EDITORIAL

THE POWER OF NORMAL

There is a drive within each of us towards normality. What is usual, typical, standard, average, natural, regular or conventional shapes our lives in many varied and important ways. We have laws, regulations, codes, guidelines and rules (written, spoken and unspoken) that specify in detail what constitutes normal behaviour. There is often a degree of comfort associated with this, even a sense of safety. As nurses we assess growth and development, indicators of health and well-being, and presenting symptoms against established norms. We can describe performance and outcomes statistically using terms such as deviation from the mean on a normal distribution curve. Normality is central to our lives in so many ways and we value the status quo; when it is challenged we tend to want to 'get back to normal'.

Normality then is a powerful construct embracing everything and everybody (Rabinow & Rose, 2003). Institutions and groups to which people belong require their members to behave in particular ways. Professional groupings (not only in health contexts) require their members to conform to established norms through regulatory means and the judgement of their peers. Disciplinary measures, both formal and informal, are exercised on members for deviation from accepted practice (Dreyfus & Rabinow, 1983). These measures are essential for a safe and quality health service, but create particular challenges when it comes to transforming the workforce to meet burgeoning population health need.

In New Zealand a patient's normal expectation and experience of first contact primary care is to be seen by a general practitioner (GP). It's an expensive model characterised by periodic consultations with attempts at curative medicine and perhaps once did meet most people's immediate health needs. Over recent decades, however, the new normal of population health and socio-economic inequalities has left the traditional GP model wanting. The norm patients should experience for integration of complex health and social needs, is a multidisciplinary approach in which nurses play a central role. Yet where it does exist (usually servicing deprived populations) and where it pushes traditional boundaries, it is tolerated as innovative and subject to funding mechanisms that lack longevity.

The Institute of Medicine (2011) report on the *Future of Nursing* states that nurses have a fundamental role in the transformation of health services, and to advance health, should practice to the full extent of their education and training. Yet transformation of our outmoded system status quo will require a revolution of thought, attitude, custom, practice and policy to properly enable a way of working that should be normal in the first place. The issue of prescriptive authority has perhaps become something of a 'touchstone' in this context with the nurse practitioner (NP) role having made considerable progress in recent years toward disrupting the norm of diagnosis and prescribing as the sole purview of medicine. Later this year prescribing authority will also be available to registered nurses (RN) working in primary health care and in specialist teams. However, the use of advanced practice roles without the autonomy to align services with community need is, as Carryer and Yarwood (2015) point out, at risk of merely shoring up a system we know to be wanting. Smarter use of the nursing workforce is important, but is only one aspect of the revolution this country needs.

The whole of system primary health care revolution we need is one that aligns services to community need and

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where *all* health professionals work to the full extent of their education and training. Nurse practitioners, with their population health focus and as the leaders of primary health care services, could lead a team of nurses (e.g. practice nurses, district nurses, Plunket nurses, public health nurses, occupational health nurses, clinical nurse specialists, mental health nurses), health care assistants and allied health professionals and refer to medical colleagues when particular expertise is needed. Consistent with the intent of the (new) *New Zealand Health Strategy* (Minister of Health, 2016), it would provide the right care at the earliest time to individuals, families and communities. Such a model would refocus general practitioners on the medical complexity for which their education and training prepares them and free them to work more closely with their specialist colleagues. Patients will be better off when cheaper, more convenient services meet the needs of the majority, while more expensive practitioners serve the needs of fewer, but expensive and high-need customers (Christensen, Bohmer, & Kenagy, 2000).

The imperative to work differently is highlighted not only in the *New Zealand Health Strategy* but also in the New Zealand Productivity Commission report on *More Effective Social Services* (2015). Re-thinking how services are organised and the rigid demarcations between different health professions will challenge long cherished vested interests. Traditional ideas of general practitioner ownership and leadership of the business, the patient and 'their' nurse's practice will not overturn easily. Further there is always the temptation for medical doctors to make a run for the moral high ground of patient safety in defence of the status quo. Witness the initial three pronged attack on extension of prescribing rights as being ''a threat to the standard of healthcare in New Zealand'' in that the ''superior capabilities'' of medical doctors need to be recognised, it surely needs a medical degree to prescribe, and nurses are incapable of making an appropriate diagnosis to underpin a prescribing decision (Moller & Begg, 2005, p.10).

The transformation we need is not a new solution, but it is innovative and it will be disruptive. Proposing nurse practitioners as a solution to the health crisis in the United States over 16 years ago, Christensen et al. (2000) caution that the preservation of existing systems will attract an eloquent defence in the interests of ensuring patient well-being. They state, however, that "customers have almost always emerged from disruptive transitions better off – as long as the disruptions are not forced into an old mode, but instead enable better services to be delivered in a less-costly, more convenient context" (p. 109).

To be ready for a revolutionary service model we will need a critical mass of nurse practitioners in the first instance, but also of nurses who are not content to reinforce the overriding norm of medical first assessment and doctor-only prescribing. Most of all we need a government that has the wherewithal to implement the systematic and long-term approach promised in the Health Strategy. Investment in the nursing workforce by way of education will be key to such reinvention, and in real terms, liberation from the status quo.

We will know we have reached the tipping point when our discourse around how health services are organised shifts from mitigation and workarounds that reduce the negative impact on patients, to one of active improvement for our whole population. The things that look extraordinary today will become the new normal of tomorrow; let's just not waste too much time getting there.

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