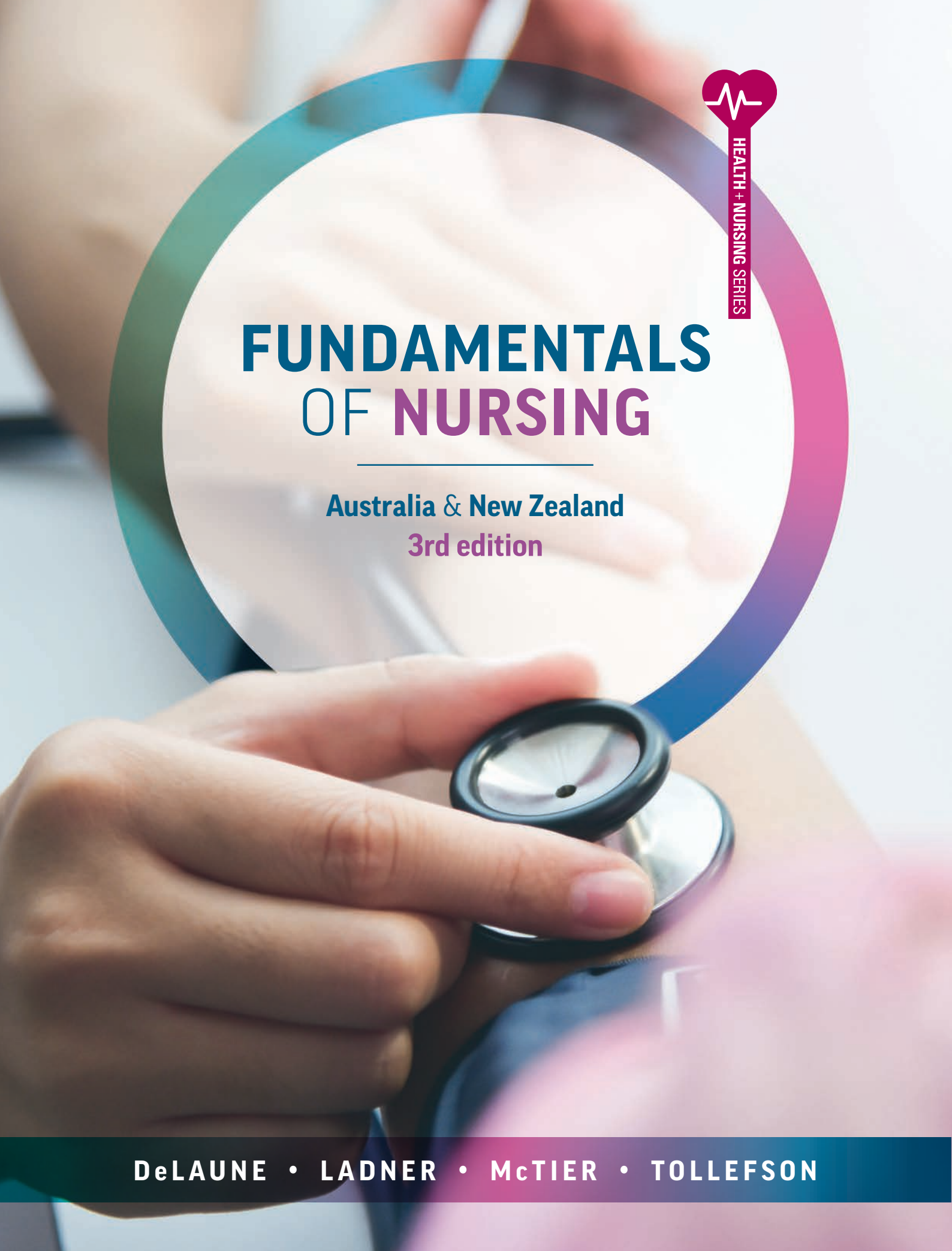

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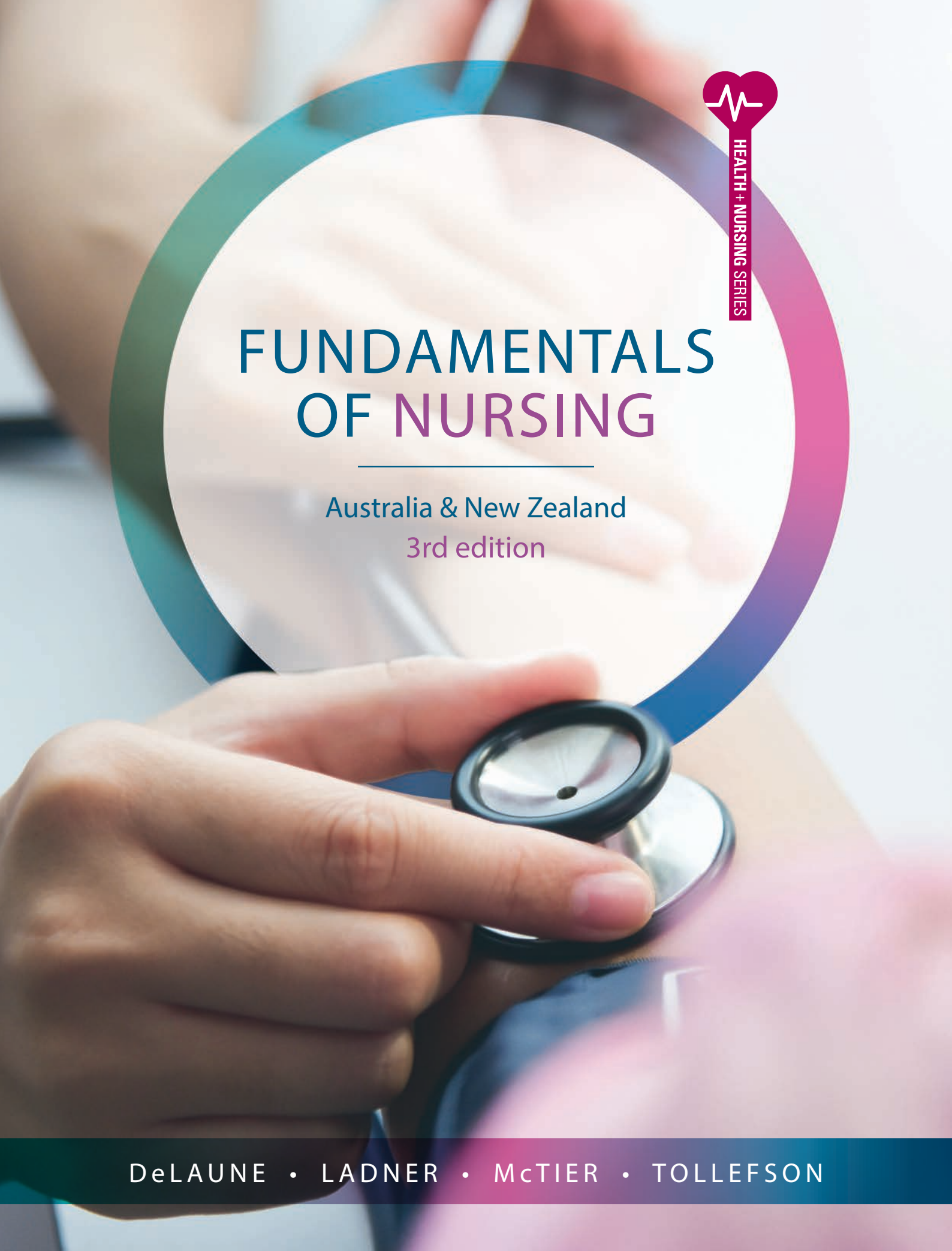

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CONTENTS

Guide to the text

As you read this text you will find a number of features in every chapter to enhance your study of nursing and help you understand how the theory is applied in the real world.

UNIT OPENING FEATURES

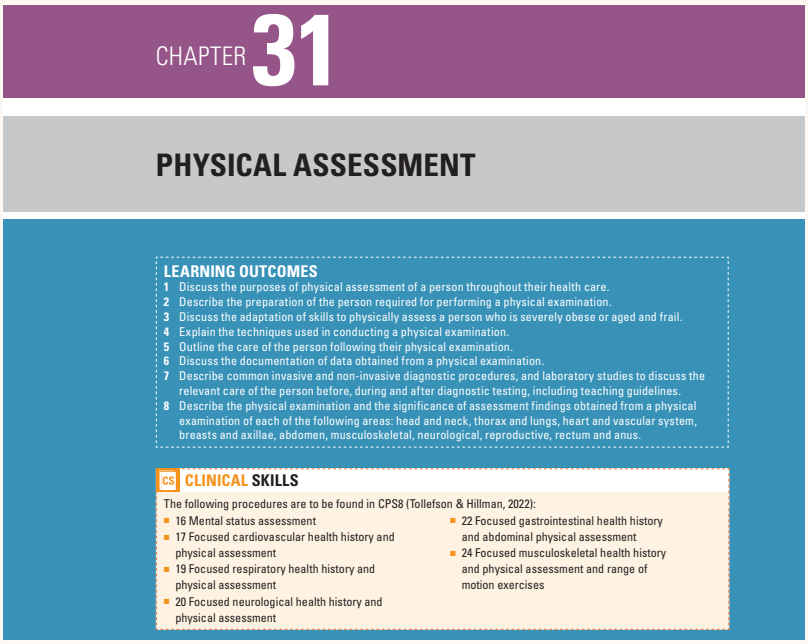
Unit opening pages list the chapters included in each Unit.


UNIT 01

NURSING PERSPECTIVES: PAST, PRESENT AND FUTURE

CHAPTER OPENING FEATURES

Learning outcomes give you a clear sense of what topics each chapter will cover and what you should be able to do after reading the chapter.


CHAPTER 31

PHYSICAL ASSESSMENT

LEARNING OUTCOMES

1 Discuss the purposes of physical assessment of a person throughout their health care.
2 Describe the preparation of the person required for performing a physical examination.
3 Discuss the adaptation of skills to physically assess a person who is severely obese or aged and frail.
4 Explain the techniques used in conducting a physical examination.
5 Outline the care of the person following their physical examination.
6 Discuss the documentation of data obtained from a physical examination.
7 Describe common invasive and non-invasive diagnostic procedures, and laboratory studies to discuss the relevant care of the person before, during and after diagnostic testing, including teaching guidelines.
8 Describe the physical examination and the significance of assessment findings obtained from a physical examination of each of the following areas: head and neck, thorax and lungs, heart and vascular system, breasts and axillae, abdomen, musculoskeletal, neurological, reproductive, rectum and anus.

CS CLINICAL SKILLS

The following procedures are to be found in CPS8 (Tollefson & Hillman, 2022):

- 16 Mental status assessment
- 17 Focused cardiovascular health history and physical assessment
- 19 Focused respiratory health history and physical assessment
- 20 Focused neurological health history and physical assessment
- 22 Focused gastrointestinal health history and abdominal physical assessment
- 24 Focused musculoskeletal health history and physical assessment and range of motion exercises

The **Clinical skills** box in select chapters identifies relevant clinical skills covered in *Clinical Psychomotor Skills* 8th edition (Tollefson & Hillman, 2022), sold separately.

FEATURES WITHIN CHAPTERS

Learn about the importance of evidence and clinical research in nursing with the **Evidence-based practice** boxes which link research to nursing practice.

EVIDENCE-BASED PRACTICE

Title of study
Physical assessment skills taught in nursing curricula: a scoping review

Authors
S Morrell, N Giannotti, G Pittman and A Mulcaster

Purpose
There is discrepancy between curricula in the essential PA skills required for entry-level RNs. This scoping review was undertaken to determine the knowledge base regarding the skills taught to undergraduate nursing students.

Questions asked were:

- Which PA skills are included in curricula?
- Which PA skills are performed by students in clinical placements?
- Which PA skills are used by RNs in practice?

Methods
Studies of PA skills taught in any undergraduate registered nursing program or used by RNs in practice were considered. PA

Findings
Thirteen records from the United States, Australia, New Zealand, Turkey, Norway, Korea, Italy and one of unknown origin were extracted for synthesis. One was an integrated review, one an author reflection, one a mixed method study, and 10 were quantitative studies. Three studies examined PA skills taught in global nursing curricula. Four others explored PA skills used on clinical placements. Six studies examined which PA skills were routinely used by RNs in practice.

In the studies, between 98 to 122 PA skills were taught in global nursing programs, although only 33 skills were routinely taught in curricula, and only 20 of these were the same across all studies (core skills). On clinical placements, students performed 32 PA skills, and seven of the 32 skills were core skills in all studies. Of the seven core skills routinely performed by students, six were taught in nursing curricula in the studies used for this scoping review. RNs performed 39 PA skills, 11 of which were the same across all studies (core skills). Also, 10 of the PA skills taught in

Respecting our differences boxes explore some considerations for nursing clients with diverse backgrounds, needs and abilities.

RESPECTING OUR DIFFERENCES

Nutritional behaviours of selected cultural and religious groups

Consider cultural or religious food preferences before assessing or recommending nutritional changes. Some differing nutritional needs are presented here:

- Asian peoples' main food types are rice, green tea, vegetables and fish. A rice-and-water soup is often fed to the sick.
- Islamic (Muslim) law does not permit the consumption of pork, alcohol, or meat that has not been slaughtered according to the Islamic code. The main meal is at midday.
- Buddhists and Sikhs can have food preferences based on their religious practices and may require a vegetarian diet.
- Orthodox Jews are not permitted to eat pork, rabbit or shellfish. Milk and meat are not taken at the same meal. A vegetarian diet is acceptable when kosher meat is not available. Strict guidelines dictate food preparation.

It is important that you assess an individual's dietary

Consider approaches to safe and respectful care for clients from diverse cultural backgrounds with the **Culturally safe care** boxes.

CULTURALLY SAFE CARE

Continuing your learning journey

- Acquire new knowledge from the IAHA's online cultural safety training modules, which uses a cultural responsiveness framework: https://iaha.com.au/iaha-consulting/cultural-responsiveness-training/
- Learn from the CATSINaM cultural safety training e-learning modules: https://catsinam.org.au/cultural-safety-1-day-workshop/
- Discover these clinical yarning e-learning modules: https://www.clinicalyarning.org.au/
- Explore Aboriginal and Torres Strait Islander peoples' experiences and learn about local cultures near you:
- Visit the Healing Foundation website to learn more about the Stolen Generations and how to educate all age groups: https://healingfoundation.org.au/
- Learn more about Aboriginal kinship systems from Sydney University: https://www.sydney.edu.au/abo vision-and-values/our-aboriginal-and-torres-strait- islander-community/kinship-module.html
- Watch this video to understand intergenerational trauma. https://healingfoundation.org.au/intergenerational-trauma/
- Explore more about the history of stolen wages: https://www.creativespirits.info/aboriginalculture/ economy/stolen-wages/stolen-wages

NEW

Identify important client health and safety issues and the appropriate response to critical situations with the **Safety first** boxes.

SAFETY FIRST

REDUCING THE RISK OF LATEX ALLERGIES

Identify people at risk
HCW are more likely to develop a latex allergy than the general population because of frequent exposure.

- If can affect anyone with a history of:
  - asthma, dermatitis, eczema
  - repeated, multiple catheterisations, multiple surgeries, especially in childhood
  - anaphylaxis during hospitalisation or following a dental visit
  - females, as they have greater exposure to latex due to gynaecological and obstetric procedures.

Protect from exposure

- Avoid contact with latex – use non-latex materials (especially gloves for HCW, but hundreds of products, from children's balloons to medical materials [i.e., some
- Display the allergy status of the person prominently (e.g., red allergy armband, notation on care plan, in medical records, on dietary notes).
- Choose latex-free contraceptives (e.g., condoms, diaphragm).

Educate

- Know the symptoms of:
  - latex allergy (conjunctivitis, urticaria, rhinitis, sneezing)
  - irritant dermatitis (although not an immediate allergic reaction, it promotes latex absorption); that is, rough, scaly, dry skin with weeping blisters/sores, exacerbated by sweating, friction and frequent handwashing with harsh soap
  - allergic contact dermatitis (similar symptoms to irritant dermatitis but occurs 12–48 hours following

Learn key information and issues in nursing with the **Nursing highlights** boxes.

NURSING HIGHLIGHTS

HERBS FOR THE CIRCULATORY SYSTEM

- Broom
- Dandelion
- Horse chestnut
- Yarrow
- Buckwheat
- Ginger
- Lime blossom
- Cayenne
- Hawthorn
- Mistletoe

Herbs for the respiratory system

Stimulants (expectorants)

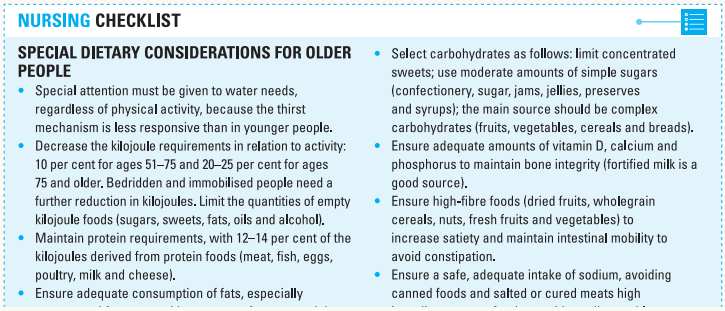
Relaxants (promote expectoration)

- Angelica
- Elecampane
- Hyssop
- Wild cherry bark
- Aniseed
- Flaxseed
- Plantain
- Wild lettuce
- Coltsfoot
- Grindelia
- Thyme

Demulcents (mucilaginous)

FEATURES WITHIN CHAPTERS

Review and revise useful lists of important concepts in nursing, client teaching and the nursing process with the **Nursing checklist** boxes.

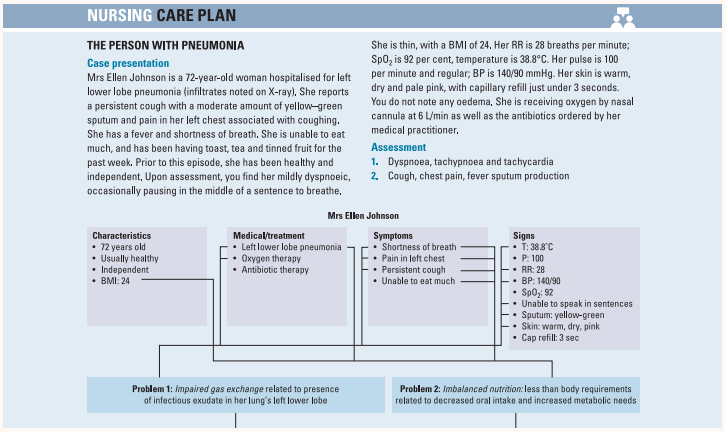


NURSING CHECKLIST

SPECIAL DIETARY CONSIDERATIONS FOR OLDER PEOPLE

- Special attention must be given to water needs, regardless of physical activity, because the thirst mechanism is less responsive than in younger people.
- Decrease the kilojoule requirements in relation to activity: 10 per cent for ages 51–75 and 20–25 per cent for ages 75 and older. Bedridden and immobilised people need a further reduction in kilojoules. Limit the quantities of empty kilojoule foods (sugars, sweets, fats, oils and alcohol).
- Maintain protein requirements, with 12–14 per cent of the kilojoules derived from protein foods (meat, fish, eggs, poultry, milk and cheese).
- Ensure adequate consumption of fats, especially
- Select carbohydrates as follows: limit concentrated sweets; use moderate amounts of simple sugars (confectionery, sugar, jams, jellies, preserves and syrups); the main source should be complex carbohydrates (fruits, vegetables, cereals and breads).
- Ensure adequate amounts of vitamin D, calcium and phosphorus to maintain bone integrity (fortified milk is a good source).
- Ensure high-fibre foods (dried fruits, wholegrain cereals, nuts, fresh fruits and vegetables) to increase satiety and maintain intestinal mobility to avoid constipation.
- Ensure a safe, adequate intake of sodium, avoiding canned foods and salted or cured meats high

Follow an individual person's case and the process of planning care, identifying problems, performing interventions and evaluating outcomes for that person with the detailed **Nursing care plans** and associated visual **Nursing concept maps**.



NURSING CARE PLAN

THE PERSON WITH PNEUMONIA

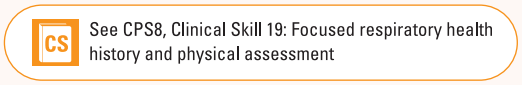
Case presentation

Mrs Ellen Johnson is a 72-year-old woman hospitalised for left lower lobe pneumonia (infiltrates noted on X-ray). She reports a persistent cough with a moderate amount of yellow–green sputum and pain in her left chest associated with coughing. She has a fever and shortness of breath. She is unable to eat much, and has been having toast, tea and tinned fruit for the past week. Prior to this episode, she has been healthy and independent. Upon assessment, you find her mildly dyspnoeic, occasionally pausing in the middle of a sentence to breathe. She is thin, with a BMI of 24. Her RR is 28 breaths per minute; SpO_2 is 92 per cent, temperature is 38.8°C. Her pulse is 100 per minute and regular; BP is 140/90 mmHg. Her skin is warm, dry and pale pink, with capillary refill just under 3 seconds. You do not note any oedema. She is receiving oxygen by nasal cannula at 6 L/min as well as the antibiotics ordered by her medical practitioner.

Assessment

1. Dyspnoea, tachypnoea and tachycardia
2. Cough, chest pain, fever sputum production

Link theory to key clinical skills with the **Clinical skills icon** throughout the chapters. These icons direct you to corresponding clinical skills in more detail in *Clinical Psychomotor Skills* 8th edition (Tollefson & Hillman,2022), sold separately.



CS See CPS8, Clinical Skill 19: Focused respiratory health history and physical assessment

END-OF-CHAPTER FEATURES

At the end of each chapter you will find several tools to help you to review, practise and extend your knowledge of the key learning outcomes.

The **Summary** section highlights the important concepts covered in the chapter and links back to the learning outcomes.

CHAPTER RESOURCES

SUMMARY

- Nursing is an art and a science in which people are assisted in learning to care for themselves whenever possible and cared for when they are unable to meet their own needs. The professionalisation of nursing has been influenced by key issues such as: the status of women, the development of the biomedical model, employment opportunities, class structures and religion. New Zealand was the first country to register nurses.
- As the nursing profession continues to evolve and respond to the challenges within the health care system, nurses will remain responsive to societal needs.
- 'Concepts' are abstract vehicles of thought and are the building blocks of theory, while 'propositions' are relational statements that link concepts together. 'Theories' are an organised, coherent and systematic articulation of a set of statements related to significant questions. Nursing uses theories from other disciplines in conjunction with nursing theory to enhance knowledge, understanding and practice.
- The complexity of theoretical frameworks is categorised as 'grand theory', 'middle-range theory' and 'micro-range theory'. Grand theories, or conceptual models, focus on phenomena of concern to the discipline. Middle-range theories provide a bridge from grand theories to effectively describe and explain specific nursing phenomena. Micro-range theories view phenomena in the everyday practice of nurse–patient interactions.
- The work of early nursing theories focused on the traditional tasks of nursing. Challenged to create synergy between the art and science of nursing, nursing theories have developed. Nursing theorists such as Peplau, Henderson, Orlanda, Rogers and Orem, to name a few, have created philosophies, frameworks, models and theories to achieve this synergy. Contemporary nursing philosophy embraces caring and nurturance with increasing prominence in recent nursing theories.

END-OF-CHAPTER FEATURES

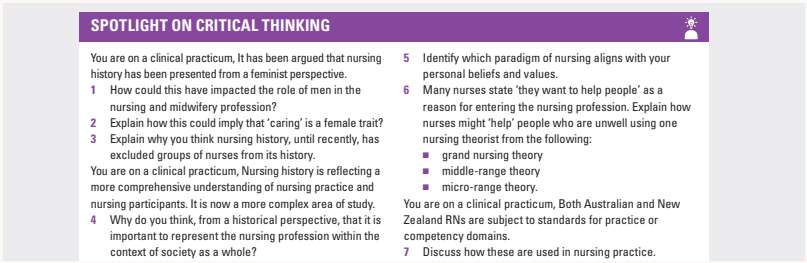
Review questions give you the opportunity to test your knowledge and consolidate your learning. Answers to review questions can be found at the back of the book.

UNIT 01

REVIEW QUESTIONS

1 Since the formalisation of nursing, notably with Florence Nightingale, social and political influences on the role of nursing have included (select all that apply):
   a the cost of living for sick people
   b the role of women in society
   c technological advances improving health outcomes
   d access to clean water, hygiene and employment
   e registration and professionalisation of nurses.
2 In the 19th century, the Anglican High Church nuns:
   a began training nurses at St Thomas' Hospital
   b introduced university-based nursing education
   c set-up their training school at the Sydney Hospital
   d were the dominant model of nursing reform in England
   e developed the first nursing theories.
3 Which was the first country to enact legislation to register nurses?
   a Australia
   b New Zealand
   c Britain
5 Nursing's metaparadigm includes:
   a concepts, theory, health and environment
   b health, clinicians, environment and nursing
   c providers, standards, models and patients
   d the person, environment, health and nursing
   e theory, health, environment and person.
6 A micro-range theory:
   a is composed of concepts representing global and complex phenomena
   b is the most concrete and narrow of theories that establishes nursing care guidelines
   c describes, explains and predicts complex situations and directs interventions
   d provides an overall framework for structuring broad, abstract ideas
   e answers questions about nursing phenomena without covering the full range of concern to the discipline.
7 An organised, coherent set of concepts and their relationship to each other that is proposed to explain a given

Spotlight on critical thinking questions challenge you to reflect on and discuss complex issues in relation to nursing.



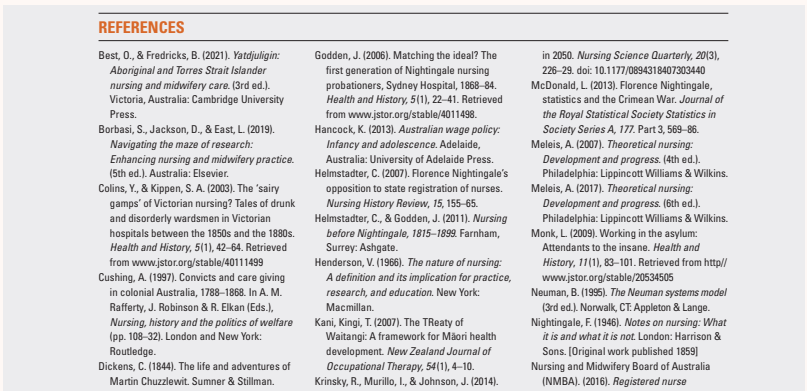
SPOTLIGHT ON CRITICAL THINKING

You are on a clinical practicum, It has been argued that nursing history has been presented from a feminist perspective.
1 How could this have impacted the role of men in the nursing and midwifery profession?
2 Explain how this could imply that 'caring' is a female trait?
3 Explain why you think nursing history, until recently, has excluded groups of nurses from its history.

You are on a clinical practicum, Nursing history is reflecting a more comprehensive understanding of nursing practice and nursing participants. It is now a more complex area of study.
4 Why do you think, from a historical perspective, that it is important to represent the nursing profession within the context of society as a whole?
5 Identify which paradigm of nursing aligns with your personal beliefs and values.
6 Many nurses state 'they want to help people' as a reason for entering the nursing profession. Explain how nurses might 'help' people who are unwell using one nursing theorist from the following:
   - grand nursing theory
   - middle-range theory
   - micro-range theory.

You are on a clinical practicum, Both Australian and New Zealand RNs are subject to standards for practice or competency domains.
7 Discuss how these are used in nursing practice.

Extend your understanding with the list of **References** relevant to each chapter.



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Guide to the online resources

FOR THE INSTRUCTOR

Cengage is pleased to provide you with a selection of resources that will help you to prepare your lectures and assessments, when you choose this textbook for your course.
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- Resource aids
- Evaluation strategies
- Links to useful online resources
- Solutions to end of chapter review and spotlight on critical thinking questions.

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PREFACE

We are very excited to share this third edition of *Australian and New Zealand Fundamentals of Nursing* with you! We hope this text will encourage you to develop an inquiring stance based on the joy of discovery and a love of learning.

Nursing is facing new challenges in delivering quality care to vulnerable peoples in a variety of settings. These settings are rapidly expanding and challenge all nurses to think creatively in applying best practices based on current research. This edition presents the most current advances in nursing care, nursing education and research relative to the demands of delivering care across a continuum of settings. Multiple theories of nursing are embraced, and nursing's elements of theory metaparadigm – human beings, environment, health and nursing – are threaded throughout this text. The organisation of units and chapters is sequential; however, every effort has been made to allow for the varying needs of diverse curricula and students. Each chapter may be used independently of the others according to the specific curriculum design.

This comprehensive edition addresses fundamental concepts to help prepare novice graduate nurses to apply an understanding of human behaviour to issues encountered in clinical settings. Physiological and psychosocial responses of both an individual and their nurse are addressed in a holistic manner. Integrative modalities are presented in an environment that encourages the individual to participate in determining their own care.

Skills and procedures have been relegated to another text: J. Tollefson and E. Hillman's *Clinical Psychomotor Skills: Assessment Tools for Nursing Students* (eighth edition), published by Cengage in 2022. This was done to decrease the size of this textbook and permit more discussion of the individual skills. Using contemporary clinical information based on sound theoretical concepts, and scientific evidence, the skills in the latest edition of Tollefson and Hillman both supplement and complement the material in this text. Therapeutic nursing interventions reflect the current Registered Nurse Standards of Practice (2016) and emphasise safety, communication skills, clinical reasoning and interdisciplinary collaboration in delivering nursing care. You will be referred to the appropriate procedure within the text.

CONCEPTUAL APPROACH

This edition presents in-depth material in a clear, concise manner using language that is easy to read, by linking related concepts. Nursing knowledge is formulated on the basic concepts of scientific and discipline-specific theory, health and health promotion, the environment, holism, health care teaching, spirituality, research and evidence-based practice, and the continuum of care. Emphasis is placed on cultural diversity, care of the older adult, and ethical and legal principles.

The nursing process provides a consistent approach for presenting information. Assessment tools specific to selected topics are presented to assist you with pertinent data collection. Critical thinking and reflective reasoning skills are integrated throughout the text. The safe and appropriate use of technology has been incorporated throughout the text to reflect contemporary nursing practice.

The conceptual approach used as an organisational framework for this Australian and New Zealand edition falls into four categories:

1. **Individuals** are viewed as holistic beings with multiple needs and strengths, and the abilities to meet those needs. Holism implies that individuals are treated as whole entities rather than fragmented parts or problems. Each person is a complex entity who is influenced by cultural values, including spiritual beliefs and practices. Every person has the right to be treated with dignity and respect regardless of race, ethnicity, age, religion, socioeconomic status or health status. Traditional terms for people who are being treated for their health care such as 'patient' or 'client' are avoided as these terms do not reflect the conceptual value of the individual.
2. **Environment** is a complex interrelationship of internal and external variables. Internal variables include one's self-concept, self-efficacy, cognitive development and psychological traits. The external environment affects an individual's health status by facilitating or hindering the person's achievement of needs.
3. **Health** is viewed as a dynamic force that occurs on a continuum ranging from wellness to death. An individual's actions and choices effect

changes in their health status. Individuals who are experiencing illness have strengths that may improve their health status. On the other hand, individuals who are experiencing a high degree of health generally have areas that can be improved.

4 **Nursing** is an active, interpersonal, professional practice that seeks to improve the health status of individuals. Nursing's focus is person-centred and communicates a caring intent. Caring and compassion are demonstrated through nursing interventions. Nursing is a professional practice based on scientific knowledge and is delivered in an artful manner.

Other important conceptual threads used to direct the development of this book include the following:

- **Health promotion** encourages individuals to engage in behaviours and lifestyles that facilitate wellness.
- **Standards of practice** are discussed, with information from national and specialty organisations (both from Australia and New Zealand) incorporated into each chapter as appropriate.
- **Critical thinking** is an essential skill for blending science with the art of nursing. It is woven into each chapter with challenges and questions.
- **Evidence-based practice** derived from scientific research is emphasised across chapters.
- **Cultural diversity** is defined as individual differences among people resulting from racial, ethnic, religious and cultural variables.
- **Continuum of care** is viewed as a process for providing health care services in order to ensure consistent care across practice settings.
- **Community**, as both an aggregate focus for health care and as the setting for the delivery of care, is evidenced in Chapter 16 and is threaded throughout the text.
- **Holism** recognises the body–mind connection and views the person as a whole rather than as fragmented parts.
- **Spirituality** encompasses the relationship with oneself, a sense of connection with others, and a relationship with a higher power or divine source. It is discussed in depth in Chapter 27.
- **Caring**, a universal value that directs nursing practice, is incorporated throughout the text, and is described in depth in Chapter 13.
- **Alternative and complementary modalities** are treatment approaches that can be used in conjunction with conventional medical therapies. Chapter 34 is dedicated to this integrative approach, and related information featuring integrative concepts is included throughout the text.

ORGANISATION

This textbook provides you with a bridge that presents theory to support clinical practice. The intent of the authors is to help you become a proficient critical thinker who is able to use the nursing process with diverse individuals in a variety of settings. Research-based knowledge that reflects contemporary practice is presented in a reader-friendly, practical manner.

Features that challenge you to use critical-thinking skills are incorporated into each chapter, and critical-thinking questions appear at the end of each chapter. Critical information is highlighted throughout the text in a format that is easily accessed and understood. Similar concepts have been grouped together to encourage you to learn through association; this method of presentation also prevents the duplication of content.

Australian and New Zealand Fundamentals of Nursing presents 43 chapters organised in six units:

- **Unit 1: Nursing's perspectives: past, present and future** provides a comprehensive discussion of nursing's evolution as a profession and its contributions to health care based on standards of practice. The theoretical frameworks for guiding professional practice and the significance of incorporating research into nursing practice are emphasised. Chapters are reflective of the parallel evolution of nursing and nursing education. Examples are provided showing the incorporation of theory into the nursing process. The concept of evidence-based practice is emphasised along with research utilisation. Quality is discussed from the perspective of health care delivery and the continuum of care.
- **Unit 2: Nursing process: the standard of care** discusses recognised competencies and standards of care established by Australian and New Zealand nursing registration bodies, the Australian Nursing and Midwifery Federation, and nursing specialty organisations. Each stage of the nursing process is discussed, with an emphasis on critical thinking.
- **Unit 3: Professional accountability** describes the nurse's responsibilities to the individual in their care, the community and the profession. Nursing leadership is discussed in Chapter 10. Chapter 11 combines legal and ethical aspects of nursing practice to reflect the interfacing of these concepts. An in-depth discussion of informatics appears in Chapter 12, which focuses on documentation.
- **Unit 4: Promoting health** was created to integrate information on health promotion, consumer demand and facilitating empowerment for the person seeking health care. Chapter 13 provides nursing theoretical perspectives on caring. Chapter 15 emphasises the nurse's role in empowering the person seeking health care to assume more personal accountability for their own health-related behaviours. Chapter 16 addresses the health needs of families and communities.

- **Unit 5: Responding to basic psychosocial needs** stresses the importance of the holistic nature of nursing. Spirituality is spotlighted in order to emphasise its impact on individuals' health.
- **Unit 6: Responding to basic physiological needs** discusses aspects of nursing care that are common to every area of nursing practice. Concepts such as safety and infection control, medication administration, assessment of the person, their comfort, mobility, fluid and electrolyte balance, oxygenation, skin integrity, nutrition and elimination are all described within the nursing process framework.

NEW TO THE THIRD AUSTRALIAN AND NEW ZEALAND EDITION

All the material has been settled into an Australian and New Zealand context, using culturally appropriate and relevant examples, Australian and New Zealand government and non-government organisation information, research, legal and ethical material and laws, evidence-based practice information, and ratified nursing standards. All chapters have been extensively reviewed to reflect contemporary Australian and New Zealand nursing practice.

Contributions for specific chapters were sought from Australian and New Zealand nurses who are expert in their fields.

Additional features include the following:

- At the end of every chapter, a set of 'Review questions' is presented. For this third edition, Review questions have been revised. The answers and rationales are located in the Instructor's Manual.
- 'Spotlight on critical thinking' at the end of the chapter focuses attention on issues relating to the caring, compassion, legal, ethical and professional components of nursing practice.
- 'Safety first' identifies critical health and safety situations and highlights strategies for the appropriate nursing response and management. These boxes are highly visible to emphasise the critical nature of the information.
- 'Evidence-based practice' emphasises the importance of clinical research by linking theory to practice. Relevant and recent research into appropriate subjects is presented. Most chapters have more than one Evidence-based practice box.
- 'Respecting our differences' challenges you to consider approaches to respectful and appropriate care for populations of people who may differ in a variety of ways, including culture, gender, age and developmental level.
- 'Nursing highlights' provide key information on nursing practice.
- 'Nursing checklists' are provided to assist you with the revision of information.

EXTENSIVE TEACHING/ LEARNING PACKAGE

The complete supplements package was developed to achieve two goals:

1. to assist you in learning the essential skills and competencies needed to secure a career in nursing
2. to assist your instructors in planning and implementing their programs for the most efficient use of time and other resources.

LANGUAGE AND TERMINOLOGY

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

This textbook has a full chapter on health issues pertaining to Aboriginal and Torres Strait Islander peoples, as well as integrated material throughout the book relating to issues, events, policies and groups. We have sought to use inclusive, appropriate and non-discriminatory terminology throughout, and for this purpose we have followed the published guidelines provided by NSW Health in *Communicating Positively: A Guide to Appropriate Aboriginal Terminology*.

CULTURAL SAFETY IN NEW ZEALAND

New Zealand has a bicultural society by legislation. This diversity creates a vibrant, rich background to daily living. Issues may arise when people of a different culture, ethnicity or religion interact and do not understand each other. These misunderstandings can result in insult, feelings of isolation and inequality of service. Culturally unsafe practices are those that 'diminish, demean or disempower the cultural identity and well-being of an individual' (NCNZ, 2012, p. 9). This definition is supported by laws on antidiscrimination that are made at the national level in New Zealand. In Australia legislation exists at Commonwealth, state and territory levels, which make it an offence to discriminate against a person because of their race, ethnicity, culture or religion.

GENDER DIVERSITY

Gender diversity describes people who identify themselves by self expression as beyond binary. Much of the language used to describe these experiences is still evolving. We have tried to use gender diverse language (names, pronouns) to acknowledge the expectation of inclusivity and to respect the gender diverse and the choices they make in their lives.

NURSING DIAGNOSIS

Fry (1953) first used the term 'nursing diagnosis', but it was not until 1974, after the first meeting of the North American Nursing Diagnosis Association (NANDA), that nursing diagnosis was added as a separate and distinct step in the nursing process. Prior to this, nursing diagnosis had been included as a natural conclusion to the first step in the nursing process – assessment.

While the notion of nursing diagnosis is imperative for the Australian and New Zealand nursing context, the specific language used by NANDA and the term 'nursing diagnosis' are not widely used in clinical practice. In the Australian and New Zealand setting, the term 'nursing diagnosis' is routinely replaced with 'problem identification', the term we have chosen to use in this text. The exact language used to name the problem is not as important as ensuring that all problems are identified in a systematic way.

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UNIT 01

NURSING PERSPECTIVES: PAST, PRESENT AND FUTURE

CHAPTER 01

EVOLUTION OF NURSING EDUCATION AND THEORY

LEARNING OUTCOMES

1 Explore the evolution of nursing, identify the major historical events leading to current nursing education, and describe the impact of 19th- and 20th-century nursing leadership on current nursing practice in Australia and New Zealand.
2 Describe the trends in nursing education specifically relating to the issues of competency development and delivery of care.
3 Define the terms 'theory', 'concept' and 'proposition'.
4 Describe the three scopes of theory: 'grand theories', 'middle-range theories' and 'micro-range theories' and discuss knowledge development in nursing.
5 Identify and interpret major nursing theories in relation to practice.

INTRODUCTION

This chapter will incorporate a historical overview of both the foundation of modern nursing and nursing education in the 19th, 20th and 21st centuries. It will also explore the development of nursing theory and how these theories support and define nursing practice in Australia and New Zealand today. Examining social forces that have influenced the development of the professional nurse and nursing education will provide foundation knowledge of how contemporary nurses have evolved. This will be followed by the stages of modern nursing education highlighting the role of the forerunner of formalised nursing education – Florence Nightingale. It is important at this stage to mention how nurses have been regulated by law and to introduce the concept of 'scope of practice'. As nurses, our profession is defined by our unique contribution to health care, which is based in nursing theory, combining art and science to care for people based on scientific knowledge, critical-thinking skills and caring behaviours. An overview of the contribution of nursing theorists will be explored giving the reader an understanding of each theorist and their contribution to the profession. Your understanding of these concepts will lead to ongoing professional responses to a changing world.

EVOLUTION OF NURSING EDUCATION IN AUSTRALIA AND NEW ZEALAND

It is important to acknowledge that nursing has a long history with origins in religious orders and the military (Roux & Halstead, 2018). As a result, the framework of early nursing education reflects characteristics of each. The following discussion will provide a brief overview of nursing education in Britain followed by a focus on the Australian and New Zealand perspectives. The evolution of nursing education demonstrates that educational opportunities and approaches are continuing to develop and to be challenged. Understanding our past directs our perceptions of the present and assists us in planning for our profession's future.

Nursing history has traditionally been presented using familiar stories of famous nurses, nursing leaders and events. It has been explored from a *grand narrative* perspective, describing the 'big picture' of nursing history and practice. However, expectations and interpretations of what a **nurse** is and does have altered based on the influence of social and political factors. The delivery of nursing education in Australia began with the arrival of the Nightingale nurses in 1868. The basis of practice for these nurses was both religious and military. Areas of conflict, such as the Crimean War and both world wars, have also served to shape the changes in education of nurses in Australia and New Zealand. It has helped to change the skills and knowledge of nurses from handmaidens for doctors to nurses with specific specialties. Although the role of the male-identifying nurse is important in our history, aligning with the emancipation of women, nurses began to reflect and theorise about what nurses 'do'. This has led to increasing self-determination, expansion of their role, and the professionalisation of nursing. Finally, the shift from nursing schools to modern tertiary education has cemented the perception of nursing as its own pursuit. When reading this chapter, consider nursing from the historical viewpoint influenced by nursing theory and how you will contribute to this body of knowledge.

Theory and practice globally, nationally and locally have been shaped by political, social, cultural, economic and gender perspectives. These perspectives and influences explain how the modern landscape of nursing practice occurs and provides insight into future potential development by emerging nurse leaders. There are polarised viewpoints about the role of Florence Nightingale, yet the value of her contributions cannot be ignored. Her influences both past and present will be discussed providing a basis for future nurse contributions in theory, practice and research. Adding to Nightingale's contributions, early nurse leaders in Australia and New Zealand provide the narrative for ongoing development of the nursing education system. The role of nursing theorists in this context has led to a reputable profession valued internationally due to unique influences. The contributions of **Aboriginal and Torres Strait Islander peoples** and male-identifying nurses continue to be explored. This approach places nursing within the wider context of the societies that it is practised within.

Geographic, social, political and economic structures contributed to nursing theory in Australia and New Zealand, which developed an almost parallel practice. Contemporary nurses practice in a manner that is a mix of the historical as well as educational, scientific, social and political influences. The evolution of these influences and development of theories have resulted in Australia and New Zealand nursing today. These theories advocate nursing individuals and communities as being a delicate balance between promoting a person's independence and dependence. The approach focuses on illness, the person's response to illness or disability, defines caring, and supports the delivery of care across the *life span*. This aspect of nursing also includes assisting a person with a terminal illness to maintain comfort and dignity in the final stage of life.

While there is not a definitive starting date, in recent years nurses have been further supported and

encouraged to participate in policy discussions. This includes the creation and modification of health policy at all levels of government, although there are concerns about the level of power or equity in the process (Rumsey et al., 2021). It is important to acknowledge at this point that nursing and midwifery have a shared history and are not entirely separate entities. While this discussion will centre on nursing, some aspects of midwifery will be included because of their close association.

Table 1-1 highlights some of the key moments in the development of nursing practice and education, identifying early aspects of nursing development while concentrating on Australian and New Zealand nursing educational history.

TABLE 1-1
Historical events influencing the evolution of nursing

DATE	EVENT
1500–600 BCE	Health religions of India – medicinal practices of the Vedic period
390–407 CE	Early Christianity – deaconesses, like deacons, also ministered to the sick and poor
1095	Antonines establish the Brothers of St Anthony Hospital in London, England
805	The first general hospital was built by Harun Al-Rashid in Baghdad, Iraq
1811	Sydney Hospital opens, New South Wales (NSW), Australia
1815	Sisters of Charity founded by Sister Mary Aikenhead in Ireland
1820	Florence Nightingale born in Florence, Italy
1836	Foundation of the Deaconess Mutterhaus next to the Kaiserswerther Market in Kaiserswerth, in the City of Düsseldorf, Germany
1838	Irish Sisters of Charity nurses arrive in Sydney, Australia, visiting workhouses, hospitals, orphanages schools and jails
1840	Treaty of Waitangi signed by the British Crown and Māori chiefs in New Zealand Elizabeth Fry establishes the Institution of Nursing Sisters and a three-month nurse training course in England
1853–56	Crimean War
1859	Nightingale's *Notes on nursing* published in England
1860	First Nightingale School of Nursing, St Thomas' Hospital, London, England
1868	Lucy Osburn arrives in Sydney to develop a Nightingale-based training school for nurses at the Sydney Hospital, Australia
1873	Grace Neill begins training at St John's Hospital in London, England
1887	British Nurses Association (BNA) is founded
1888	Australia and New Zealand are requested to form chapters of the BNA BNA publishers the journal *The Nursing Record*
1890–95	Royal Commission into Charitable Institutions is held in Victoria, Australia
1896	Mereana Tangata becomes the first Māori hospital-trained nurse in New Zealand
1899	Australasian Trained Nurses Association (ATNA) is established in NSW, Australia Foundation of International Council of Nurses (ICN) proposed by Ethel Gordon Fenwick at the Annual Conference of the Matron's Council of Britain and Ireland
1900	The first issue of the *American Journal of Nursing* (AJN) is published
1901	The *Nurses' Registration Act 1901* is passed in New Zealand New Zealander, Ellen Dougherty, becomes the first registered nurse (RN) in the world The Victorian Trained Nurses Association (VTNA) is established in Victoria, Australia
1908	Public health nursing commences in both Melbourne and Sydney, Australia Ākenehi Hei is the first Māori RN and midwife in New Zealand
1909	The first three-year nursing diploma course starts at the University of Minnesota, US District nurses replace Māori health inspectors in New Zealand
1911	Queensland becomes the first state in Australia to register general and psychiatric nurses and midwives
1915	Establishment of the New Zealand Army Nursing Service
1919	The *Nursing Act 1919* is passed in Britain
1939	New Zealand's Nurses' Registration Act is amended to allow men to train and register as nurses
1940	New Zealand assumes state responsibility for public general and psychiatric hospitals
1943	The Australian hospital ship *Centaur* sinks off the Queensland coast

→

DATE	EVENT
1945	The psychiatric nurse qualification is acknowledged and administered by the Nurses and Midwifery Board in New Zealand
1956	Faith Thomas is one of the first Aboriginal people to complete her nursing training in South Australia
1970	The community health movement begins in Australia
1971	The *Carpenter report* recommends the transfer of nursing education to the tertiary education sector in New Zealand The Nursing Council of New Zealand (NCNZ) is established Sally Goold, Fred Hollows and Dulcie Flower establish the Aboriginal Medical Service
1973	Postgraduate nursing education commences at Victoria and Massey universities in New Zealand
1974	The amended Australian *Nurses' Registration Act 1974* (Tasmania) allows men to train, register and practise as midwives for the first time
1976	John Chapman is the first man to qualify as a midwife in Tasmania
1978	The Alma Ata Conference on Primary Health Care and Community Development, supported by the World Health Organization (WHO), is convened in Almaty (then called Alma-Ata), Kazakhstan
1983	Australia's first diploma-level course is introduced by the College of Nursing NSW Government announces it will transfer pre-registration nursing to the tertiary sector by 1985 Medicare and universal health care is introduced by the Australian Government National Council of Māori Nurses is established in New Zealand
1984	Hawke Labor Government announces that all Australian registered nursing education will be transferred to the tertiary sector by 1992
1989	Last hospital training school closes in New Zealand
1990	Last intake of hospital-trained nurses in Australia
1991	Degree nursing programs replace the Diploma in Nursing in Australia
1992	Degree nursing programs replace the Diploma in Nursing in New Zealand The NCNZ introduces cultural safety as a curriculum requirement for all nursing students
1993	The first Māori midwives meeting in New Zealand
2000	Ngā Maia (Māori Midwives Aotearoa) is established in New Zealand
2004	Nurse practitioners receive practice rights in Australia and New Zealand
2010	Establishment of the Australian Health Practitioner Regulation Agency, which implements a national registration and accreditation system for health professionals, including nurses and midwives Pharmaceutical Benefits Scheme, prescribing rights for Nurse practitioners in Australia
2011	Royal College of Nursing (RCN) Australia and the College of Nursing unite to form the Australian College of Nursing (ACN)
2016	Medication prescribing rights for designated specialist RNs in New Zealand
2020	The International Year of the Nurse and Midwife COVID-19 becomes a pandemic

The introduction of nursing training and the development of nursing care are frequently attributed to Florence Nightingale, who remains a much-celebrated individual in nursing circles. The following section highlights her contribution to nursing practice and education. It also identifies some of the inconsistencies in her practice. While Nightingale's practices were innovative at the time, scientific and practice advances have naturally outdated some of her ideas in relation to patient care.

Florence Nightingale (1820–1910)

Florence Nightingale was born on 12 May 1820 in Florence, Italy into an affluent British family. The way she conducted herself during her life consistently reflected the ideas of her time – the Victorian era. This was a period of economic, political and social expansion for Britain, which contributed to the growth of the British Empire. Britain continued to colonise regions of the world, allowing the Empire to expand production and manufacturing at home. This was the time of the Industrial Revolution (Roux & Halstead, 2018).

In 1844, Nightingale began studying in Germany and then developed her nursing practice on the European continent with French and German religious orders. She was subsequently appointed the superintendent of an English hospital for ailing governesses, which gave her an opportunity to practise and develop her form of nursing care. Nightingale maintained that control of the environment was essential for the restoration of health, and her care regimen included fresh air and cleanliness. She advocated rest and a quiet environment for patients.

In 1853, the Crimean War began. Newspapers reported that resources were scarce and that soldiers were living and dying in squalid conditions. Political pressure required action, and Nightingale was asked to take a team of 34 nurses to Turkey to oversee a military hospital at Scutari (Fee & Garofalo, 2010). This crucial time epitomises the popularised notion of Nightingale.

To understand Nightingale's nursing theory and the practices that led her to Turkey, it is essential to contextualise Nightingale within the time that she lived. One of the results of the Industrial Revolution in Britain was rapid urbanisation characterised by poor housing and sanitation, and the overpopulation of rapidly expanding city suburbs. These were filthy, diseased communities (Finkelman, 2019). In 19th-century Britain there were two general theories relating to the spread of infections and disease. The 'theory of miasma', which originated in the Middle Ages, argued that the vapours released from rotting organic materials were poisonous and the offending smell was the cause of disease. The 'germ theory', which originated in the 18th century, was a newer development in understanding disease. It was gaining some momentum but did not become the accepted theory until the start of the 20th century. Considering the stench and poor sanitation that permeated suburban Britain in the 19th century, it is understandable that health reformers believed that cleanliness and fresh air was the key to good health.

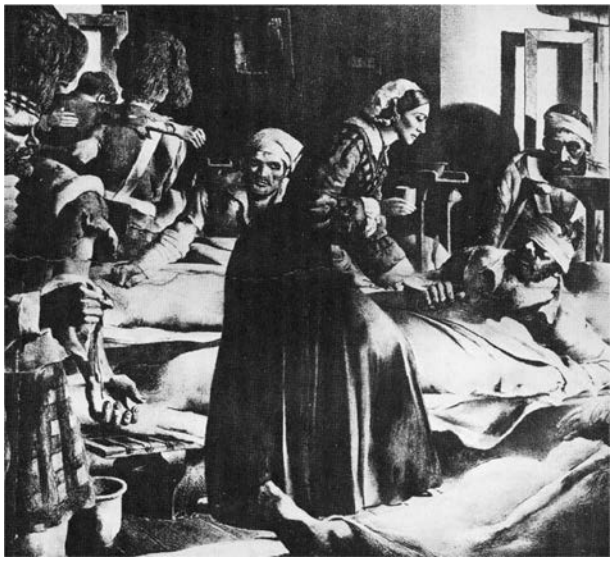

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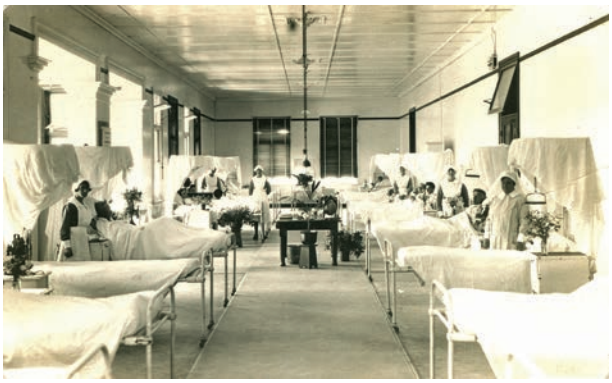
FIGURE 1-1
Florence Nightingale in the Crimea

The Nightingale principle of 'fresh air and light' continued to dictate nursing care into the 20th century. The image of the Ipswich ward presented in **Figure 1-2** shows how people were kept in open wards with high ceilings and large windows that provided natural light and fresh air. The image of the Nhill Hospital in



IPSWICH HOSPITAL MUSEUM COLLECTION, PICTURE IPSWICH, QUEENSLAND

FIGURE 1-2
Male medical ward, Ipswich Central Hospital, Queensland, 1927

Figure 1-3 demonstrates how people were encouraged to spend time outdoors. Note that one person has a camp stretcher to rest on and another has a chair with the capacity to support and elevate their leg.

MUSEUM VICTORIA [MM 003512]

FIGURE 1-3
Nurses with patients in the grounds of Nhill Hospital, Victoria, 1928

Nightingale supported the miasma theory over the germ theory (Fee & Garofalo, 2010), remaining committed to the principles of fresh air and a clean environment while arguing against the 'new' concepts of bacteria and viruses. As such, her achievements while in the Crimea remain contentious and a topic of historical debate. The standard accepted narrative is that she increased the survival rates of injured soldiers in her care (Fee & Garofalo, 2010), but this has been questioned in recent decades. It has been argued that infection and death rates at Nightingale's hospital rose following her arrival (McDonald, 2013) due to the hospital being built over an open sewer (not unusual for 19th-century hospitals). Due to her misunderstanding of infection control, Nightingale did not correlate sanitation and illness, and conditions only improved after the War Office sent the Sanitation Commission to investigate the high death rates and subsequently ordered that the sewers be flushed. Following this, the death rates dropped dramatically (Fee & Garofalo, 2010).

Regardless, on her return to London Nightingale was celebrated. She was awarded prize money that she invested to develop nursing training at London's St Thomas' Hospital. Her nursing model required strict discipline. It supported the notion that nursing was a vocation for women and that nurses should be unquestioningly obedient to senior staff and doctors. It was in Nightingale's time that nursing became increasingly identified as a female role offering middle-class women a respectable occupation and the opportunity of economic independence (McDonald, 2013).

Nightingale was a prolific writer who published a series of nursing texts and wrote letters to various individuals in search of data understand health care needs, record statistics and to continue to reform practice across the Empire (Shellam, 2012). She also used a variety of techniques to advocate for improved health care, including political, administrative, educational and statistical methods. She became an iconic figure in her lifetime and remains a celebrated member of the nursing community today – we celebrate International Nurses Day each year on the anniversary of Nightingale's birthdate. Her nursing theory will be revisited later in this chapter.

NURSING CHECKLIST

Nightingale's basic principles of nursing education were:

- placement of the program in an institution supported by public funds and associated with a medical school
- affiliation with a teaching hospital, but also independent of it
- a nursing program directed and staffed by trained nurses
- a residency to teach students discipline and character.

The sisterhoods

Florence Nightingale's biographers have often presented her as the sole reformer of modern nursing – indeed, as its founder – but this is far from the truth. There are several other reformers who contributed to the education and training of nurses in Nightingale's time. While it is the experience of Britain, Australia and New Zealand that will be discussed here, it should be acknowledged that nursing reform occurred in various parts of the Western world during the same period.

In the early 19th century, hospitals were not places where individuals chose to go. Along with asylums, they were places of last resort, places where the poor, homeless and destitute went for assistance, for shelter and to die. Most individuals paid private nurses to care for them in their home when they were ill or in need of midwifery services. All classes of society sought the assistance of private nurses although this was difficult for the very poor. They were autonomous practitioners and often competed with the medical profession for work (Finkelman, 2019). Nursing was not regulated at this time. It was not until the late 19th century that the certificated, uniformed woman based in a clean hospital environment began to be the dominant image of a nurse. It is worth noting that at the time men were excluded from this version of nursing.

In the 19th century, diverse approaches to nursing practice and training existed. The Nightingale system of nursing training was but one of many. Some religious orders offered limited training that was usually only available to members of the order. In London, Anglican High Church nuns, known as 'sisterhoods', were the dominant model of nursing reform. These orders acted as social service agencies for their communities, providing care for those who could not support themselves. The church and sisterhoods worked for specific hospitals and developed training methods to support a medical practice that was beginning to make advances in disease management and surgery (Helmstadter & Godden, 2011). The Anglican nuns had a vocational drive to care for the acutely sick, disabled and **vulnerable** in their communities. The nuns expanded their training beyond their order and trained *lay* nurses (not part of a religious order). Both Australia and New Zealand benefited from this model of nursing training. Benefits included larger numbers of nursing students for the workforce and the alignment with other health professionals.

Mary Weeden, who trained at London's Charing Cross Hospital from 1878 to 1881, immigrated to Australia and was appointed matron of the Brisbane Hospital. She established the first comprehensive training program for the colony of Queensland. Grace Neill, who was largely responsible for campaigning for nursing registration in New Zealand, had been attributed as training at Nightingale's St Thomas' Hospital, but she trained under the Anglican nuns at St John's Hospital from 1873 to 1876 (Helmstadter & Godden, 2011). Similarly, it was an All Saints sister, Helen Bowden, who established the first training school in the United States (US).

For their time, the sisterhood hospitals took a unique approach to patient care, advocating for nurse–patient ratios to be established and for nurses to be self-directed, autonomous practitioners. But when the Anglican Church began to establish modern administrative practices in its hospitals, and because health care was funded by charitable organisations and by subscription, conflict arose between the sisterhood's principles of practice and the economic reality of supporting its model of patient care and nursing training. It was determined to be too expensive to continue to fund. Due to such conflict and different health agendas, the Anglican nuns

increasingly withdrew their services and training programs from London's hospitals. This had two major outcomes. First, it allowed them to re-establish their practices in community-based environments (Helmstadter & Godden, 2011). Second, it opened the way for the Nightingale model to become more widely adopted. By the end of the 19th century, it had become the template for nursing training, creating a cheaper training program and more compliant nurses who infrequently challenged the decisions made by hospital administrators and medical officers.

Nursing registration

Professionalisation, training and education reform are common themes in nursing history. All three topics encompass the increasing demands made by nursing leaders from the late 19th century into the early 20th century. Medicine had been regulated in Britain from the 1830s and was beginning to make advances in professional standing and political influence, and in improving health care outcomes for people. Utilising scientific advances, medical research was developing new surgical and medical treatments. To support the medical model of care, medicine required the support of nurses trained specifically for hospital work. It was in the late 19th century that medicine began to advocate for hospital care to be the linchpin of health care services. It was an efficient method of administering complex treatments (Helmstadter & Godden, 2011).

British nursing leaders had seen the advances made by medicine since it had become a formalised and regulated profession. They recognised the application and potential benefits for the nursing profession. Ethel Bedford Fenwick, matron of St Bartholomew's Hospital, was the chief advocate for nursing registration in Britain. In 1887, she formed the British Nurses Association (BNA), which lobbied for such registration. The vision of the BNA was that registration would define nursing as a recognised profession, offering equal ranking with other professions and improving nurses' social standing and rates of pay while disallowing non-trained nurses to continue to practise.

Fenwick's specific goal was to make nursing a legally recognised profession where only hospital-trained women could call themselves a nurse. She wanted nursing to become a self-regulated, self-determining profession where doctors were not able to credential or determine nursing practice. Yet due to the complexity of the issue and the lack of female influence in political and economic circles at this time, her ambitions for nursing were not realised. She had to compromise, due to her dependence on the support of the medical profession and its influence in holding key positions within the BNA (Helmstadter, 2007). The presence of medicine within the structures of the BNA resulted in it determining the function, role and credentialling of nurses. Doctors wanted nursing training to support their interests, and nurses to just follow their orders. It would be over 50 years before nurses were able to determine their profession without the presence of medical officers on nursing boards.

Nursing was being confined to hospital-based training and service delivery, and in the process it became increasingly subordinate to medicine. The educational structure of hospital training encouraged this subordination, isolating nursing from the communities that it had traditionally served – something medicine did not allow. Doctors maintained private practices that were based in the community and increasingly determined who was admitted to a hospital and who remained in their home.

In 1888, the BNA asked NSW and New Zealand to form chapters of the organisation to encourage an expansion of its vision for nursing training and practice within the British Empire (Helmstadter, 2007). Fenwick's world vision for advancing nursing was further apparent as she was the founder of the International Council of Nurses (ICN).

To achieve nursing registration, the unqualified and untrained private nurse had diminished areas of employment, so there were several campaigns to discredit their work. However, the private nurse played a pivotal role in the community, attending births, caring for the sick and laying out the dead. Charles Dickens, the social commentator, social reformer and author, included an uncomplimentary depiction of the private nurse in *The life and adventures of Martin Chuzzlewit* (1844). Dickens characterised the private nurse as drunk, addicted to gin and snuff, immoral and of low character. Those requesting reform, formalised training and regulation used the characterisation to their advantage. Only now are historians starting to explore the practices of the time and questioning the validity of the depiction of the private nurse by Dickens and the supporters of nursing regulation (Colins & Kippen, 2003).

Not everyone supported registration and the professionalisation of nursing. Florence Nightingale was one vocal critic of the plan. She did not support a written examination because it did not test a nurse's moral or personal character. It also excluded a large group of nurses, those from the working class, who at this time had marginal literacy and numeracy skills. Interestingly, Australian and New Zealand nurses would achieve registration prior to nurses in Britain.

An introductory history of nursing education in Australia and New Zealand

Australia and New Zealand had established societies prior to European settlement. The ancestral owners had instituted complex methods to care for and treat

the sick and injured. The complexity of Aboriginal, Torres Strait Islander and Māori peoples' health care and treatments are only now beginning to be understood and appreciated (Best & Fredricks, 2021). In 1840, the British Crown and Māori chiefs in New Zealand established the Treaty of Waitangi (Kani Kingi, 2007). In contrast, Aboriginal and Torres Strait Islander peoples in Australian were not given any constitutional status (Lam, 2011). The impact of this is seen in the ongoing disparity of health outcomes between ancestral owners and their descendants, and non-Indigenous people. This history is important when considering nursing theorists such as Madeline Leininger (described later in this chapter) and the inclusion of First Peoples in nursing.

Upon European settlement in Australia, convicts and soldiers offered care to the sick, injured and infirm (Cushing, 1997). The disparate demographic in Australia of an overpopulation of men compared with women, which lasted into the early decades of the 20th century, was the consequence of the transportation of predominantly male convicts. As a result, Australia has a rich history, yet to be fully explored, of male nurses, or attendants as they were often known. In fact, the first trained nurses to reach Australia were five Irish Sisters of Charity, who arrived in Sydney in 1838. Their practice was based in the community and did not offer any nursing training.

It is important to acknowledge that men have always been nurses and there have only been very specific periods when they experienced social or legal exclusion from nursing. There are many traditional masculine working environments, such as religious orders, ships, armies and mines, where men have always been required to provide nursing care (O'Lynn & Tranbarger, 2012).

Sydney Hospital opened in 1811, and was originally staffed by 23 male attendants and five female caregivers who were drawn from the reformed convict population. The hospital was managed by a board of directors who were elected annually by the subscribers. The administration was continually in conflict and mismanagement prevailed. The premises were in an awful state, with vermin, lack of water and poor sanitation. The nurses were often reported as being drunk while on duty. In 1867, Sir Henry Parkes, a prominent NSW politician, wrote to Florence Nightingale requesting the introduction of her model of nursing training to the Sydney Hospital (Godden, 2006). Consequently, Lucy Osburn (1836–91), pictured in **Figure 1-4**, who trained at St Thomas' Hospital, arrived in Sydney in 1868 with five other Nightingale-trained nurses. Formal nursing training had arrived in Australia, and it immediately impacted on how nursing care was offered.

COLLECTION MUSEUM SYDNEY HOSPITAL/SYDNEY EYE HOSPITAL

FIGURE 1-4
Lucy Osburn

The Nightingale model was predominantly a female-centric model, so when Osburn became the matron of the hospital, she advocated the training of female nurses at the exclusion of males. This put her in conflict with previous administrators (Godden, 2006).

New Zealand does not share a history of convict transportation with Australia. Instead, it was settled by the British when convict transportation was in decline. Until the 1860s, New Zealand had limited health services, primarily cottage hospitals in the settled regions. By the end of the 19th century, the role and function of nurses had become more defined as in Australia and the British model of nursing was introduced.

Historically, nursing care in New Zealand, as elsewhere, had been performed in various environments, including institutional care, with which it has a long association. Men and women have long worked together in institutions, such as asylums and psychiatric hospitals. Asylum employees in the 19th century were given the title of 'attendant'; although some women that worked in this environment were trained nurses. Asylum workers have often been represented as desperate individuals with no choice but to seek employment in such an institution. However, this is now being questioned. There were some attractive aspects of asylum work, such as it being an autonomous work environment with limited interference and supervision. It is often assumed that men were sought to work in asylums