteria postulated to measure this standard are 'research processes and outcomes [that] are wellgrounded, cogent, justifiable, relevant and meaningful' (Hall & Stevens 1991:20).

In other words, do the results accurately reflect the phenomena the researcher claimed they did? This is similar to Hammersley's (1992) idea of validity.

2. The standard of reflexivity. The criteria of measurement are: Is there an integrative linking of ideas; are values made explicit; is theory as ideology obvious?
Also, are initial member validations used to provide a measure of authenticity?

3. The standard of rapport. The criteria of measurement in this case are related to a recognition of a need for sensitivity to language, feelings and relationships; a depth of information sharing; and a concern for participants' comfort and opinions.

In other words, is there an appropriate level of trust?

4. The standard of coherence. The measurement criteria here relate to the level of unity within the research account.

In other words, are major inconsistencies absent from the research?

5. The standard of complexity. The criteria here are: Does the research take account of everyday life; social and political structures; and history?

In other words, is the research a contextualised, rather than a decontextualised, account?

6. The standard of consensus. Here the criteria are concerned with the presence of recurring themes.

In other words, are there continuities and discontinuities?

7. The standard of relevance. The criteria relate to whether the research supports the interests of the participants.
In other words, does it aim to improve women's lives?

8. The standard of honesty and mutuality. These criteria are related to ethics. Does the research deal with power imbalances and avoid deception?

In other words, is it democratic and non-hierarchical?

9. The standard of naming. In this case, the criteria requires that participants' verbatim stories be presented as 'data'.

In other words, are active voices present?

10. The standard of relationship. Here the criteria are related to the need for a dialogical approach to knowledge production.

In other words, is there collaborative and participatory knowledge development?

In a discussion that contained elements of the postmodern and that linked rigour and ethics in feminist ethnography, Stacey (1991:16) contended that:

While there cannot be a fully feminist ethnography, there can be (indeed there are) ethnographies that are partially feminist, accounts of culture enhanced by the application of feminist perspectives. There also can and should be feminist research that is rigorously self-aware and therefore humble about the partiality of its ethnographic vision and its capacity to represent self and others.

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The above discussion has explored the rejection of criteria of rigour such as reliability, generalisability, and grand truths and theories. It has moved to a discussion of validity in terms of a crisis of representation and interpretation. Furthermore, validity as an acceptable measure of rigour in qualitative research and its rejection as a useless criterion which should be replaced by understanding was explored. The contribution of feminist constructs of validity was also explored. This move was based on the contribution feminism has made to the present methodology, together with the utilisation of a hegemonic (realist) analysis of the 'data'.

Given the above exploration, I am more convinced by those who would reject foundationalist criteria and propose anti-foundationalist criteria within the notion of validity as an appropriate 'test' of
rigour. Therefore what follows is an exploration of validity in the context of this research.

Validity and postmodern feminist research

As I have suggested in an earlier work (Davis 1993a:205), tests of rigour have been based on notions of 'multiple truths, honesty, responsiveness, reflectivity, ... contradiction, transferability, consistency, and credibility'. Furthermore, notions of transformation, iterative cycles and triangulation has been put forward by Lather (1991) as considerations when determining the validity of praxis-orientated research. The question here is: To what extent are concerns for validity relevant to postmodern feminist research? Is it merely a matter of applying criteria that, in the past, have been utilised in the evaluation of ethnographic work? Lather's (1992b:93) answer to this would suggest that this is not possible, for she saw 'feminist postmodernists [as] part of the "rhetorical turn" in social science ... which is critical of enlightenment assumptions'.

On this matter Clifford has stated that a 'rigorous partiality' that, rather than leading to relativism may lead to 'more subtle, concrete ways of writing and reading' (1986:25) which traverses disciplines, needed to be considered.

Stacey (1991) also echoed some of the above thoughts. She contended that the trends in post-structural and postmodern ethnography have much to offer feminist ethnographic research. The main features of a critical postmodern ethnography were 'critical', 'self-reflexive', and rejecting of the 'hierarchical and power-laden relations' in the representation of ethnography (Stacey 1991:115). Further to this, Stacey (1991) cited the collaborative and subjective nature of the research relationship and the willingness to openly discuss the
distortions and limitations of the authoritative voice. She challenged researchers to construct modes of representation which gave equal voice to others. And which recognised partial notions of truth.

Examining validity further, there are echoes of Wolcott (1994) in Denzin’s assertion that 'clear descriptions, as defined by the genre, provide the basis for interpretation, understanding and verisimilitude' that the reader can 'live their way into' (1994b:505,506).

However, descriptions can be replaced by inscriptions and territorialisation.

Thin descriptions report facts, independent intention or context, while thick descriptions contain the 'context of experience' and 'state intentions and meanings' (Denzin 1994b:506). According to Denzin (1994b:506), '[a] text and the authors authority can always be challenged' because:
1. inscription can occur in different ways
2. all texts are biased
3. 'interpretive criteria and text can always be questioned'( Denzin 1994b:506).
Therefore, what is important is the logic of the texts. Texts therefore should consider the:
1. real world of lived experience/representation in the text
2. text /author (1st/3rd person)
3. lived experience/transcription
4. subject/intentional meanings
5. reader/text.

In the post-structural feminist interpretative style there is an emphasis on:
1. 'researcher and textual reflexivity'
2. action/praxis
3. affective emotional component
4. grounding in everyday life.
(Denzin 1994b:510)
If theory is interpretation, it can therefore be read as 'theory-as-criticism'. Criticism and theory therefore cannot separated.

Other ethnographers such as Hammersley (1992), who has taken up a subtle realism position, are critical of the position taken by Denzin (1994b) and Lather (1993). He has argued that there is no way to evaluate work within a postmodern frame, and that this type of framing imposes an interpretive frame that does not allow the voice of the participant.

However, I would argue that this view reflects a lack of understanding of the postmodern sensibility and post-structural criteria that answer a different set of problems.

Denzin (1994b:511) has argued for a 'morally informed social criticism [which is] humane, caring, holistic and action based ... celebrates uncertainty ... lets prose speak for itself ... [and is] sensitive to voice and multiple perspectives'. Lather (1993:674) has stated:

*Fragmenting and colliding both hegemonic and oppositional codes, my goal is to reinscribe validity in a way that uses the antifoundational problematic to loosen the master code of positivism that continues to so shape even postpositivism.*

In doing this Lather (1993:683) proposed four validity frames within what she has called 'transgressive validity'. These are:

1. Validity as irony: Here the criteria are: that truth and realism is viewed as problematic; research generates practices which account for the crisis of representation; and research utilises a doubled analytic practice which does not
block understanding. In an earlier work Lather (1992b) utilised four different tales to tell the story of the research. These were juxtaposed realist, critical, deconstructive and reflexive narratives which formed a 'playlet' (Lather (1992b:93).

2. Validity as paralogy or neo-pragmatism. Here the criteria are; 'openness to counter-interpretations'; using member checking and 'peer debriefing' (Lather 1993:679); the utilisation of textual strategies which juxtapose voices, thus destabilising the authoritative voice; and allowing us to recognise difference and marginality. Moreover, the research should encourage difference and heterogeneity; be concerned with justice at a local level; take account of 'undecidability, limits, paradoxes, discontinuities, complexities' (Lather 1993:686); and identify the oppositional in everyday life.

3. Rhizomatic validity. This is used as a metaphor for Deleuzean rigour and is the creation of a questioning text which is partial, tentative, disruptive of stable meanings, creative, and playful. Moreover it should 'unsettle ... from within' and 'generate ... new locally determined norms of understanding', and 'proliferate ... open-ended and context-sensitive criteria' (Lather 1993:686).

4. Situated validity. Here the criteria concern 'risky ... engagement and self-reflexivity' (Lather 1993:682); the construction of a text which is questioning; and the merging of ethics and epistemology.

Some of the above discussion drew on ethical criteria as a measure of validity. I too, like Lather (1993) and Stacey (1991), have taken the view that valid research is ethical research and now wish to explore this aspect of the research and its representation.

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Ethical constraints

Particular ethical and political dilemmas arise in representing the lives of people who are marginalised within, and by, the domain of public knowledge. In order to remain critically self-aware about the decisions we take as researchers we need to be able to make explicit both the nature of the dilemmas we face, the losses, as well as the gains, that result from our decisions (Alldred 1998:147).

The following is an account which attempts to bring together epistemology and ethics. Both the section on research ethics in Chapter Two and the previous section in this chapter on validity demonstrate clearly the epistemological and ontological influences on the ethical framing of this research. While these previous sections focus more on epistemological issues, the aim of the following exploration is focussed more predominantly on the ontological and representational aspects.

The constraining ethical aspects of the research included the consideration of the
anonymity of participants, especially where this related to representation of findings. Also, my ability to accompany nurses in their work with clients in their homes was limited by what was considered to be possible excessive exposure to confidential health-related material in this context.

I intend to approach this discussion by examining the research design, the research processes in the context of the above questions, and the research outcomes.

Doing the research

The posing of a series of questions concerning ethical consideration would recognise the dynamic, reflexive nature of the ethical context and would contribute to the construction of research as ethical praxis.

In other words, what type of ethical theory and practice has evolved while conducting this research? And in what way has this then shaped the research?

The research design

As mentioned previously, the original design of this research intended to include
women's health nurses as one of the participating groups. In fact, ethics approval was gained from the Area Health Service with this group included as research participants. On approaching both the Director and Manager of Primary Health Care Services for permission to conduct the research, the inclusion of this group of nurses was denied; however, inclusion of the generalist community nurses was approved. At about the time that I began this research, and unknown to me at that time, an inquiry was about to be launched by the NSW Health Department. This inquiry was to examine the client reporting practices and records of cervical screening results by women's health nurses. It was thought that legal proceedings could eventuate.

What options were then available to me?

As ethics approval had been given by the
Area Health Ethics Committee, I could have chosen to interview this group of nurses outside of the work situation, as private citizens. On the other hand I could wait for the media reports to be released and any court proceedings to be completed and then deconstruct the texts. Although I was being supported and encouraged to pursue one of these courses of action I decided to consult as widely as possible before making any decisions. I chose to speak to academics and practitioners in the area of law and criminal justice. The outcome of these discussions can be summarised in the following way. If I chose to talk to women’s health nurses as private citizens then there was a possibility that any information (data) that I collected could be subpoenaed as evidence in any court proceedings. While that could have been beneficial it may also have had some negative outcomes for those involved.
including the participant, the university at which I worked, and the university at which I was enrolled as a student. As harm on several levels was a possible outcome, proceeding with this option did not sit well with the ethical constructs of this particular research.

The second option of waiting for media and court proceedings texts to become available seemed logistically difficult for two major reasons. Firstly, there was minimal media coverage as all parties involved were anxious to prevent publicity concerning the situation. Secondly, legal proceedings in this country have historically taken an extensive time to commence and be completed, and this fact had the potential to excessively extend the time over which the research was conducted. I decided that this could possibly be post-doctoral work.
In summary, then, the decisions placed an emphasis on value-rational action and the consideration of power.

I would gain but others could lose.

Furthermore the decisions considered the avoidance of manipulation and control, and were supportive of harmonious, non-hierarchical, non-dualistic intra/interpersonal relationships that were caring and growth-oriented.

On reflection I had to acknowledge that I was unwilling to manipulate the situation and would need to be content with a modification of the research design, although this would have significant consequences in terms of the chosen methodology.

The research processes

There were several major issues that arose during the fieldwork that modified some of the research activities. Firstly, visiting the homes of clients as a participant observer and not a practitioner. I initially wanted to be in the field with the community nurses, going with them each day to gain a sense of what it was like for community nurses 'on the road' and in people's homes. On the first day the nurse I was to
accompany each of her clients, explained what I was doing, and asked for their permission for me to accompany her during her visit. After one day of this I was prevented by management from any such further activities. I was restricted to one client/nurse interaction for each nurse who was a participant in the research. The given-basis for this was consideration of the privacy and confidentiality of the clients. It was further aimed at reducing the workload of the nurse, in that she/he would not have to take the time to gain client approval of my visits, apart from the one session. Unfortunately, I could not contact the clients myself to reduce the nurse’s workload, as confidentiality requirements prevented me from knowing who was receiving care. Apart from the one person each nurse contacted for permission to visit, I was not allowed to know 'who was on the books'. Strategies of
containment were evident in the following fieldnotes.

'Mikalia [a nurse manager] asked to see me today and she voiced some concern about not feeling involved in the process of what was happening and therefore not knowing exactly what I was doing.

She rechecked with me that what we had originally arranged to happen was happening as planned. I explained that my time with Gayle today was an orientation day. That I was attempting to become familiar with what a community nurse did on a particular day and to give myself some sense of what it feels like to be a community nurse.

Mikalia seemed anxious to establish that, having done this now, there would be no need to repeat it.

To allow her to feel more in touch with everything, we decided on the following – that I would:
1. meet with her of a Monday around 09.00
2. check in with her on Friday and let her know of any changes or what was happening or leave a note if she was not there
3 leave a roster type form for people to let them know when I was available'.

Therefore my understanding of the work of community nurses is derived from being 'on the road' with one nurse for one full-day caseload; interviewing and travelling with
each individual nurse to the client's home, and a participant observation of the client/nurse interaction, and then an interview of the client; participant observation of the tearoom activities and meetings; and interviews with two nurse managers who did not, at that time, have a client load.

The other major issue I found was that all of the clients, with the exception of one, were decidedly uncomfortable with being tape-recorded during our interview, and all but one refused me permission to do so. The taking of notes during the interview was considered the most comfortable option both for myself and the clients. As much as taping would have captured more of the emotional components of the interaction, and although paying attention to this in my notes, I am sure that some aspects have been missed.
The third issue was one associated with the form of the 'interview'. The choice of conversation or dialogical method was a deliberate ethical move. It was considered that this form of interaction was supportive of harmonious, non-hierarchical, non-dualistic intra/interpersonal relationships. Also, as each conversation was reflected upon before the next one commenced, issues raised previously could be discussed in each forthcoming conversation. In this way the activities of the research established a closeness within the interaction and a mechanism for self-reflection and self-reflexivity.

The fourth issue concerns anonymity. All of the nurses were deeply concerned that what they said should not be able to be identified. While I had no deliberate intention of them being identified, the problem posed here was the nature of small rural communities. I had originally
planned, in keeping with the methodology and ethics of postmodernism, to represent the data in narrative form. The problem was that, while readers from outside the area might not recognise individuals, those readers situated within the geographical area could be provided with such thick description; be so familiar with some of the stories and signposts within specific locations, that they would be able to 'recognise the speaker'. My dilemma then became, how could I represent the data in a methodologically consistent form and respect the participants' privacy and anonymity? Certainly the use of pseudonyms would reduce the risk; however, having stated that I was using them would only mean that any reader could ignore the name and still be able to recognise the speaker. The need to revisit the method of analysis became apparent, therefore, and the deconstructive method employed in
chapters three, four and five represent a deliberate move away from narrative or story into a form of representation that reduces considerably the chance of recognition of the speakers.

Fifthly, the decision was made to return a paper copy of the transcribed tapes to the participants. There were several aims associated with this activity. The participant was asked to check the material for accuracy; to clarify any information they felt was inadequately conceptualised; to respond to sections where I had been unable to transcribe the tape because of technical difficulties, (for example, background noise); and to remove any information that they no longer wished to have recorded or which they felt could identify them.

Sixthly, the decision to structure the thesis utilising several voices was a deliberate move to construct the text utilising a form
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that tells a story and is accessible to a range of readers.

In terms of the research product Stacey (1991) conceived of a disjunction between the practice of fieldwork and the reporting of the research. This is conceptualised in notions concerning voice, authority, intention, interpretation and representation of the research. She contended that 'inequality, exploitation and betrayal are endemic to ethnography' (Stacey 1991:114). Although she noted that representation of the research can be negotiated with the participants, she also believed the problems raised above are contradictory to feminist principles of research.

The outcomes
Stacey warned that 'the greater the intimacy - the greater the apparent mutuality of the researcher/researched relationship - the greater the danger' (1991:114) that the ethical context could be severely compromised.

While this may be so for some researchers, the carrying out of this research was based on the establishment of trusting, non-hierarchical, non-dualistic interpersonal relationships where the sharing of knowledge and skills was an unexpected outcome.

In other words, there was equality and power sharing.
For example, occasionally, in a client interaction, mutual respect was demonstrated when the nurse would ask my views on certain therapeutic issues. During and since completion of the fieldwork I have become a resource person for the participants. I have been involved in a number of situations, some of which include consenting to be a referee for grant applications and programs of study; assisting in the development and analysis of a research project undertaken by some of the participants; and providing advice concerning choices in further education. A long-term outcome has been the involvement of one of the nurses in education sessions in the undergraduate nursing program. The following field note entry records some of these activities. Mikalia had asked my advice about the analysis of a research project she and others were working on:
'I spoke with Mikalia today about the health needs survey project and suggested it would help if the responses were set up in such a way that an analytic computer package like Statview could be utilised. I also said I would be happy to help her but she said that the health department had some software and staff she could access'.

At another point I noted:

'Ann rang yesterday and asked about the naturopathy programme, and I managed to drop some information off to her today. While I was there she said that she was interested in doing some workshops for the students on 'Drink Stop', as part of her health education/promotion project for the year. I said I would contact her when the timetable was out. She is very enthusiastic about it and I believe it will be an excellent opportunity to have clinician involvement in the Primary Health Care module'.

After the fieldwork was completed and I was continuing the writing of the thesis, I had the opportunity to meet up with Rachel at her Bachelor Degree graduation. That evening I made the following note, which I added to my transcriptions.
'It is important that a mutual exchange occur and that I am not just taking from them but also giving back something in return. I spoke to Rachel at grad. today about getting together and working on a short story or book. We both love story telling, and I think we could work together. It would be a very exciting outcome'.

In an analysis of the ethical context of her own ethnographic research, Stacey (1991) was of the view that the context of interpersonal experientiality of ethnography raised issues of betrayal of trust and manipulation. She also referred to the intrusive nature of fieldwork and the freedom the researcher had to enter and leave the 'system of relationships' (1991:113), thus creating an imbalance in the power relations. Stacey is firm in her belief that this is so unavoidable that most researchers tend to see it as no more than 'grist for the mill' (1991:113). And she stated:

This and other fieldwork experiences forced my recognition that conflicts of interest and emotion between the ethnographer as authentic, related person (i.e., participant), and as exploiting researcher (i.e., observer) are also an inescapable feature of the ethnographic method (Stacey 1991:114).

Letting go was not easy. I can only say that it would have been made even more difficult had I not had to return to work after taking six months leave to complete the fieldwork. The sudden immersion in a heavy workload that left little time to write
or revisit the field was frustrating and disruptive. Although contact with nurse participants was maintained for several years, it was slowly reduced to intermittent as time past. With regret, the sheer weight of commitments prevented Rachel and I from ever being able to 'write' our stories, and that has been one of my greatest disappointments.

Stacey (1991) raised the problematics of withdrawal and closure of ethnographic research. However, she also believed that 'rigorous self-awareness of the ethical pitfalls in the method enables one to monitor and then mitigate some of the dangers to which ethnographers expose their informants' (Stacey 1991:117).

Concluding thoughts

Wolcott (1994:368) has stated that 'we sometimes learn from poorly reported studies and poorly analysed ones, while seemingly truthful, or correct, or neatly analysed accounts may have no impact at all'.

With my panic somewhat subdued by Wolcott's (1994) view on 'good' research being that from which we learn, I will now explore the degree to which I believe this
research has 'got it right'. In doing so, I am also troubling the constructs of what constitutes acceptable research. Denzin (1994b:505) deliberately pushed the boundaries when he challenged us to have 'the guts to say ... [Y]ou may not like it, but here I am'. With that in mind; however, ultimately it is a question of whether the reader has learnt from what is written.

Representation

In several chapters of this thesis I have argued the case for a coherent and consistent writing of the research, one which is inherently intertextual (Game & Metcalfe 1996). The utilisation of multiple voices to create intertextuality was a writing strategy, as I suggested earlier, which I developed in the writing of my Masters thesis in 1993 (Davis 1993b). In the final chapter of that thesis
I discussed the possible perceived sense of incompleteness and unreality which I sensed with the rereading. That same sense returns to me now as I reread the voices in this present work. Is some of what is said 'out of character'? Could I have uncovered voices which more clearly represented the speaker? Is this representation one which can be reworked and reworked until finally there is some resonance which sits more comfortably? There is no doubt that time constraints dictate that it is time to let go. Continual tinkering is not a strategy that will ensure that the final product is more complete. Unlike for the fiction writer, there are boundaries and constraints.

While there is a partiality about the voices at discrete places, overall there is a sense of coherence, while there may not be a sense of completeness.

However the question is: Am I bored by the conversational writing style? I have to
say that I am not. And that I was reassured when a colleague, on reading the present work, suggested that it reminded her of the writing of the author Jeanette Winterson (1992), whose book 'Written on the Body' is one of my favourites.

Moreover, she suggested that there was a sense of discovery and an anticipation of what would be following next.

As Denzin (1994b:504) has suggested: '[w]riting, then, relives and reinscribes experience, bringing newly discovered meanings to the reader'.

While I have chosen to utilise Lather's (1993:683) 'transgressive validity' to 'test' the validity of the research, the reader may chose another.

Validity
Firstly, is there evidence of irony?

The writing strategy adopted has generated practices which account for the crisis of representation, in that multiple voices were utilised. The research also utilised a doubled analytic practice from which a third analytic
practice was developed. For example, a realist analysis followed by an oppositional analyses and a postmodern reconstruction.

I believe that these writing and methodic strategies have not significantly hampered understanding.

Secondly, in terms of paralogia or neo-pragmatism.

The invitation in the preface for the reader to record their own understanding on a page at the end of each chapter has recognised the possibility of counter-interpretations.

Although member checks were utilised they were minimal and did not involve interpretation of the interview text or field notes. While it was not intended that peer debriefing be used, this did occur on those occasions when participants suggested that they had never talked to anyone about what they raised in the interview. The use of multivocality as textual strategy attempted to destabilise the authoritative voice. And the research has significantly dealt with marginalisation, difference, justice, advocacy, discontinuities, complexities, and the oppositional in the context of the
working life of rural community nurses and members of the community.

Thirdly, in terms of rhizomatic validity.

The use of the reflective voice has opened the research up to questions and self-reflexivity.

Lather (1996) has utilised this writing strategy in her work on women and HIV/AIDS.

I have been unable to identify any work in nursing that has attempted such an approach.

Based on that, it could be accepted that this research has disrupted the accepted 'norms' of research within nursing. By creating an ironic but serious text, reliant on local contextual knowledge production, the research has avoided generalisability or grand theory. The decision not to depend on one theorist in particular to frame the interpretation was also a deliberate strategy aimed at disrupting the authoritative voice.

Fourthly, in terms of situated validity.

I believe the research is 'risky' for the reason provided above, and that self-
reflexivity is a fundamental part of the writing of the research.

And finally, the relationship between ethics and epistemology/ontology has significantly shaped the research.

One of the major concerns, however, is the question: What makes this research feminist postmodern? Grosz (1994:160) suggested that the 'key issues and concerns in feminist theory - [include] ... women's experience, subjectivity, desire, pleasure'. Methodological assumptions of postmodern feminist research have included the acceptance of a localised, contextual generation of knowledge that accepts multiple voices, multiple realities and multiple truths.

The singling out of gender as a category is the most problematic feature of this research.

While this may be so Lather's (1992b) argument is that she is concerned predominantly, not with feminist method, but rather with how research is conducted at a time of crisis in knowledge production.

I have previously discussed the design and ethical constraints. It was an unfortunate series of events that occurred in relation to this matter. While I was able to gain ethical approval to include women's health nurses in the research, the legal and ethical
issues prevented me from including this group. Moreover, the concerns related to identification of participants has restricted the emphasis on gender as a category of analysis and to some extent has limited the thick descriptions. However, again I am reassured by Wolcott (1994), who cited Geertz’s (1973) view that ‘[c]ultural analysis is intrinsically incomplete … the thicker the description the greater the doubt’.
Chapter Seven

Final Reflections
The question can be asked: How do you represent reflections on your own work and present multiple voices, rather than a monologue? The answer to this question was provided when a colleague, friend and senior nurse academic began to ask me about my research. I realised then that our conversation would become my final thoughts concerning the research and its representations. Therefore, I have transcribed our conversation, and then returned to it at a later time and added further reflections. My colleague begins:

**Shay:** 'Tell me what it is about your thesis that makes so great a contribution to the discipline'.

**Kierryn:** 'The type of contribution that the research makes is that it validates the findings of other researchers in the two areas of rural community nursing, and PHC. It has identified the general discrepancies in services in rural areas and the difficulties rural nurses have in terms of the disciplinary power of policy, the rhetoric of policy, the lack of education[al opportunities and], deskilling that have been identified by past researchers. So it validates that.'
Interestingly enough, it also seems to suggest that while all of these findings have been around for many years, as early as the nineteen eighties, very little has been done to ... deal with those sort of problems. I think NSW is making a tremendous effort in the establishment of the two chairs of nursing, one in rural and [one] in remote area nursing, to deal with some of the educational problems, ... however what this research revealed was that nurses in this study weren’t looking ... for education in rural nursing [rather] for postgraduate education on PHC. ... So, I think that it makes a contribution in terms of educational needs'.

As a group, nurses need to ensure that changes similar to those in NSW are implemented in all states. It is important that professional nursing groups respond appropriately. This is evidenced in the latest move by such groups to establish a national postgraduate curricula and accreditation for rural nurses.

'I think that NSW is making a tremendous contribution in terms of the establishment of the nurse practitioner programmes. In relationship to that, I believe this research makes a contribution to our understanding of rural nursing practice as an advanced practice. Therefore, it supports the need for accreditation by the state in terms of recognising advanced practice status. So in those areas I think the research has contributed extensively.

I think that the other major area is in relationship to identifying the continued problem of the rhetoric of policy,
and the disciplinary power of the state in determining what it is that nurses actually do in relation to PHC. Because the funding is predominantly based on the aged care HACC funding then the major work that nurses are funded to carry out is that based on continuity of care in relationship to the aged. So their ability to be able to meet the needs of the community and have either an individual or population focus, on health promotion education has been severely limited by the funding base'.

However, this is not new and researchers such as Hegney (1996) have clearly identified these issues. The more important question remains: What can be done to resist the disciplinary power of state control? And how can this be achieved?

Shay: 'One of the things I find about theses in general is that they make a great contribution to the discipline but hardly anyone ever reads a thesis. So what are you going to do about making sure that it reaches people in the discipline?'

Kierrynn: '... I think that there are two aspects to [this question. Firstly I plan to submit] the work for publication in journals and [talk] at seminars and conferences. One of the major difficulties is the style in which the thesis is written. It is a conversational style and [this style] is not always acceptable within journal publications. So the form of writing may ... need to change. ... Secondly, I have already presented a paper in relationship to some of the findings at an International Critical and Feminist Nursing Conference this
year. Obviously putting the work out at the next one coming up in 1999 in the USA would be appropriate. The other major area in terms of getting information out and creating a situation where it can have some effect. ... I have already responded on behalf of our school in the form of a report to the NRH, based on the findings of the present research. This is one way that I will [hopefully] influence the direction of national perspectives on postgraduate education for rural and remote area nurses'.

Shay: '... So the thesis has brought to light many other issues which are pressing to disseminate. I imagine that it was part of your original aim which was to investigate ...'

Kierrynn: 'The question was: What were the understandings and the everyday meanings rural community nurses had of PHC in the context of their service?'

Shay: 'So it is not only that you have investigated that question but now you’re wanting to fully put that 'out' because now you have a comprehensive understanding of their particular issues'.

Kierrynn: 'That’s correct. I think there are [other] major issues that I haven’t mentioned. One of them is the degree or the ability of nurses to implement the principles of PHC. While the health education and promotion are underlying principles of that philosophy, [there are others such as] principles of social justice, advocacy, equity of access and the social definition of health. ... What this research clearly identified
is that nurse have a tremendously deep understanding of those principles, what happens though, is, in their attempt to implement those principles, they are marginalised'.

Shay: 'As you know I have read the thesis and I enjoyed it immensely. One of the reasons was that ... often the most important part of their practice was hidden. ... What I think was interesting about your work was ... the idea of [not just] the margins, but also what you called the 'in-between' [which brought] forward what was hidden as well ...'

Kierryynn: 'I would agree with you. One of the things the research has done is to make visible the invisible practise of rural community nurses'. There are two major things I discovered in relation to this work. One is not particularly new, and it is distressing that it continues to happen. It is [the] confusion between the use of the terms, primary care, primary nursing care and primary health care. A fair amount of people writing in the area have failed to differentiate them. And the other thing I find distressing is that we have a tendency to see nursing as such an homogenised profession, and that practises in all the fields are the same. While there has clearly been a move to differentiate remote area from rural area nursing in terms of similarities and differences between those two professional groups, there is a continued failure to differentiate rural hospital from rural community nursing and I think this is one of the contributions that this particular research has made, in that it has clearly said that there are differences [and furthermore names these differences]'.

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Shay: 'I think that comes through really clearly [but] you talk now of rural community nurses as a group but what comes through for me in postmodern feminist is recognising one's individuality and one's uniqueness and difference and the socio-political contexts. So, how is it that you make a difference in this research by talking so generally about rural nurses as a group when their individual stories are the things that matter? — How do you pull it all together? Do you theme identify? Is that important in the end?'

Kierrynn: 'I think there are two things here. What has not been evident in the way that research has been written [in the past] is that it has been written as if there was one voice — [as] a monologue. What I have attempted to do in this research it to bring out the voices of nurses as individuals and by doing that I have attempted to tell a story and stay true to the voice as much as I possibly could - to give lot of information related to that voice which at times may seem excessive - the aim is to produce depth ...'

Shay: 'And, also set the scene for their own socio political context, and ... for who they are as people. Is that why at times you have put in stories concerning people having their lunch or including conversations with family concerning fears and so, for example?'

Kierrynn: 'Yes, ... the idea in ethnography is to have thick descriptions. One of [the] dilemmas I articulated in the thesis was presenting the information in such a way that people can't be identified, and also the tension of giving enough of the story to contextualise, localise and individualise the story. So, what at times seems like extraneous information is aimed at
contextualising, and individualising the story. Now while that is so, there is a direct or obvious tension between the individual and what that means for the group. I think there is a misunderstanding in the reading of the postmodern. My understanding is that while there is localised, individualised and contextualised meaning, there is a point in which the postmodern understands truth as a community truth, or a group truth. Rosenau refers to this and says it is quite acceptable within the more affirmative pragmatic postmodernists to say that truth is acceptable within the community, [or] if [there] is a community or group understanding of a particular situation, then that is a particular truth for that group - a particular reality for that group'.

Shay: 'Right, that has been important to clarify. I think that if your work is disseminated then you need to have some level of community truth.'

Kierrynn: 'Yes. One then has to ask the question: What is point of research if it is so individualised that one can't accept that there may be some mutual understanding of this information and mutual resonance? [In other words that] these stories could be other nurses stories that they would recognise themselves in those stories. And I think another important point is in relationship to what one accepts as stories from the postmodern. I think this leads on to some other features of the research that were related to resistances, to the policy rhetoric of governments and particular funding bases. While I started off within the feminist postmodern, and I felt that
framed the research fairly well, there has been for me a type of journey which has reinforced the position that I wish to be placed in relation to this body of knowledge. This is the idea of a resistance postmodernism, a type of border postmodernism that Giroux, McLaren and Walker talk about. For example, nurses attempted to put into practice a comprehensive rather than a selective PHC, they attempted to put into practice the social definition of health rather than a medically orientated health, they were quite able to implement continuity of care based on scientific principles and aspects of physiology and medicine, however, they clearly attempted to balance that with concern about individual and family emotional and psychological health, about the materiality of life, the state of the housing, poverty, income [of those they cared for] – those types of things'.

Shay: 'The social issues come forward in ... the chapter on the Margins especially concerning social injustice. The middle chapter brings forth their expertness as rural community nurses and their love of their work and how much they are valued by each other, their clients and themselves. That chapter also shows how they incorporate social issues into the everyday'.

Kierrynn: 'Yes. I have a sense of that and yet, if I think anything about the representation of the work, then it is the sheer complexity of what it was that was uncovered'.

Shay: 'I think one of the things for me, on reading chapters three, four and five, ... concerning those issues of social injustice was in what you called the 'in-between' states. It's not like chapter three is different from chapter four and
five — there is really a complex interwoven theme of that coming through. Was that intentional?"

Kierrynn: 'The interweaving was intentional. It was a way of trying to deal with the complexity. And yet, on reflection, I am dissatisfied. I have a sense that I have not been able to capture the complexity as much as I wished to be able to do. ... I believe the interweaving, the dividing up into different chapters, [the] carrying through of the realist, oppositional analysis and the postmodern reconstruction has attempted, by [way] of trifocality to bring forward the complexity. [On the other hand] or that there is so much complexity that the subtlety of some of the themes is actually lost'.

On reflection, another level of interpretation and complexity was introduced by leaving a page at the end of each chapter for readers to record their own understandings and interactions with the text. This provided another gaze, and form of engagement with the work. How that will be perceived awaits a reply.

I disagree with those who believe that deconstruction becomes endless and leads nowhere As Opie (1992:67) has contended:

... qualitative research using deconstructive methodology permits a more reflexive, flexible
understanding of our location and it obviously introduces a new 'strategic formation' for sociological research. In particular it helps focus fundamental questions in a new way.

Shay: 'That probably reflects you as a person and a researcher. I essentially think we all strive to represent ... the complexity of individual experiences. But it also raises the issues of letting the work go. Which leads me to the next question which is: What awaits further study?'

Kierrynn: 'There is a fair degree of tension surrounding letting the thesis go. I found myself just one week ago, as this thesis draws to an end, surfing the net and coming up with two articles and thinking in panic: "Well this is not in there and maybe this is something that I have missed".'

Shay: 'Your ontological panic?'

Kierrynn: 'Yes. So there has been a real need to be firm and strong, and say enough is enough. Maybe it is in the post doctoral work that these other ideas can be added to something [for publication]. And so there is that aspect of the tension. The other part is knowing that what has been uncovered is this idea of space. The idea of how one situates those that are on the margins, and how one talks about those sorts of things. I do agree with those that have written in the area who say that nursing has really failed to deal comprehensively with the marginalised. ... There is a tendency, as Walker has said, to
have a mode of desire which seek that which we lack, the Hegalian notion of desire, rather than putting some form of investment into what it is that we actually possess'.

Shay: 'One of the good things about Kim Walker's work is that he puts forward ideas where he really wants people to feel nervous and think about their particular positions as nurses. It's a position I take. Nurses should be encouraged not to stand still in terms of how they see their own practices. I think we need to be careful though, of this 'nursing failure business' — are we then saying that nurses are not good enough? — rather than an optimistic notion that now we are learning more about nursing, and how could it be better?'

Kierrynn: 'Sure, being too tough is important to avoid. However, I do think that we need to be challenged, and can't be to complacent about it. I think the area that have been challenging for me, is to look at the way space is conceptualised. I believe that one of the things the research has bought out is the spatio-temporal location of rural nurses and obviously it would hold for remote area nurses. We must begin to articulate more clearly, models that uncover some of the problematic aspects of spatiation within nursing'.

And also develop and implement strategies to deal with this, some of which is already being implemented in NSW as a result of the rural nursing summit.

Kierrynn: 'The other exciting area is a conceptual one, and that is the development of concepts related to space. For
example, this research talked about the 'in-between' space and that is the space between the margins and the centre (the centre being the controlling centre of the state or the centre of the service) – and the way in which nurses made that work for them. Looking at space in a way that refuses to accept space as transparent, that can see the paradoxical nature of the spaces that nurses find themselves in, and will uncover the rhetorical and undecided. One thing of value, I believe, within the postmodern, is that things are undecidable, nothing is absolutely set in concrete, things are on the move, things are capable of transformation and change. Particularly, the work of Deleuze, that accommodates the phenomenological understanding within postmodernism, and allows us to move from intertextuality into intersubjectivity. In other words allows us to recognise the suffering that occurs within individuals and populations. It provides a conceptual basis for that development, and I think that is very exciting. I think that it is an area for nursing that has tremendous potential to develop in relation to research, [and conceptual models of nursing].

Shay: 'Earlier you talked about the postmodern feminist framing of the research and moving on towards a pragmatic resistance postmodernism'.

Kierrynn: 'It's not so much a moving on, it's just a reframing. The thing about postmodernism is that it makes gender the major issue, and while that is fundamentally important, I think that resistance postmodernism allows you to accommodate gender, class, ethnicity'.
Shay: 'So given that, how did that fit with the whole process of doing the research? Now, at the end of the research are you still happy with that framework?'

Kierrynn: 'I think I am still happy with it. I have some concerns about it. I see it to be a major problematic area of the research. I am happy from the point of view that I believe that the principles of feminist research are fundamentally important to who I am as a person, for example, equal power relations, not a top down approach, mutuality, reciprocity. I also believe that the postmodern feminist ethical model that I developed for this research provided me with a framework for dealing with the dilemmas that arose. ... I think that has been a very valuable contribution to this type of research. However, I am a little concerned about the aspect of voice. I don't think I have drawn out enough [the idea] that this research has enabled those women in the research to have a voice, - that it has de-silenced them. [In that respect] I believe it has made a valuable contribution from a postmodern feminist point of view. The other aspects of postmodern feminism [that] have also been evident in the research, are the ideas of diversity and valuing difference because the thesis has been written as voice, it then allows each voice to come through clearly. What I haven't done is to link each voice to a particular analytic framework in the hegemonic discourse of women's oppression. I have spoken mainly of it in terms of the disciplinary power of the state. One of the writers I have referred to earlier makes the statement that postmodern feminist research is not looking
so much at gender alone, rather, the issue is to make sure there is no homogenised women's voice. Therefore, by creating individual stories I have given each women voice, and avoided the homogenise woman's voice from anywhere. The problematic ethical area was not being able to differentiate the male and female voices, but that remains something I just have to live with ... in an effort to stay true to their wishes'.

Shay: 'It's not only ethical, it's feminist and postmodern. It's about having data that is rigorous'.

Kierrynn: 'Yes. What Lather does is she links ethics with epistemology, and clearly says, knowledge development that is not ethically sound, is epistemologically weak. And by linking epistemology and ethics, the validity of the research is strengthened. It's important to realise that research is carried out in the everyday. Changing frameworks right in the middle is difficult. The everyday is full of changes and suprises, and importantly we must take account of the changes and their implications for the research'.

Finally, the limitations in the implementation of PHC needs to be acknowledged. Postmodern feminist perspectives do not necessarily avoid an 'adherence to values such as democracy, equality and social justice' (Lupton 1998:3). However, posmodemism is interested in interrogating those values and asking: Who is articulating these values? Why? And what do they stand to gain?
Mapping the methodological: Final conversations

A reader's interaction with a text creates a conversation. What follows, as the final conversation is a dialogue with the examiners of this thesis. However, they are not individually identified by name nor given a pseudonym. I chose this strategy in order to clearly identify the role of each conversant. In keeping with the representations in this chapter their questions are framed as participant conversations with myself. The conversation predominantly centres on some methodological decisions that shaped this thesis.

Mapping places others, and us.

Examiner: What are your ... 'reflections about what is rural'?

Kierrynn: 'I had moved from Sydney to the 'country' in 1986 after an extremely severe illness that necessitated leaving my career in nursing education. At first it was believed that I was suffering a form of System Lupus Erythematosus, a disease
that in some cases can be terminal. However, much to my relief it was eventually discovered that I was suffering from extreme chemical hypersensitivity. I was allergic to the city. Even now when I must visit a metropolitan city I try to stay for the least amount of time possible. Anything longer than three days usually results in the return of some symptoms. The decision to move to the country was life saving. And, within three months of rural living (on 100 acres of bush eleven kilometers from the nearest town), I had completed, together with my partner, the internal carpentry of our house and had began working in the paid workforce again. The country had provided me with a quality of life that had been impossible to achieve in the latter part of my life in the city.

However, to some extent I was a collaborator in the notion of a single rural space devoid of significant heterogeneity. I was aware that geographically there were towns, a provincial city, villages, and large tracts of farmland, national parks, coastlines, mountains, rivers, floods and fires. And, while I was aware of such issues as lack of transport, health care facilities and infrastructural support I still unconsciously held the idea of a homogenised and transparent space, where little consideration was given to the diversity and difference within the region I had chosen to live. Was it because I had been born and spent most of my life in a metropolitan city? Perhaps. I certainly had a huge investment in the positive outcomes of rural living. The research that I have undertaken has not provided me with a definite and fixed construction of the concept of rural. Rather, I am convinced by Deleuze and
Guattari’s (1988) argument that the map is open and heterogeneous, capable of constant transformation in the same way that the landscape is in a constant state of movement.

While Hegney (1996) refers to the myth of rural Australia as a healthy place to live, it was not a myth in terms of my own experience. The value of Hegney’s (1996) work is that while recognising the lack of common definition of rural, her Chapter entitled Rural Australia provides a comprehensive discussion and sets a coherent and consistent landscape for her discourse analysis of rural nursing. I would encourage a continued conversation with her work, which presents the discursive formation of rural Australia.

The next conversation concerns the decision to include nurse administrators in the study.

Examiners: ‘Why were two nurses managers included in the study’?

Kierrynn: ‘The decision to include nurse managers was based on my belief that to exclude them would continue to support the theory/practice divide that has adversely affected nursing for many years. Furthermore, the two administrators who were included had managed a client load in the past and were eager to tell their stories. Furthermore, I was not attempting to match client with nurse and do a comparative study. Finally, I believed that inviting them to tell their stories would provide insight into the policy rhetoric of PHC that would otherwise be absent, therefore adding to the richness and thickness of the data. An ethnographic study requires key informants who are
able to provide cultural insights, these managers fulfilled that role.

The following conversation concerns methodological decisions that had implications for notions concerning gender and subjectivity.

Examiners: Firstly, why were ...‘male nurses’ included and secondly, what was the reason for ‘not identifying male from female? Thirdly, how does this then relate to the ‘issue of the subject’?

Lather (1993) has suggested that we have reached a time of crisis in knowledge production and therefore, she has called for an ethical framing of the means by which knowledge is produced.

Epistemology and ethics are therefore linked.

Kierryyn: ‘There are two aspects to the questions of including male nurses and differentiating gendered voices. Firstly, there is the ethical aspect of knowledge production that intersects with the ethical aspect of the self-in-relations as described in Chapter 2. Secondly, there are those issues that are related to the substantive theme of the self in this research. The work is situated in a movement between modernist and postmodernist or between role and subject positions. The more skeptical of the postmodernists reject the
humanist themes within modernity. Their view is anti-subject, seeing the modern self as no more than a mask or role’.

Furthermore, such scholars as Judith Butler (1990) have challenged the unquestioning acceptance of gender role identity by modernist feminists. Butler (1990; 1992) tends to articulate a poststructural position viewing sexual difference as socially constituted by language/discourse. She has specifically called into question the binary oppositions of sex and the naturalisation of gender as constituted prediscursively.

Butler’s (1990) critique of fixed gender categories also offers up new political possibilities for the subject that enables repetitive gender norms to be radically displaced.

Kierrynn: ‘While the present project has emphasised an affirmative postmodern rather than poststructuralist framing of the research, Butler’s (1990;1992) work does admit the possibility of a return of the new subject. Moreover within her work there is some justification for the inclusion of males and the lack of differentiation of male voices within this study.

The methodological decisions taken at that time however, were fundamentally related to how I had positioned my self ethically. I had accepted the link between epistemology and ethics, and ontologically, ‘I’ as subject was positioned in a trusting respectful relationship with all participants. While this positioning may have created some methodological inconsistencies I find ethical knowledge production which
contributes to the validity of the work more convincing than validity framed by methodological consistency'.
Bibliography


Aldridge J 1993 The textual disembodiment of knowledge in research account writing. Sociology 27 (1):53-66


Anderson D 1991 Primary Health Care Education in Australia. Planning for Balance in Rural Health Care Conference Papers. Deakin University, Warrnambool


Australian Health Ministers' Advisory Council 1988 Continuing Education for Primary Health Care in Australia. AGPS, Canberra

Australian Nursing Federation 1990 Primary Health Care in Australia: Strategies for Nursing Action. ANF, Melbourne


Berger R 1993 From text to (field)work and back again: Theorising a post(modern)-ethnography. *Anthropological Quarterly* 66:174-86


Brodkey L 1987 Writing critical ethnographic narratives. *Anthropology and Education Quarterly* 18(2):67-774


Caring for Rural Communities: Budget 1992-3. 1992 AGPS, Canberra


Cixous H & Clement C 1986 The Newly Born Women. Translated by Wing B and Gilbert S. University of Minnesota, Minneapolis


Cook M 1997 Preparation for Professional Practice — The Hole is getting Bigger. Proceedings 4th National Rural Health Conference. Perth Western Australia. 9-12th February. National Rural Health Alliance, Canberra


Coxhead J 1992 United We Stand — Devided We Fall. In: Courtney M (ed) Issues in Rural Nursing. Proceedings of the 1st National Conference of the Association of Rural Nurses. 27-29th November UNE, Armidale


Davion V 1991 Integrity and Radical Change. In: Card C (ed) Feminist Ethics, University Press of Kansas, Lawrence


Davis K 1993b Who are We kidding, Action Research for Whom? Critical Theory Feminism and Nursing. Empowering Nursing’s Future. Proceedings National Nursing Conference. Quality Health Forums, Melbourne

Davis K 1996 The Unhappy Marriage of Feminism and Postmodernism. Post Graduate Seminar Series. Unpublished paper. Faculty of Health Sciences Southern Cross University, Lismore

Deleuze G & Guattari F 1983 Anti-Edipus: Capitalism and Schizophrenia. Translated by Hurley R Seem M & Lane H. University of Minnesota, Minnesota


Denzin N 1989 Interpretive Interactionism. Sage, Newbury Park


Department of Community Services and Health 1991 A Fair Go for Rural Health. AGPS, Canberra

Dick B 1990 Rigour without Numbers: The Potential of Dialectical Processes as Qualitative Research Tools. Interchange, Brisbane


Dodds S Albury R & Thomson C 1994 Ethical Research and Ethics Committee Review of Social and Behavioural Research Proposals. Commonwealth Department of Human Services and Health, Canberra


Dowd T & Eckermann A 1992 Cultural danger or cultural safety: Remote area health services. The Australian Nurses Journal 21(6):11-12


Druzec L 1989 The necessity for and evolutions of multiple paradigms for nursing research: Poststructuralist perspective. Advances in Nursing Science 11(4):69-77


Fahy K 1997 Postmodern feminist emancipatory research: Is it an oxymoron? Nursing Inquiry 4:27-33


Flax J 1990 *Thinking Fragments: Psychoanalysis, Feminism, and Postmodernism in the Contemporary West*. University of California Press, Berkeley


Fox N 1993 *Postmodernism, Sociology and Health*. Open University Press, Buckingham


Giroux H 1990 *Curriculum Discourse as Postmodernist Critical Practice*. Deakin University Press, Geelong


Glass N 1997 Breaking a social silence: Registered nurses share their stories about tertiary nursing education. *International Journal of Nursing Practice* 3(3):173-177


Grosz E 1989 *Sexual Subversions*. Allen & Unwin, Sydney

Grosz E 1994 *Volatile Bodies: Towards a Corporeal Feminism*. Allen & Unwin, Sydney


Hanson E 1994 Issues concerning the familiarity of researchers with the research setting. Journal of Advanced Nursing 20(5):940-942

Harding S 1986 The Science Question in Feminism. Cornell University Press, Milton Keynes


Harvey D 1973 Explanations in Geography. Arnold, London


Hassan I 1987 The Postmodern Turn. Ohio State University Press, Ohio

Health For All Australians 1988, Report of the Health Targets and Implementation Committee to the Australian Health Ministers

Hecker R 1997 Participatory action research as a strategy for empowering Aboriginal Health Workers. Australian and New Zealand Journal of Public Health 21(7):784-788


Hodgeson L & Berry A 1993 Rural Practice and Allied Health Professionals: The establishment of an Identity. Darling Downs Regional Health Authority, Toowoomba


hooks b 1990 Yearning: Race, Gender, and Cultural Politics. SouthEnd Press, New York


International Council of Nurses 1988 Nursing and Primary Health Care: A Unified Force. ICN, Geneva


Jameson F 1984 Postmodernism, or the cultural logic of late capitalism. *New Left review* 146:53-92.

Jameson F 1991 *Postmodernism, or the Cultural Logic of Late Capitalism*. Duke University Press, Durham


Kelly A & Sewell S 1988 With Head Heart and Hand: Dimensions of Community Building. Boolarong Publications, Brisbane


Kreger A 1991a Enhancing the Role of Rural and Remote Area Nurses. National Nursing Consultative Committee, Perth

Kreger A 1991b Remote Area Nursing Practice: A Question of Education. Council of Remote Area Nurses of Australia, Perth


486


Lennox G & Piercy N 1993 Innovation in Rural Health Care. Australian Hospital Association, Canberra


MacDonald J 1993 Primary Health Care: Medicine in its Place. Earthscan, London


Mahler H 1985 Nurses lead the way. WHO Features 97:1-3


Massey D 1994 Space, Place and Gender. Polity, Cambridge

Meleis A 1995 Towards a Cultural Competent Health Care. 11th Research Conference Rutgers State University, Alpha Tau Chapter of Sigma Theta Tau, Princeton New Jersey

Merriam S 1990 *Case Study Research in Education*. Jossey-Bass, San Francisco


*National Aboriginal and Torres Strait Islanders Nursing Forum* 1997 Australian Nursing Federation, North Fitzroy

National Rural Health Alliance 1998a *Issues Paper 1 Rural Health - The Big Picture*.

National Rural Health Alliance 1998b *Issues Paper 2 Indigenous Health*.

National Rural Health Alliance 1998c *Issues Paper 3 Rural and Remote Nurses*.

Natoli J 1997 *A Primer to Postmodernity*. Blackwell, Malden
Nebraska Sociological Collective 1983 A feminist ethic for social science research. Women's Studies International Forum 6 (5)


NSW Department of Health 1994 Future Roles and Direction of Community Health in NSW. NSW Dept of Health, North Sydney

NSW Department of Health 1994 Progress in Health. NSW Dept of Health, North Sydney

NSW Health Department 1996 Nursing Recruitment and Retention Taskforce. NSW Health Department, North Sydney

NSW Health Department 1998a Background Paper for Rural and Remote Nursing Summit. Rural and Remote Nursing Summit, Coffs Harbour

NSW Health Department 1998b Rural and Remote Nursing Summit Report. NSW Health Department, North Sydney


Opie A 1992 Qualitative research, appropriation of the 'Other' and empowerment. Feminist Review 40:52-69


Parsons C 1995 The impact of postmodernism on research methodology: Implications for nursing. Nursing Inquiry 2:22-28


Report of the Health Targets and Implementation Committee 1988 Health for All Australians. AGPS, Canberra


Rose G 1993 Feminism and Geography: The Limits of Geographical Knowledge. Polity, Cambridge


Sandelowski M 1993 Rigor or rigor mortis: The problem of rigor in qualitative research revisited. Advances in Nursing Science 16 (2): 1-8

Sargent L 1981 The Unhappy Marriage of Marxism and Feminism. Pluto Press, London


Schoenhofer S 1995 Rethinking primary care: Connections to nursing. Advances in Nursing Science 17 (4):12-21


492


Smart B 1992 Modern Conditions, Postmodern Controversies. Routledge, London


Southwick M 1998a Personal conversation 9th Annual International Critical and Feminist Perspectives Conference 24-26th June, Adelaide, South Australia


Stevens J & Herbert J 1997 Ageism and Nursing Practice in Australia Discussion Paper No 3. RCNA, Deakin ACT

St John W 1991 An investigation of the views of practising community health nurses regarding the educational preparation of nurses for practice in primary health care. Unpublished Master of Nursing Studies Thesis. La Trobe University, Bundoora

Streubert H & Carpenter D 1995 Qualitative Research in Nursing: Advancing the Humanist Imperative. Lippincott, Philadelphia


Walker K 1993 *On what it might mean to be a nurse: A discursive ethnography*. Unpublished PhD Thesis. La Trobe University, Victoria


Wass A 1994 *Promoting Health: A Primary Health Care Approach*. Saunders, Sydney


Wicks D 1995 Nurses and doctors and discourses of healing. Australian and New Zealand Journal of Sociology 31(2):122-139


Willis E 1994 Illness and Social Relations. Allan & Unwin, Sydney


Wolcott H 1994 Transforming Qualitative Data: Description, Analysis, and Interpretation. Sage, Thousand Oaks


World Health Organisation 1979 *Primary Health Care*. WHO, Geneva


Younger J 1995 The alienation of the suffer. *Advances in Nursing Science* 17(4): 53-72
Appendix One

Human Experimentation Ethics Application

Aim
The aim is to explore the practice of primary health care nurses, and client’s perceptions of that practice. The potential significance of this research project is that this study has direct relevance for the education of nurses in primary health care and students of nursing in undergraduate nursing programmes. It also has direct relevance for the shaping of primary health care nursing and the infrastructural support associated with the implementation of an effective primary health care service. Given the qualitative nature of this research there is no hypothesis to research. However there is a primary question and a set of derived research questions to be answered. These are:
What shapes nurses’ practice in women’s health and community health care and what in turn does this practice shape?
From this general question flow several other questions:
what is the nature of the practice?
what are the tensions within the practice?
what are the effects of these tensions?
what are the effects of the practice? or
how is the practice perceived by those people who participate in it?

Methodology and methods
This ethnographic study is intended to involve a self selected sample of ten women’s health nurses and ten community nurses, and one client of each nurse in a one hour critical conversation which will be tape recorded and one participant/observation of a therapeutic interaction between a nurse and client. Potential participants will be invited by letter to participate in the study. On receipt of a reply stating that they agree to participate I will then arrange a time and place for me to meet with the potential participants. During that meeting I will provide an information sheet explaining the research and an attached consent form. As well as providing the information sheet which the participants can read and keep for future reference, I will verbally explain the research and answer any questions which might arise for the participants. I will reiterate that they may withdraw from the research at any point with no prejudice. Should they be agreeable to participating in the study I will ask them to sign the consent form. Therefore, the consent will be obtained before any data is collected. I will then detach the consent form, leaving the information sheet with the participant. I will reiterate that some time will be spent in the field attempting to become familiar with them and the practice setting before any interview or observation is recorded (Field 1987, Kellehear 1993). The conversations from each individual nurse and recipient of care and the participant/observation notes (recorded after the session) will be analysed to identify the main features guiding nursing practice in the context of primary health care. Once the conversation/dialogue has been analysed the transcript will be returned to the participants for critique. This research technique is known as member checking (Riley 1990).

Ethical implications
The Postmodern turn in feminist ethics values such ethical concepts as internality and autonomy of individuals in the research context. It is interested in showing the ethical context of who has power and how certain dominant ways of thinking about the world actively alter our way of being in the world in a professional and personal way. It has a practical rather than theoretical ethical context. For example, for nurses in this particular research context the question would be, how can the research project be carried out in such a way that it validates autonomy, respect for difference and creativity?
It stresses that we must avoid creating a discrepancy between moral theory and social reality. Bent Flyvbjerg (1993:20-22), has developed methodological guidelines for research situated within practical wisdom and he place emphasis on:
1. values… whose values should be considered as relevant?
2. Power … who gains and who loses and what are the mechanisms and possibilities for changes in power relations.
3. Closeness ... a need for being embedded in the research and for self reflexivity.
4. the asking of small questions and the provision of thick descriptions
5. a focus on actual daily practices.
6. a utilisation of concrete cases or exemplars
7. a context dependent approach which therefore raises the issue of applied ethics as situational ethics
8. the asking of how questions, which places the emphasis on process rather than cause.

Further considerations of feminist Ethnography include:
1. the problems of trust especially when there are differences in 'class, race, ethnicity or sexual preference' (Reinharz 1992:64), therefore trust must be earned.
2. the question of rapport when researcher is a feminist and the participants are not.
3. closeness/distance; the question of 'reciprocated nurturing' ... 'full reciprocity ... [leading] ... to mutual identification' (Reinharz 1992:67).

Some settings require anonymous relationships while others are intensely personal. The setting rather than the methodology should determine the role.

Other researchers identify ethical problems with the 'ethnographic gaze' (Bruni 1994; Reinharz 1992; Field 1987; Lipson 1987). These include:
1. loyalty vs justice; power and equity; anonymity; confidentiality; and the analysis of data out of context.
2. Role conflict of the nurse as a scientist and the nurse as a practitioner and the problems of the need or desire to intervene. This can be viewed as the advocacy role vs research purity. In some research this has been assisted by introducing the observer as a nurse-researcher and the researcher role was emphasised and continued to be dominant. However, nurses aware of the observer may see the researcher as evaluating care.
In the present area that this research aims to explore, intervention by the researcher may be viewed as a threat to validity as this research involves nurses beliefs about nursing and the influence those beliefs have on care. A partial answer to this problem is that credibility is needed to gain access but having found entry into the field the researcher may be then viewed as a consultant by the nurses in problematic situations.
3. questions of rights; justice and humanness.
4. questions concerning being a "marginal native" or "real native"
There is a need to consider the distortion which can occur with a once off observation and raises the importance of spending time in the relevant cultural setting without actually collecting data in order for the observer to become 'acclimatised' to the presence of the observer. This strategy also assists with entry into the field; the gaining of trust and confidence; the establishment of rapport and reciprocity and a clear understanding of the research projects, its aims and outcomes.

All participants have a right to a full and clear disclosure. Further strategies therefore include the fact that all participants will receive a written and verbal explanation of what the research involves, including, the aims and processes of the research and the level of expected participants involvement. In the aged group of possible participants only those without any form of cognitive impairment will be included. If there is any doubt about the participants ability to fully comprehend the nature of the research project then they will not be included. Advice of the nurses involved in the therapeutic interaction will also be sort in this matter. Where English is a second language the assistance of an interpreter will be gained to ensure full comprehension and informed consent. If this is not possible then those people will not be included in the research.

Participants will be assured of the right to ask questions, discuss concerns or withdraw at any time from the research. Privacy, confidentiality and anonymity will be assured throughout the research with the use of pseudonyms or code names. This also applies to identifiable information concerned with health care settings, events or situations revealed during audio taping or observation, in that, all data will be pooled and analytic methods will not single out individual persons, health care organisations or events.
Should any conversation illicit negative emotions for the participants, all due care will be taken to ensure appropriate support is provided. The implementation of counselling skills gained as a health care worker of more than twenty years and knowledge gained from higher degree studies in communication and counselling will be the initial step. Should it appear appropriate, referral will be initiated. For example, should the client begin crying while relating information concerning a particular event, I envisage two strategies to be appropriate. Firstly I would cease
the conversation concerning the event, then deal immediately with the client's distress, staying with the client until the acute distress has resolved. Secondly, if the client consents I would then refer them to an appropriate counsellor should the client believe that is appropriate. This strategy reaffirms autonomy and individual right to informed decision making. I would also reaffirm to the client that they can discontinue their involvement in the research should they wish to. All due care will be taken to ensure that participants are not harmed emotionally by any conversation of distressing events and/or situations.

The analysis of the data will be checked by the participants who are the source of the information. The methodology and methods utilised in this research makes a clear commitment to equalising power relationships through enlightenment, reciprocity, mutual respect and growth. The research also makes a commitment to the presentation of multiple perceptions concerning the interpretation of information (the data) thus avoiding theory imposition and providing a mechanism by which multiple truths concerning what shapes nursing practice can be presented.

References
Aamodt, Agnes., Ethnography and Epistemology: Generating Nursing Knowledge, in Morse, Janice, (ed), 1987, Qualitative Nursing Research, Newbury Park, Sage.
Australian Nursing Federation, 1990, Primary Health Care in Australia: Strategies for nursing action, Melbourne, ANF
International Council of Nurses, 1988, Nursing and Primary Health Care: A Unified Force, Geneva, ICN.
NSW Health Dept, in March 1994 released a discussion document entitled 'Future roles and Direction of Community health in NSW'.
Report of the Health Targets and Implementation Committee, 1988, Health for All Australians, Canberra, AGPS.
Riley, J., 1990, Getting the most from your data, Bristol, Technical and Educational Services.
Appendix Two

Declaration of Research Intention

UNIVERSITY OF WESTERN SYDNEY, HAWKESBURY
FACULTY OF HEALTH, HUMANITIES AND SOCIAL ECOLOGY

Invitation to Join a Research Project

Research Title: Nursing and Health in the Context of Primary Health Care and the New Public Health Agenda.

Researcher: Kierrynn Davis

Contact Number: 066 203673 (w) 066 822602 (h)

Supervisor: Professor Bob Hodge

Contact Number: 045 701673

Project Description:
This research project is being undertaken to explore what it is that shapes practice in community and women’s health nursing and what in turn this practice shapes in terms of health care. This study has direct relevance for the education of nurses in primary health care and students of nursing in undergraduate nursing programmes. It also has direct relevance for the shaping of primary health care nursing and the infrastructural support associated with the implementation of an effective primary health care service. Given the qualitative nature of this research there is no hypothesis to research. However there is a primary question and a set of derived research questions to be answered. These are:

What shapes nurses’ practice in women’s health and community health care and what in turn does this practice shape?

From this general question flow several other questions:

what is the nature of the practice?
what are the tensions within the practice?
what are the effects of these tensions?
what are the effects of the practice? or
how is the practice perceived by those people who participate in it?

This ethnographic study is intended to involve a self selected sample of ten women’s health nurses and ten community nurses, and one client of each nurse.

If you decide to be involved in this research, I would like to spend sometime with you in your work situation so we can get to know each other and establish trust and confidence (Field 1987, Kellehear 1993). After that, at a mutually agreeable time I wish to participate in a conversation about the nature of your practice and what it is that you feel influences your therapeutic interactions. To help initiate the conversation such questions as:

Tell me about a time when?
Tell me about what you did when?
Tell me about what others did?
could begin the interaction.

I am also interested in being present as an participant / observer during a therapeutic interaction. The aim is to gain knowledge of practice through the observation of the events and outcomes of that practice. The intention is not to evaluate the standard of practice but rather to gain some insight into how your perception of your practice shapes the nature of the practice.
I will need to meet with you on at least two occasions for an informal conversational dialogue which will last for approximately one hour. I am able to travel to your home or I am willing to arrange a time and place that is convenient for you. The conversation will be tape recorded. I would also like to be present at a therapeutic interaction and record observation notes at the end of the interaction. However, you will be anonymous and all information will remain confidential and disclosed only with your permission. The analysis and publication of the information will be based on pooled data and identification of individuals or health care settings will not be possible. All information recorded will be secured in such a manner that only the researcher will have access.

After I have analysed the information I will return my findings to you and ask you to comment on the interpretation. I am particularly concerned about whether there is a match between what I have written and your own beliefs about your practice. This research technique is known as member checking (Riley 1990).

I am undertaking this research as a PhD student. I am a registered nurse, nurse academic with 25 years experience in the nursing profession. Should you have any questions about the research at any stage of its progress, then please ask me if I am in the setting or contact me on the above home phone number and I will be happy to answer any queries.

Receipt of Interest

I am interested in participating in the research project entitled: 'Nursing and Health in the Context of Primary Health Care and the New Public Health Agenda.'

I am willing to be contacted on the following phone number or at the following address to arrange a convenient time to receive further information concerning the research.

Name: 

Phone number: 

or 

Address: 

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Appendix Three

Nurses Consent Form

UNIVERSITY OF WESTERN SYDNEY, HAWKESBURY
FACULTY OF HEALTH, HUMANITIES AND SOCIAL ECOLOGY

Research Title: Nursing and Health in the Context of Primary Health Care and the New Public Health Agenda.

CONSENT FORM

This is to certify that I,

________________________________________________________________________

hereby agree to participate as a volunteer research participant in the above named project. I have read and understand the above description and have been given the opportunity to ask further questions and clarify information if required. All questions have been answered to my satisfaction.

I understand that in the course of the research I may refuse to answer specific questions and that I am free to withdraw my consent and participation at any time without giving reasons.

I understand that my name or employer’s name will not be used in association with any data arising from this research. On the basis of this understanding I agree to dialogue/conversations related to this research being tape recorded and to observation and note taking related to therapeutic interactions.

Participant

Date

Witness

Date
Appendix Four

Clients Letter of Invitation

Kierrynn Davis
Lecturer,
Faculty of Health Sciences
Southern Cross University
PO Box 157
Lismore 2480.
8th August 1995

I am a nurse undertaking a research project as part of furthering my education. The research is entitled 'Nursing and health in the context of Primary Health Care and the New Public Health Agenda'. It is felt that this research will help in the education of students of nursing and in helping to determine the type of health service people in the community need or want.

I am therefore writing to invite you to participate in this research study which concerns what influences nursing care for community and women's health nurses and what that means for people who receive that care.

I have asked nurses in both community and women's health to distribute these letters to their clients so that confidentiality is maintained and I remain unaware of who is receiving care at this point.

Involvement in this research would mean talking to me for about one hour about what you think about the care you have received. Also it would involve me being present during a time that you are receiving nursing care.

If you feel that you would like to participate in this project please fill out the the form below, detach and return it in the self addressed envelope provided. After receiving your receipt of interest I will ring you to arrange a convenient time to provide you with written information concerning the research, to verbally explain the research and answer any questions you may have. Agreeing to receive more information at this point does not mean that you have consented to be involved in the research. You may withdraw from the process at any time during its progress without providing reasons.

Yours Sincerely

Kierrynn Davis.
Appendix Five

Clients Expression of Interest

Receipt of Interest

I am interested in participating in the research project entitled: 'Nursing and Health in the Context of Primary Health Care and the New Public Health Agenda.' being conducted by Kierrynn Davis.

I am willing to be contacted on the following phone number or at the following address to arrange a convenient time to receive further information concerning the research.

Name: ____________________________ Phone no: ____________

or

Address: ____________________________________________
Appendix Six

Clients Consent Form

UNIVERSITY OF WESTERN SYDNEY, HAWKESBURY
FACULTY OF HEALTH, HUMANITIES AND SOCIAL ECOLOGY

Research Title: Nursing and Health in the Context of
Primary Health Care and the New Public
Health Agenda.

CONSENT FORM

This is to certify that I,

____________________________________________________________________

hereby agree to participate as a volunteer research participant in the above named project. I
have read and understand the above description and have been given the opportunity to ask
further questions and clarify information if required. All questions have been answered to my
satisfaction.

I understand that in the course of the research I may refuse to answer specific questions and
that I am free to withdraw my consent and participation at any time without giving reasons.

I understand that my name or employer's name will not be used in association with any data
arising from this research. On the basis of this understanding I agree to dialogue/
conversations related to this research being tape recorded and to observation and note taking
related to therapeutic interactions.

Participant ____________________________________________

Date ______________________

Witness ________________________________________________

Date ______________________

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Cartographies of Rural Community Nursing and Primary Health Care: Mapping the In-between Spaces.

Kierrynn Miriam Davis
RN; Dip Neuroscience Nursing; BSc (Macq); Grad Dip Edn (Nurs) (SCAE); MSc (Hons) (Soc Ecol) (UWS-H)

Doctor of Philosophy
1998
University of Western Sydney, Hawkesbury
PLEASE NOTE

The greatest amount of care has been taken while scanning this thesis,

and the best possible result has been obtained.
Certificate of Originality

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma of a university or other institute of higher learning, except where due acknowledgement is made in the text.

Signed

Date 28.12.98
Acknowledgements

Many thanks to my supervisor Professor Bob Hodge for allowing me the freedom to be. A special thanks to the rural community nurses and their friends in the community whose generosity was unbounding. Their welcoming of me into their work and home lives and the sharing of their stories filled me with awe and was a truly humbling experience. I can only leave to the readers to judge if the words between these pages brings the 'actual' of rural community nursing closer to actuality.

To my colleagues and friends whose support and encouragement has sustained the journey I thank you. To Chris, Bev, Ruby, Mozzy, Leisa, Louise, Katie, Lou, Winifred, Helen, Lyndia, Viv, and Mijan — there is life after a PhD.

To my partner Nel for her unfailing support, critique, generosity and good humour, without her and our furry friends Tao and Ms Marmalade I surely would have lost my way.
Dedication

Nicholas Fox's words are here dedicated to those who shared the journey, especially to the rural community nurses and the members of the community both individually and as a group who have inspired me to continue the journey of discovery.

Postscript: a postmodern prayer

Where there is identity
    may there be difference
Where there was truth
    may we celebrate ambiguity
Where there was control
    may we be generous
Where there was repetition
    may there be multiplicity
Where there was inscription
    may there be desire
(Fox 1993:160)
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Abbreviations and Key Words or Terms

ACAT  Aged Care Assessment Team
AHMAC  Australian Health Ministers' Advisory Council
ANF  Australian Nursing Federation
CATSIN  Council of Aboriginal and Torres Strait Islander Nurses
CRANA  The Council of Remote Area Nurses of Australia
ICN  International Council of Nursing
HCW  Health Care Worker
HCS  Health Care System
NSW  New South Wales
NRHA  National Rural Health Alliance
NRHS  National Rural Health Strategy
NWHP  National Women's Health Policy
PHC  Primary Health Care
RDAA  Rural Doctors' Association of Australia
WHO  World Health Organisation
Abstract

This postmodern feminist ethnographic research aimed to explore the everyday meanings of primary health care (PHC) held by rural community nurses. Secondly, the research aimed to explore the everyday meanings of care held by the clients of the rural community nurses who participated in the study. The representation of this research is written in four voices which converse with each other to varying degrees in each chapter. This writing strategy is a deliberate one aimed at destabilising the usual approach to representation of research. It is also a strategy which seeks methodological coherence. The third aim therefore is to deliberately trouble the acceptable grounds concerning how nursing research is represented.

The research utilised dialogical (conversational) and participant observation methods concerning the everyday meanings of nurses and their clients. The meanings I made of the information were created from a deconstruction of the texts. These texts included fieldnotes of participant observations and transcripts of conversations with nurses and their clients. The form of deconstruction utilised was informed from multiple sources and involved three levels of analysis. A realist interpretation was followed by an oppositional interpretation and then a reconstructive movement.

The results revealed that rural community nurses practice is both spatio-temporally contextualised and metaphorically situated in an in-between space. This in-between space is situated between the margin and the centre. Rural community nurses working on the margins traverse this space in order to overcome further marginalisation whilst working with Indigenous Australians and the aged. Moreover, the in-between space encompasses and creates opportunities to mutually exchange the gift of desire that being — empowering and compassionate relationships with clients and colleagues.

Furthermore, whilst rural community nurses are strongly committed to the philosophy of PHC, their everyday working life is discursively constructed by powerful discourses which result in oppositional tensions. The tensions and the 'in-between' space allow the rhetoric of PHC to be resisted and reframed. Consequently, the oppositional constructs of their practice were displaced.
Moreover, this necessitated the negotiation of space and place, and required the reconstruction of subjectivity, intersubjectivity and becoming.
Part One

Mapping the Terrain
The possibilities for creating a much more overtly postmodern text are certainly exciting and the shape and content of a truly 'ex-centric' ethnographic text awaits exploration (Hutcheon 1988:240).

Preface

The genre

The conversation that follows takes up the challenge that Walker (1993) has put forward. The thesis that unfolds for you; the reader/critiquer, is a conversation with narrative intent. It is a story which is told in four voices. The decision to so structure the thesis is one which seeks methodological coherence and consistency. Further, this 'writing' of the thesis reflects my commitment to presenting research which is demystified and 'available' to multiple audiences. This approach was also important in developing an appropriate method to represent 'data' within postmodern feminist research which avoids the positivist's reliance on the objective presentation of facts. The research outcomes are not aimed at the development of grand theory or generalisable 'data'. Rather, the thesis, by utilising its particular writing style, tells a story which is personal, localised and situated in the subjective voice. No doubt the question of research rigour is one which must be grappled with; however, research rigour should be assessed by the criteria which is methodologically consistent. Chapter Six will explore this aspect of the research in greater detail.

The question of the possibility of theory development within postmodern feminist ethnography is also addressed in Chapter Two. At this point, however, it is important to note that postmodern feminism is not atheoretical in the same way that ethnography is not atheoretical. Even highly descriptive information is underpinned by theory. The extent to which ethnographic descriptions can contribute to theory development or theory testing is dependent on the epistemology which frames the descriptions, the focus of the
research, and the degree to which certain variables can be quantified. A further exploration of this aspect of the research will be taken up in Chapter Two.

The decision to structure the thesis in such a way that it resembles a conversation represents a form of engagement with the 'self' and the 'not self', the audience (or reader/s). The voices which tell the story of this research are the aspects of the 'self' which converse with each other. Conversation with self allows one to converse with others (Raymond 1986). We are multiplicities. Atkinson (1990:1,3) is concerned with 'the textual construction of social (and sociological) reality', and refers to 'ethnography as method and genre'. He has challenged the traditional textual conventions exemplified in sociological ethnographies. At the same time he has asserted that this challenge is not aimed at undermining 'epistemological security', nor does it seek to disrupt the scholarly standing of this type of research and reportage (1993:175). The decision to structure this ethnography in an alternative style is aimed at achieving a level of critical self-reflectivity, intertextuality and parody that has predominantly been absent from past representations. Like Natoli (1997), I have used this writing strategy to interrupt the standard thesis text. It is an act of subversion and interrogation. The strategy operates on both myself and the reader in a deliberate effort to interpenetrate the reality of both worlds. It is a strategy aimed at delimiting the tendency for academic writing to lean towards early closure and appropriation. This notion is echoed by Linda Brodkey (1987:67), who has suggested that, following the formulation and publication of an academic narrative, 'that narrative is likely to function as the authoritative text to which all subsequent retellings and problems of interpretation will be referred'.

My question is Opie's (1992:55): 'What does it mean to write critically but less authoritatively when the act of writing is so strongly associated with authority and centrality?'

A deeper exploration of methodological consistency and the writing of postmodern ethnographies will be covered in Chapter Two. At this point, however, the words of Liz Grosz describe the riskiness of such a decision.
In my opinion, this is politically dangerous ground to walk on. But if we do not walk in dangerous places and different types of terrain, nothing new will be found. No explorations are possible, and things remain the same. The risks seem to me worth taking ... (Grosz 1994:173).

In their book *What Is Philosophy?*, Deleuze and Guattari (1991:2) wrote that 'philosophy is the art of forming, writing and fabricating concepts ... between friends ... [or] conceptual personae'. In an earlier work they refer to a similar notion of 'rhythmic personage' ('Deleuze & Guattari 1988:329). Therefore, it is time to meet the speakers in the dialogue between friends.

**The writers**

In keeping with the previous ideas, then, the voice of the conceptualiser writes the story of the ideas which frame the research. In positivist frames, the content provided by this speaker/writer would form the theoretical framework of the research. Further to this way of thinking, this writer would give birth to the descriptions, analysis and interpretation of the stories. In this thesis then, the voice of the conceptualiser is written in Palatino font and set at the left-hand margin.

**Example:-Voice Conceptualiser (Palatino Font)**

The main principle was that of equity, including equity of: access; resources; human rights; and participation (Hegney 1996).

The reflector in this narrative is the voice of critique. The essence of critical thinking is the ability to critique one's own work with the same rigour as one
would the work of others. This voice is an aspect of the conceptualiser, who reflects and asks questions and transforms the discourse of the thesis as 'writing' which is always open to interrogation. It is recorded in Helvetica font, bolded and set 3 cm in from the left-hand margin.

Example:- Voice of the Reflector (Helvetica Font)

The lack of explanation concerning these concepts, differing interpretations, and also a lack of clear strategies to achieve them, has however, created a myth of social justice.

The narrator is myself — as a participant in the research (including the fieldwork) and the 'writer' of the narrative. The position taken in this research is that the field work and the writing of the thesis cannot be considered as two separate events. The emergence of this self is as the narrator, who has been deeply embedded in the process of both the research and the writing of the thesis and is now standing back and, in that dual role, setting the story in time and connecting the characters, events and outcomes, thoughts and feelings within the lived experience of this research. In the context of this research the participant observer has two aspects. Firstly, the self in the field, who is therefore a participant in the research whose observations become, in positivist terms, 'the data'. And, the participant observer of the writing process. This voice is recorded in New Berolina MT font and set halfway across the page from the left hand margin.
Example: Voice of Participant Observer

New Berolina NT Font

Although I did not work with any Aboriginal people during this research their position on the margins was clearly demonstrated by a series of events that preceded a conversation with one of the nurse participants.

Finally, the participant is the voice of individual collaborators who tell their own story. This voice also tells my story, which was woven from field notes recorded over a six-month period. The question of inclusion/exclusion is a pertinent one, at this point, and it is worth noting that such decisions are framed by the 'nature of the questions asked in reference to the methodology in which the question/s are situated' (Davis 1993b). This voice is also what might be described in positivistic frames, as the 'data'. It is recorded in Monaco font, set at the left-hand margin and placed in inverted commas.

Example: Voice of Participant Monaco

'There is [a bus] ... [but it] depends on what colour you are. If your Aboriginal, you can't go on [the bus]. That's how racist the community is ... racism is alive and well.'
The critical conversation between the voices varies. The voices converse appropriately, which means that they are not all present in each chapter. The extent of their conversation also varies with the substantive content of the chapter. I have referred to three words so far — story, narrative and conversation, — that require differentiation. 'Story' refers to the events or the 'what', and 'narrative' to the 'how'. So, in the writing of the research, there is both. The conversation that is spoken and read is therefore a productive strategy, aimed at creating instability of the usual third person ethnography.

Furthermore the thesis is structured more like a book than the typical thesis. The present conversation occurs as a preface to the thesis, setting the scene and tone of the work. As the conversations continue, Chapter One explores the contexts of the research, Chapter Two frames the research methodologically and discusses the research design, Chapter Three is the first of three chapters which explores my own and other participants’ stories, and is predominantly concerned with being and working on the margins from a realist, oppositional and reconstructed perspective. Chapter Four is concerned with a description, analysis and interpretation of the 'new' subject from a realist and oppositional perspective, Chapter Five explores in depth the two major aspects of the research. Firstly, the 'new' subject is constructed as a desiring subject in a gift relationship. Secondly, it is proposed that both the 'new' subject and the gift relationship are created intersubjectively. Chapter Six explores those events that shaped the research and contributed to modifications to the 'doing' of the research and the writing of the participants' stories. The rigour of the research is also explored in this chapter, and a case is made for criteria of rigour in the context of postmodern feminist ethnographic research. Chapter Seven explores the final reflections on the research and the thesis.

**Brief overview of the methodology/methods**

This research was situated in postmodern feminist ethnography and utilised a multiple methods approach (Reinharz 1992). The methods used were critical conversation (dialogue) and participant observation. The analysis of the
results was addressed on three levels, those being: a realist analysis, an oppositional analysis, and a postmodern feminist reconstruction.

**Brief overview of the findings**

Rural community nurses practice is both spatio-temporally contextualised and metaphorically situated in an in-between space. This in-between space is situated between the margin and the centre. Rural community nurses working on the margins traverse this space in order to overcome further marginalisation whilst working with Indigenous Australians and the aged. Moreover, the in-between space encompasses and creates opportunities to mutually exchange the gift of desire that being — empowering and compassionate relationships with clients and colleagues.

Furthermore, whilst rural community nurses are strongly committed to the philosophy of PHC, their everyday working life is discursively constructed by powerful discourses which result in oppositional tensions. The tensions and the in-between space allow the rhetoric of PHC to be resisted and reframed. Consequently, the oppositional constructs of their practice were displaced. Moreover, this necessitated the negotiation of space and place, and required the reconstruction of subjectivity, intersubjectivity and becoming.
Part Two

Representing the Study
Preface

The following three chapters seek to represent the research dialogues in conversational form. The dialogues are framed by notions of marginalisation, spatiality, and the return of the new and desiring subject. Although Chapter Three is concerned predominantly with marginalisation and spatiation and the relationship 'between', these are also 'themes' which contextualise Chapter Four. Chapter Five explores the return of the new subject as a desiring subject, challenges the post-structuralist restrictions of textuality, and argues the case for an implicit intersubjectivity within intertextuality. Chapter six seeks to explore the factors that shaped the research design, implementation and representation.

The presentation is an effort to avoid the
marginalisation of some voices. As pointed out in the words of Edwards and Ribbens (1998), our own intentions as researchers may not only marginalise but also silence those that we seek to represent.

There is danger that the voices of particular groups, or particular forms of knowledge, may be drowned out, systematically silenced or misunderstood as research and researchers engage with dominant academic and public concerns and discourses (Edwards and Ribbens 1998:2).

What follows, particularly in the realist framing, may seem everyday or 'mundane' (Edwards & Ribbens 1998:2). However, it seeks to share on a personal level rather than a disciplinary level those thoughts and experiences that were shared within this research.

While the dialogue that is represented here involves self-reflectivity, it is also an attempt to establish with the 'other' a mutual although partial exchange. I have
tended to conceptually summarise the exchange in places and have sought clarification and assurance from my fellow participants as to the accurateness of my thinking in relation to their thoughts and feelings. It was an effort to avoid positioning myself as the only interpreter of this work. I am conscious, however, of the words of Edwards and Ribbens (1998:2) that: 

...even as the researcher may seek to make herself apparent as the translator, via self-reflectivity, she risks making herself more central to the discourse.

I was literally stopped in my tracks when, on listening to the tape recordings, I realised just how much I heard my own voice. After a discussion of this with a colleague, I noted:

'While I have attempted to silence myself, I have found that the conversational or dialogical method that I have chosen has allowed or even encouraged me to have my own voice'.
The question then becomes: To what degree is the method part of a process of colonisation of the participant's knowledge? One strategy that was implemented to reverse this was to return the full transcriptions to each of the participants and ask them to make any changes they wished. I did ask, however, that they make the changes without removing the previous work so that I would be able to have some sense of the degree of my own collusion in the perpetuation of the dominant academic discourse. I found, however, that the changes were minimal and mainly involved correcting the grammar or filling in words that had been difficult to interpret due to sound difficulties on the tape, and, finally, to remove any material that, having had some time to reflect on, they decided should not be made public. It was a strategy aimed at allowing the participants to decide what text would be
made available for explanation.

I did not return my descriptions and explanations of their words to them for member checking. Although this is now a 'common' strategy which seeks to produce valid post-positivist research (Janesick 1994; Denzin 1994), several pragmatic considerations combined with Sandelowski’s (1993) critique of member checking contributed to my decision. Firstly, when I asked the participants if they wanted to be involved with this process, all of them stated that the pressures of time were extensive (as will be clearly demonstrated in the following chapters) and that they did not know how they would fit it in to their work and personal life. As they had already been extremely generous with their time and energy, I was hesitant to increase their load any further. Secondly, this decision was further supported by the length of
time it took participants to return the transcripts to me after checking on what they wanted to be made public. Also, while time was certainly a factor, to some extent I also felt (however I did not confirm this verbally) that they believed that the next part was really my 'job' and they had done their 'part'. Therefore I felt that I would just have to 'live' with this as just 'grist for the mill' when carrying out research with people in the 'real' world.

On receiving the transcripts back, all of the participants were horrified with the structure of the conversation. They and I also realised that we do not speak in the same way that we write. They asked: 'Did we really say this'? or 'Do I really speak like this'? Everyday conversation, even with professionals, is often disjointed, grammatically incorrect and difficult to follow when written. While I recorded in my field notes that:
'The conversations are flowing well and I feel connected and at ease. Some participants have even indicated that they have never spoken to anyone about their working life in quite the same way and that this is either a relief or is 'cathartic' in a way'.

This also held true for my own dialogue. I was surprised at the number of times I began broaching a topic or articulating a concept only to find I cut it off to begin another. It was as if I needed to be so present that words began to emerge even before I had decided what it was that I wanted to say. I noted:

'I am horrified at how inarticulate I am. My thoughts seem all over the place and I need a few words at the beginning, it seems, to cover my silence. Added to that is a consciousness of how precious the time is, and there seems so much to explore'.

Furthermore, although my clinical work had been in the area of acute Neuroscience nursing, mainly neurotrauma, I noted at
'Being in the everyday with them I feel so involved that I have realised that I would love to be a rural community nurse. It is almost as if I have become involved in the pattern and rhythm of their worklife'.

This feeling has stayed with me right up to the present time of writing. It has influenced my commitment to writing the present text as one which attempts to avoid the presentation of a subjugated knowledge and puts forward a representation that allows a diversity of voices to be heard.

My original plan had been to present the dialogue as individual narratives; however, this decision was soon abandoned as I realised the ethical implications of this strategy. All of the participants were deeply concerned with the possible lack of anonymity within the presentation of their words. Although I had given my reassurances concerning this matter, I
was asked several times by each participant about ensuring that what was said could not be linked to them. Interestingly, I also found that most of the participants spoke more freely and quite extensively once the tape recorder was turned off.

Having given my commitment to maintaining anonymity, I realised that the narratives would inevitably provide enough sequencing of information for the voice to be recognised. While I will discuss this in greater detail in Chapter six, it is important to note that the participants' voices are protected from recognition by several strategies. Firstly, the use of pseudonyms for both participants and the geographical areas where they worked or lived. Secondly, the interweaving of different voices to suggest the notion of a group conversation.

On the other hand, I have also attempted
to find some balance by providing large sections of text in some places. This strategy was aimed at providing 'thick descriptions', which are contextualised, and which is a hallmark of post-positivist ethnography. Providing small snippets of text tends to decontextualise a story. I am aware of the need within academic writing to ensure that the 'data' which is selected for inclusion accurately reflects the idea being put forward. I am also aware of criticism of texts in which the 'data' inclusions are extensive and perhaps not supporting the 'theme' as efficiently as possible. And, after several rereads just before submission of the thesis, this issue did concern me. After feedback from colleagues who read the texts I decided to stay with more rather than less story. As I read though the conversations, because I know each person so well, I can recognise the voices. Although the general
geographical area of the study is recognisable, I can only hope that in attempting to find a balance between anonymity and methodological requirements such as contextualised thick descriptions, no one person or place within the study will be recognised. To some extent this is also assisted by the fact that some of the nurse participants rotated through sections of the service and were not tied to one geographical area at all times.