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SHAPING NURSING PRAXIS

- Some Registered Nurses' Perceptions and Beliefs

of Theory Practice

A thesis presented in partial fulfilment of
the requirements for the degree
Master of Educational Administration
at Massey University

E. Marion Jones
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ABSTRACT

This thesis investigates the beliefs and perceptions of registered nurses in relation to the theory practice gap. In order to discover these perceptions and beliefs, this qualitative study used critical ethnography, a framework and process in which the participants share in the journey of discovery which sets out to explore, describe and transform these beliefs and perceptions of theory-practice.

The theory-practice debate has been highlighted in nursing for some time and is interpreted in many ways. This multiple interpretation causes confusion and has an impact on the development of the discipline of nursing.

The participants were six nurse clinicians and six nurse educators from a large metropolitan hospital and a School of Nursing and Midwifery within a tertiary educational institution.

Within the critical framework, the research methods used were interviews, observation, participants' personal logs and triangulation between methods and within methods. Data analysis was through content analysis using themes, patterns, and categories arising from the data. The analysis of data indicated that through reciprocal dialogue, the participants' theory-practice perceptions and beliefs had been transformed. This transformation was being premised on an assumption of the existence of a theory-practice gap to an acceptance of the theory-practice relationship as an integrated concept where nursing praxis is shaped by an ongoing development process.

Empowering strategies and recommendations for the development of nursing praxis include coaching, clinical supervision, mentoring, case management, ongoing education, research, faculty practice, joint appointments and reciprocal advisory groups. These strategies provide opportunities for nurses to come together, and reflect on practice in that by becoming aware of their beliefs and perceptions, they gain the confidence and knowledge to begin transforming conditions of power and control, thereby promoting change which results in praxis and professional autonomy.

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CHAPTER 1

INTRODUCTION

The aim of this thesis is to discover and describe nurse clinicians' and nurse educators' perceptions and beliefs of the link between theory and practice. By this means, it will be possible to address the question, "Does a theory-practice gap exist within nursing?" This question seeks to clarify whether such a gap is a reality, or a myth. The answers to this question will help to explain how nursing practice is shaped.

This chapter outlines the background of the thesis, and provides a statement of the research questions and an outline of the organisation of the thesis.

Background to the study

The theory-practice debate has been an issue in nursing for some time and many authors have discussed it (Miller 1985; Moccia 1992; Chinn 1991; Schon 1983; Speedy 1989). Confusion exists in defining and explaining the concept of theory-practice. It has been perceived that education ideals are often different from practice ideals both in teaching and nursing contexts (Clare 1991:19). It is crucial to determine whether the identification of a theory-practice gap is in fact intended to refer to an education practice gap.

New Zealand nursing has been dominated by imported ideas largely from North America and the United Kingdom. This study is the first of its kind in New Zealand and takes into consideration the context in which nursing practice occurs for New Zealand nurses. Have nurses been too preoccupied with the theory-practice gap to see past it or within it? The opportunity to explore these trends is timely in today's dynamic health environment.

There are many nurses in the profession who question the emphasis on theory when the practice of nursing is active, skill and practice based. Doubts are reflected in such statements as - 'There is a theory-practice gap and nursing does not need to pursue a theory base to the degree it does'. The question is asked 'What does theory mean' when used in this way. Nurse educators are often labelled as those who are full of the jargon of academia, while nurse clinicians are seen to use a more reality based language. Miller (1985:417) emphasises that these two groups of nurses have differing perceptions of patients and of

nursing and do value different kinds of nursing knowledge. Meleis (1985:43) made the point that in the minds of practitioners, theorists who were associated with the ivory towers of educational institutions were castigated for being far removed from practice. The literature portrays nurses as perceiving the theory-practice gap as an important issue for research and nurses seek its resolution for the very survival of nursing as we know it today (Lewis 1988; Miller 1985; Stevens 1990; Meleis 1985; Benner 1989). This study aims to discover whether this is reality or myth and will enable participants to reflect on their perceptions of theory and practice and the reasons for their particular theory-practice understanding and reality.

Coeling and Wilcox (1988) view understanding of the current work group culture as an essential step in bringing about change. Myths, beliefs and rituals are important issues to identify in the theory-practice gap. Killman (1987:93) makes the point that the gap between the outdated culture and what is needed for dynamic complexity gradually develops into a culture rut - where it becomes a habitual way of behaving without asking any questions: He goes on to say that human fear, insecurity, over-sensitivity, dependence and paranoia seem to take over unless a concerted effort of establishing an adaptive culture is undertaken. Miller (1985:417) points out that, in the course of time, many unexamined and unproven beliefs and assumptions are incorporated into an integrated and consistent personal attitude towards life and reality which underlie nurses' central and shared purposes. It therefore seems to be very important to identify the 'what is' and 'what ought to be' aspects of nurses' practice and to endeavour to reconcile the differences. The actual beliefs about what practice includes are explored in this study and help in discovering the realities of any theory-practice gap which might exist.

With the changes in the Health Care System in New Zealand which have occurred over the last five years and the National government's proposal for 1993, there is a real possibility that socio-political forces will further undermine the nursing profession. At no other time have nurses reached such a cross road of decision making. The unravelling of what nurses really think of theory-practice and nursing knowledge will assist the researcher to uncover the assumptions and myths inherent in nursing. This could help put nursing as a profession on a pathway of collegiality and unity so crucial for the survival of nursing into the 21st century. Clare (1991:21) emphasises this point:

> *I believe that we must seize opportunities that the education and social legislation has given us and work together towards uniting and strengthening the professional value of nursing.*

Some of the issues that appear to impact on the very essence of nursing are the historical roots of the "Nightingale ethos" (Chinn and Kramer 1991) and the "handmaiden" concept perpetuated by the biomedical model of health. Nightingale in the 1850's was determined to raise the profile of nursing and developed the model for nurse training schools (Kozier, Erb and Blais 1992). Throughout history, Nightingale's influence on the development of nursing has been evident along with the impact of war and colonisation. Her strong insistence on the hierarchical relationships with nursing superiors and doctors was designed to legitimate nursing as a good profession for women (Street 1992:5). Political, economic, technological and consumer demands are all factors that influence contemporary nursing practice. Kozier et al (1992:25) emphasise that "the history of nursing is intertwined with the history of women." Approximately 90% of the world's nurses are women. As Watson (1981:19) points out professional socialisation involves changes in attitudes, skills, knowledge and values and reinforces this view in a definition of professional socialisation:

> *the process whereby the values and norms of the profession are internalised into ones own behaviour and concept of self; it is the process whereby the knowledge, skills, and attitude characteristic of a profession are acquired.*

Professional nursing today in a dynamic socio political environment, requires development of critical values, a strong commitment to autonomy and education, and a belief in the individual's worth and dignity. The transition from the traditional apprentice style, task-orientated positivist model to the professional student-based holistic interpretivist model has been difficult for many nurses. Nursing is still viewed as subordinate and secondary to the medical profession (Morrow 1988). Roberts (1983:26) believes nurses

> *have internalised the values of physicians to such an extent that they can be said to be marginal.*

Some writers believe that the medical profession has used the myth that 'nurses are born' to keep nurses as second class citizens (Lovell 1981; Roberts 1983). Nursing is struggling to find its professional identity and many nurses, who have

low self esteem, and low professional self concept, still seek support from doctors to represent or support them rather than deal with the issue themselves (Rodgers 1981; Strasen 1992). This has an impact on the development of nursing knowledge, theory-practice relationships and the development of collegiality and unity within the nursing profession. A clear professional purpose is inter-related to professional identity and coherence of purpose contributes to a collective identity when nurses agree on the general practice domain (Chinn and Kramer 1991:24).

Statement of Research Question

In order to address the more general question, "Does a theory-practice gap exist within nursing", two questions were constructed. The following questions will form the basis of this qualitative research study which uses critical ethnography as a framework for investigation.

1. What are nurse clinicians and nurse educators perceptions and beliefs of the link between theory and practice in nursing?

2. How do their beliefs and perceptions shape their practice?

Nature of the Study

In this thesis, critical ethnography was used as a framework for understanding the beliefs and perceptions of the theory-practice gap of registered nurses. A group of nurses were involved in reciprocal dialogue that encouraged reflection, action and transformation. In order to gain this perspective, interviewing and observational study were used to make sense out of the nurses' world at first hand. Ethnography, as a research method, allowed the researcher to get close to the participants who were involved in the theory-practice 'journey of discovery', to see the variety of situations they met, to watch their way of life in practice, to listen to what was said and to ask questions that might shed light on the issues under discussion. As a result of this process, this ethnographic study facilitates the development of conceptual frameworks that can help us understand and interpret behaviour and situations across a wide range of social situations (Boyle 1991:277). In order to justify the addition of the term 'critical' to ethnography, the research needed to involve critique and transformation of oppressive and inequitable conditions which might affect the participants along with the historical relations of power, and authority being recognised as an integral part not just as background to the study (Simon & Dippo 1986).

Critical ethnography enabled the researcher to view the study as a journey of discovery, with the participants emphasising the importance of dialogue and sharing, insights, knowledge and experience. As part of this reciprocal relationship with the participants, the researcher attempted to become part of the registered nurses' world both in clinical practice and educational settings and to discover with them, the issues underlying their beliefs and perceptions of the theory-practice gap and the ways in which these may shape their practice. In order to discover and describe the beliefs and perceptions of the participants in this study, dominant themes were identified and analysed from the data, with possible directions being identified for the future.

Organisation of the Thesis

This thesis is organised into 8 chapters.

Chapter 1 provides a brief overview of the underlying reasons for the research and outlines the research questions and framework of critical ethnography.

Chapter 2 in setting the scene provides the reader with a picture of the assumptions underlying the theory-practice debate, the impact of being a majority culture of women and the struggle for professional identify which is affected by the bureaucratic structures, power and the social context within which nursing knowledge is practiced.

Chapter 3 provides the reader with an outline of the theoretical framework of critical social theory, critical ethnography and its suitability as a model for this thesis.

Chapter 4 describes the methods used to explore the proposed questions and includes data collection methods, ethical issues, triangulation and issues of reliability and validity. The issues and problems encountered in this journey of discovery are illuminated through the researcher reflecting on her role.

Chapter 5 and 6 summarise under themes the data obtained and shares with the reader some participant realities of the theory-practice debate.

Chapter 7 involves the discussion of the data with justification from the literature and the participants. It gives the reader the opportunity to experience some of the insights and reflections of the researcher through

theoretical interpretations and critical analysis.

Chapter 8 links the preceding six chapters and gives the reader a conclusion that explores not only the findings but also the areas of limitation, the impact of the research upon nursing along with further research opportunities.

CHAPTER 2

SETTING THE SCENE

This chapter provides a description of the assumptions and beliefs underlying the theory-practice debate from the literature, knowledge development, the struggle for professional identity and the inter-relationship of each of the above. The theory-practice gap is a recurrent theme in the literature and it appears to be accepted that although there is polarization, there are many schools of thought on how theory and practice may be integrated and reconciled (Miller 1985; Cook 1991; McCaugherty 1991). Theory development is included within knowledge development and therefore it is important to examine the ways of knowing prior to exploring in greater depth the issues surrounding the theory-practice debate.

Nursing is establishing its place as a field which functions as an inventor of theory, a discoverer of knowledge and educator of its principles (Vistainer 1986:33). Nursing uses many types of knowledge to achieve its goals and Meleis (1991:129) sees the purpose of knowledge development being:

> *empowerment of the discipline of nursing; empowerment of the nurses; and empowerment of clients to care for themselves, to take advantage of the resources available to them.*

Ways of Knowing and Knowledge development

Nursing is a complex and varied discipline with no single theory being able to answer all the questions of practice. Many theories have evolved that encompass both the shared and diverse views of nursing. Nursing has developed its knowledge base with an emphasis more on structure of its knowledge than content substance (Meleis 1992). Knowing is seen as the weaving of threads of conceptions, perceptions, remembrances and reflections into a fabric of meaning (Smith 1992:b).

Carper (1978:14) identified four patterns of knowing:

1. *empirics, the science of nursing;*
2. *esthetics, the art of nursing;*
3. *the component of personal knowledge of nursing;*

and 4. *ethics, the component of moral knowledge in nursing.*

The empirics pattern is considered the objective, quantifiable knowledge and it is often considered synonymous to the positivist framework of science (Leddy & Pepper 1989). This area of knowledge is often considered the only reliable and valid way of gaining knowledge. Inductive and deductive reasoning are one process by which empirical knowledge is gained along with hypothesis testing. These processes facilitate the description, explanation and prediction of phenomena in relation to nursing and human life processes - the science of nursing. This area of knowledge is still developing with theoretical models and new perspectives that relate to health and illness being present (Carper 1978; Leddy & Pepper 1989).

The esthetics pattern of knowing is the art of nursing which is made explicit through the actions of the nurse to meet the client's needs and thereby making a difference to that client's health. Esthetic knowledge is unique, subjective and involves helping and caring action. Leddy & Pepper (1989:114) believe

> *the result is a richness and appreciation of the practice of nursing as an art as well as a science.*

Ethical knowledge involves the moral aspects of knowledge and the "what is right, what is good, what ought to be" positions of ethical decision making.

Carper believes that personal knowledge involves knowing the self and is the most difficult pattern to master and teach. It is important to allow time for the emergence of this knowledge, which comes from first hand experiences. Moch (1990) stresses that there are difficulties in making personal knowing explicit and she identifies three components - experiential, interpersonal and intuitive knowing. Personal knowing is thought to be primary to all other knowing. Smith (1992b) believes that our knowledge sources are similar and different and that we select from these sources through personal choice. In this way all knowing is fundamentally and primarily personal knowing (Smith 1992:b).

These ways of knowing are interdependent and interrelated, while they focus on the diversity of knowledge and demonstrate the ever changing dynamic knowledge base of nursing. Nurses within practice settings are still coming to terms with the complexity of nursing and its ability to stand tall as an evolving discipline. Cull-Wilby & Pepin (1987) consider that, although nursing is a profession of nurturing and human interaction within a social context, it attempts to hold on to tradition and inappropriate methods to explore, explain and predict

phenomena. It is seen as essential to reflect on the epistemology of nursing knowledge because we gain a clearer view of our theoretical progress and the future development directions (Meleis 1985).

Theory and Practice - what is it?

Ways of knowing and theory development have become large issues which nurses have to become familiar with and must use as a base for their practice. Pushes, from management within health care, for evidence of a theory base in practice to show how nursing makes a difference, appears to have bulldozed nurses into using frameworks that perhaps they do not fully understand, feel committed to or believe are restrictive to practice and do not reflect the humanistic values of nursing. The desired effect is that theory will influence practice and nursing practice will contribute to theory development (Sparacino 1991).

The term, "theory" can be interpreted in many ways. The tendency to perceive theory as being different from practice represents a dichotomy between "what is and what ought to be done". Nursing theory has been a term used to show the difference between clinical practice and classroom practice - that is anything that is given in a teaching environment outside a practice area (Miller 1985). Theories were aimed at explaining, predicting and organising knowledge about nursing practice (Chinn and Jacobs1983; Stevens 1990).

Other interpretations of the distinction between theory and practice include:

- The differentiation of theoretical and practical nursing and judging writing as being too theoretical, therefore giving an anti-intellectual focus.
- Theory being any knowledge while practice is the action.
- Theory being seen as apart from practice and as activities that are separate; Theory, therefore, is seen as the principles that underlie practice.
- Theory and practice are inter-related to make a nursing discipline that is unified. In this way theory may evolve from practice as practice may evolve from theory (Stevens 1990).
- Nursing theory and nursing practice depend on each other for their own development (Moccia 1992).

- Theory informs and transforms practice by informing and transforming the ways in which practice is experienced and understood. The transition is not therefore, from theory to practice as such, but rather from irrationality to rationality, from ignorance and habit to knowledge and reflection (Carr & Kemmis 1986:116).

Nursing theory is seen to be a way of describing and explaining what nursing is and it is like a road map that gives one perspective or framework to guide or explain practice (Stevens 1989). Meleis (1991:12) is more precise with an understanding that

> *Theory is an organised, coherent, and systematic articulation of a set of statements related to significant questions in a discipline that are communicated in a meaningful whole.*

Within the literature there are many definitions that focus on nursing theory either from a structure, practice goal, research or nursing phenomena viewpoint that give some framework for practice.

Practice on the other hand is seen as the action, knowing how to and the reality of nursing as it is (Miller 1985). Practice displays the action that theory affirms in words and together

> *the theoretical affirmation and the effective practice develop dialectically at any one time in what Gramsci (1971) calls an 'ensemble of relations'. (Moccia 1992:35) .*

Practice can be seen as the source of theory by some and by others theory guides practice (Speedy 1989[a]).

Nursing's History of Theory and Knowledge Development

Florence Nightingale, in 1860, first identified nursing as an art and a science, believing that both were equally important (Cull-Wilby & Pepin 1987) Nightingale not only began the development of nursing as a discipline but also stressed the importance of nursing education. Over the rest of the 19th century and into the 20th century, two main theoretical models evolved - the medical model and the logical empiricist model.

Although Nightingale had identified nursing knowledge as being different from

medical knowledge, nurses allowed themselves to be stereotyped as handmaidens and to rely heavily on the medical model for development to such an extent that it was evident in interpretation of phenomena and structure of textbooks (Meleis 1985). The influence of logical empiricism was reflected in the medical model along with the society's belief of the time that women were subordinate to men. A patriarchal dominated society was, and is still evident in the health professions. With logical empiricism valuing the results of scientific inquiry more than the process of science, theories developed that were aimed at describing, explaining and predicting phenomena as well as showing relationships between them (Carr & Kemmis 1986; Chinn & Jacobs 1983).

The early 1950's evidenced a boom of nursing theorists and theories of nursing expanded the body of nursing knowledge with the flavour of logical positivism and borrowed theory from other disciplines. Nursing partly lost sight of the importance of the art of nursing and concentrated primarily on the science of nursing (Cull-Wilby & Pepin 1987:517). Quantitative aspects of practice were highlighted while the qualitative aspects were neglected and de-emphasised as they were more difficult to demonstrate.

By the 1980's the logical empiricist approach was being challenged in nursing circles. The transfer of nursing education from the hospital based apprentice style to a tertiary institution education and student approach was well established. The systems process and humanistic perspectives became alternatives which began to aim at the development of each individual's unique potential and which addressed some of the issues of personal development, culture and society. Ideological perspectives broadened and socio-economic-political approaches became evident along with the more recent feminist and critical social theory approach.

> *Rather than separating women's experiences from the contexts in which they occur, a feminist perspective recognises women's everyday experiences as inextricably connected to the larger political, social and economic environment. (Hall & Stevens 1991:18).*

Critical social theory is an approach that involves a process of socio political critique with the aim of transforming rather than maintaining the status quo. The advantage of critical science for nursing is that it offers an opportunity to shatter the ideological mirror that traps us and our clients in despair and

hopelessness. Taken seriously, it forces us to question that status quo at every turn, sifting and winnowing our personal and working lives to enable us to formulate a truly alternative plan (Allen 1985:64). These different approaches reflect the alternative views of theory and practice (Carr & Kemmis 1986). A single theory or approach from only one paradigm could seriously impede the creativity and autonomy needed to promote professional practice. The different approaches discussed have driven curriculum and research development, introducing new paradigms of practice that in the attempt to be integrated into practice, caused, in many instances, a double bind situation for the practitioners involved, eg. teachers, health professionals (Watson 1981 : Carr & Kemmis 1986). There is little doubt that nurses embrace multiple paradigms (Nagle & Mitchell 1991). Nursing theories in some way describe:

- humans as wholes,
- the universe as interacting with the human and,
- health as an entity (Parse 1992:35).

Two paradigms or aspects of the nursing discipline that are shared are the totality and simultaneity paradigms. The totality paradigm has flavours of the positivist mode in that there is a cause and effect human-universe relationship which has the goals of promotion of health and prevention of illness. The simultaneity paradigm specifies the human-universe relationship as a mutual process, of reciprocity and patterns of life that explore the meanings of lived experience with the goals being emphasized, of quality of life and optimal wellbeing and health. With the history and tradition of nursing and nursing theory development along with the different theoretical approaches, interpretations of the theory-practice debate are understood to be wide, variant, polarising and sometimes confusing. The focus on the dichotomy between theory and practice seems unproductive when the basis for it is not clear. Through maintaining the view of a theory-practice dichotomy, the structures of a positivist paradigm are endorsed and maintained (Street 1990).

Culture of Nursing

While exploring the theory-practice debate within nursing, it is apparent that some of the issues related to the historical trends of theory development and the place of women within professions should be considered within the context of nursing culture.

Culture is seen as a

> *set of definitions of reality held in common by a group of individuals who share a distinctive way of life. (Strasen 1992:3).*

Within this view are the crucial elements of shared values, beliefs, expectations, attitudes, assumptions and norms (Kilmann 1984). Often these are not written, discussed, or recognised as they are lived and internalised as norms that provide social sign posts for behaviour. Culture involves every aspect of the individual including gender, ethnicity, age, class and the socialisation that accompanies this. Nursing culture includes practices, beliefs, knowledge, language and resources which are particular to nursing along with its relationship to its hierarchical power relationships with medical culture, allied health professionals, and educationalists (Lovell 1981; Street 1992; Sohier 1992). As described previously within theory development and the development of nursing as a practice discipline, society identified and accepted that women were subordinate to men. Nurses were seen in the role of ministering to and caring for everyone within a hospital. This included doctors as well as patients (Buckenham & McGrath 1983). For nurses joining a new unit, practice or institution their socialisation into that new secondary culture becomes an issue of acculturation.

Research indicates that women have low self esteem and self image which directly influences performance, motivation and relationships (Strasen 1992). The struggle for nursing to separate from the medical profession and see the roles as complementary and not dominated is magnified by the male dominated medical profession (Strasen 1992). As a result nurses still see themselves as being socialised for dependence on others and to avoid taking risks with the power of bureaucracy and hierarchy. Street (1992) stresses that the greatest factor, in the problems of oppression nurses are experiencing, appears to be the reification of Florence Nightingale's nursing regime of hierarchy, compliance and obedience. Roberts (1983) believes that nurses are an oppressed group and emphasises that there is a perceived need to reject or hide evidence of one's culture, as it is a means of dealing with the negative feelings that exist. The internalised values of medicine have been evidenced in the development of nursing theory and its use of medical model concepts that reinforce the dominance of a positivist paradigm.

Power and knowledge are inter-related and where power is strong within leadership, knowledge continues to develop. Along with knowledge, language is

an important part of social power which is impacted by self esteem. It should be recognised that words have different meanings for different people and, in this way they can be used as powerful tools of control in relation to information sharing and practice (Henry et al 1987). Nurses disempower themselves through resisting endorsing a nursing culture based on written practices and persist in reinforcing an oral culture that in their view saves time. Perry (1987) emphasizes this through her argument that nurses' reluctance to document knowledge and skills, results in limiting their access to channels of power. Discomfort with written language immobilizes nurses in their knowledge development and critique along with perpetuating the traditional myths and rituals that maintain the status quo. Doering (1992:26) believes that

> *oppression of women results from the existence of male dominated power relations. These power relations mould subjectivities that subtly support male dominance and reinforce female submissiveness.*

Ways of knowing as described by Carper (1978) are not based on a male world view and nurses are beginning to speak out about the strength of nursing and its uniqueness as a discipline.

Although the anti-theoretical bias that existed in the early 1960's is less obvious, it still persists and

> *is evidenced by the continued confusion in the use of the terms theory, concept, model and framework. (King, 1991:94).*

It is evident that the theory-practice debate is not an issue for nursing alone as a number of disciplines are wrestling with the issues, e.g. educationalists and psychologists (Speedy 1989[a]). McCaugherty (1991:1056) emphasizes that the theory-practice gap in nursing has never been accurately described. Many unanswered questions remain.

Conclusion

This study aims to explore theory-practice beliefs and perceptions of registered nurses in order to clarify what may be some of the issues that fuel this ongoing debate.

The theoretical framework for this study will be described in the next chapter.

CHAPTER 3

THEORETICAL FRAMEWORK

This chapter contains an overview of the theories which have provided the basis for this research study and the writer explores the underlying concepts which will be used in the analysis of data. Within reading, experience and consultation with colleagues in a variety of practice settings, it was evident that nursing as a predominantly female profession, has proved to inhibit its own growth and acceptance in a professional sense (Hedin 1986; Lovell 1980; Morrow 1988; Roberts 1983; Strasen 1992). The impact of hegemony and its paternalistic thrust within the medical model has further inhibited this growth by maintaining the power and control overall in the health industry and, thus, perpetuating the status quo. Hegemony in this context is influence, authority, power over others and not emancipatory or freeing from domination which allows a complementary practice to occur. Paternalistic in this context encompasses male domination, hierarchy and positivist structure that equates with a medical model of health care. Meleis (1985:41) emphasises this in stating that

> *many characteristics of women have been considered antithetical to creativity and scientific productivity.*

From Habermas' (1974) perspective, critical social theory stresses the importance of understanding the communication of people and social action. Underlying critical social theory is liberation, freedom from the oppression from many forces including social, political, economic and minority group influences. The aim of social theory is to enlighten people about hidden coercion, thereby freeing them to grow, reflect and thus be independent. Critical social theory involves human action in freeing agents from any kind of coercion, recognising that it may be partly self imposed. Coercion is used as an extension of the patriarchal dominance where inequalities of power and leadership exist. This in turn creates a continuance of minority groups being oppressed in that independence, autonomy, and self directed action is not encouraged or facilitated. When a group is dominated, the power of the dominant group creates in the oppressed low self esteem, lack of confidence and a false security in that it is easier to stay in this position than to rise above the dominance. This hegemonic state results in the status quo being maintained. Critical social theory involves knowledge development that incorporates a critique of ideology and reflective not objective

action (Geuss 1981). Habermas regularly speaks of an ideology as a 'world picture' which stabilises or legitimises domination or hegemony (Herrschaft) (Geuss 1981:15) Privilege, exploitation and powerlessness, therefore become issues to be examined as inhibitors that produce hegemony. Stevens (1989) identifies seven concepts of critical social theory derived from the literature:

- oppression and domination,
- liberation in that it is freedom from the constraint and coercion of oppressive social structures,
- dogma or ideology is the dominant authoritarian system that has not been significantly challenged,
- critique that includes reflection, analysis, and dialogue, dialogue as a mutual interaction,
- conscientization in that oppression and domination is recognised and ways to act are conceived,
- action that is deliberate, informed, meaningful and involves critical reflection and dialogue.

This equates with the myths, rituals and beliefs of nurse educators and clinicians who can be seen as being in the powerless and oppressed group within health care (Roberts 1983; Allen 1985; Perry 1985). Specifically

> *through socialisation, hegemony acts to saturate and shape the consciousness of people so that existing belief and value systems, as well as existing social practices and institutions, are maintained and perpetuated. (Perry 1985:33).*

For a social critique to be useful in liberating persons and aggregates from domination it must be aimed at the fundamental structures and ideologies of social systems (Stevens 1989:58). Habermas (1972) argues that critical social theory acknowledges that a genuinely emancipated society is one in which its people actively control their own lives. This control is gained through understanding the totality of their circumstances. Use of critical social theory in this study helped the participants begin to gain this understanding.

Critical social theory relates well to the social practice of nursing and, with its emancipatory dimension, requires action, dialogue and reflection to reach conscientization or explicit awareness of the internal contradictions and false understandings of the patriarchal or positivist paradigm. With this explicit

awareness comes critique, action, and the ability to empower themselves to change. Fay (1977) emphasises this through acknowledging that with this ability to examine competing paradigms critically, individuals are able to move from a powerless to a powerful position where they are in control of their own life and actions. The critique and challenge of a critical social approach allows nurses to recognise that the established structure, hierarchy and order is only one way of seeing reality (Thompson 1987). Nurses have become increasingly sensitised to the previous patriarchal domination and power relations. Nurses have been described as having all the indications of an oppressed group in that there is a fear of freedom, lack of pride and a refusal to join others so a divisiveness exists along with low self esteem (Allen 1985; Roberts 1983; Hedin 1986). This perspective has guided this study in traversing the theory-practice debate within nursing practice.

The aim in using this critical social theory as a framework is to discover and explain issues that evolve from the data and to facilitate the participants to become aware of the basis for their beliefs and perceptions. This in turn may result in the creation of social change in nursing. In being part of social change, there is freeing up of thought from historical roots of 'that's the way it is' and as an outcome new ways of acting upon, thinking and reflecting may evolve. Comstock (1982:378) reinforces the place of social change, in stressing that critical social science tries to show its subjects how they can emancipate themselves by conceiving of, and acting upon, the social order in new ways.

In a critical framework people are not observed or interviewed in a positivist sense. The researcher endeavours to involve the participants in self reflection and action. Reciprocal interaction is the cornerstone of critical social theory and research (Stevens 1989:65). The dialogue between the investigator and those investigated - co-researchers - takes the place of controlled observation. Through dialogue, the participants, are encouraged to examine the 'what is' of their every day existence and are enlightened "about unrecognised social constraints and possible courses of action, by which they may liberate themselves" (Comstock 1982:378). The process of dialogue heightens self awareness of each individual's potential and the potential of the group with which they are involved. Possible political and social strategies, which may facilitate the change, result as an outcome of the dialogue. This dialogue uncovers the history, beliefs and understandings that surround it, along with the active reflections on why these realities may exist. These factors can include

the dialectical relationship of dialogue between the behaviour of the participants in the specific setting, social and organisational structure and the inter-relationships that may consciously or unconsciously exist (Angus 1986; Simon 1979; Maseman 1982).

Ray (1992) refers to Habermas and his identification of two processes of rationalisation: - "lifeworld" spheres and "system" spheres. The former is concerned with the social, cultural and personal dimensions and the latter is concerned with economic, administrative and political dimensions. In identifying these two spheres it is acknowledged that conflict arises along the seams of the lifeworld and the system spheres. Depending on the political ideology it is through interplay between the spheres that the hegemonic influences of power and control impact on the socio-cultural dimensions of the group involved - in this case it would be nursing. In examining the theory-practice debate using a critical approach, a shared understanding of the reasoning relating to the social, economic, and political conditions should result. Ray (1992:100) believes that a critical science approach places the consciousness of nursing directly in relationship with the lifeworld and the administrative system, and integrally links theory with practice, and practice with theory. Thus, theory and practice are inseparable.

Fay (1987) emphasises that, for a theory to be a critical social theory, it must demonstrate certain conditions. There must be a condition of crisis present within the social system, along with a false consciousness experienced by people within that social system and the acceptance that the false consciousness can lead to enlightenment, emancipation and a changed social system. An overview of critical social theory dimensions should include some explanation of the concepts of ways of knowing, hegemony, power and control, and emancipation as they have been introduced as being the very essence of a critical approach. These will now be more fully examined.

Ways of Knowing

Epistemology encompasses what people know, how they came to know it and how they evaluate what makes up knowledge. It includes patterns of knowing:

> *Nursing epistemology is the study of knowledge shared among the members of the discipline, the patterns of knowing and knowledge that develops from them, and the criteria for accepting knowledge*

claims. (Schultz and Meleis 1988:217).

Carper's (1978) four patterns of knowing about nursing - empirics or science of nursing; esthetics or the art of nursing; personal knowledge; and ethics or the moral knowledge in nursing - although separate, are seen as interrelated and interdependent. Understanding the four patterns of knowing makes possible an increased awareness of the complexity and diversity of nursing knowledge (Carper, 1978:21). Nursing depends on scientific knowledge of human behaviour in both health and illness as well as understanding the uniqueness of each individual and making decisions based on the moral, ethical, and scientific knowledge gained.

Habermas (1974) emphasised the notions of technical, practical and emancipatory knowledge. Habermas believes that knowledge evolves from natural needs of the human being and that these needs are shaped by social and historical conditions. Therefore for Habermas, knowledge is the result of human activity instigated by natural interests and needs (Carr and Kemmis 1986). The complexity of nursing knowledge can be likened to Habermas' description of knowledge in that there is technical and practical along with emancipatory knowledge which nurses still need to gain (Lovell 1981; Stevens 1989; Thompson 1987).

The technical knowledge espoused by Habermas involves empirico analytical knowledge and objective knowledge. Practical knowledge which is grounded in social activity, and interaction along with interpretation and mutual understanding, encompasses the historico-hermenuetic science. Finally, emancipatory knowledge which has implicit within it reflection, action, and reciprocity, helps people to understand themselves, to secure freedom from oppression, gain power and promote change. Emancipatory knowledge encompassed within critical social science is the way through which Speedy (1989) suggests oppressed nurses would be empowered to view their situation in relation to the dominant structures in which they work. This brings in the strength of Carpers' personal knowledge where self awareness and self discovery through reflection are seen as essential to nursing knowledge development (Moch 1990).

Belenky et al (1986) in relation to women, identified different patterns of knowing that can exist simultaneously and equate with the ways of knowing

which have already explained. These include:

- Silent knowledge - where women accept the authority as being right and they must be obedient; eg medical authority within health care

- Received knowledge - where knowing comes as a result of listening to others; eg borrowed theory, authority from the other professionals.

- Subjective knowledge - where knowledge is of self and experiential knowing with the emphasis on intuition and experience, not cognitive and analytical knowledge; eg definitions of nursing, broad outlines for planning care, emphasis on nurses not patients/clients.

- Procedural knowledge which is made up of
  - separate knowledge which is believed to have evolved from the logical positivist or empiricist philosophy (Kidd and Morrison 1988).
  - and connected knowledge which has included phenomenology that explores the lived experience of people, Schultz and Meleis (1988:219) believe that while educators emphasise the research based practice clinicians are joining the ranks of the rational, procedural knowers in nursing.

- Constructed knowledge which is seen to be an integration of all the types of knowledge - intuition, rationalisation, and self knowledge - the eclectic approach! It is not until the constructed knowledge level is reached that transformation is possible and the emancipation inherent in critical social theory can become a reality.

These different ways of knowing along with Habermas' notions of knowledge demonstrate that development of knowledge is ongoing, complex and a process that is never ending. Kidd and Morrison (1988) expand this process and equate the ways of knowing to Benner's (1984) five stages of knowledge development that includes novice, advanced beginner, competent, proficient and expert. These different ways of knowing have commonalities that perhaps give direction for critiquing what we do know and finding out what we still want to know.

Emancipatory Knowledge

Clare (1991:39) emphasised that emancipatory knowledge involved 'an interest in reason, in the pursuit of knowledge for its intrinsic worth'. Concepts of power, control and hegemony result in oppressing people in society and maintaining the status quo. Ways of knowing can help to empower nurses and help them recognise the power of knowledge. Empowerment and the power of knowledge which can be gained through theory, practice and research, will cement the professional role of nurses and demonstrate the expertise of nursing (Rodgers 1991). While in New Zealand, Rodgers explained that the question of professional leadership was the most important issue for nursing, as was the need to develop a vision for the future of nursing. The characteristics of critical theory exhibit an inter-relatedness between theory and practice while considering the people and the context within which it occurs. Critique of the status quo is required to explicitly highlight the inconsistencies and inequalities in a society, along with recognition of rationality, action and reflection being positive tools of emancipation.

Hegemony

Hegemony, as previously discussed, is the power to repress, influence and exert authority over others, and therefore implies the maximisation of the status quo (Geuss 1981). The existing order is accepted as if there are no alternatives of action. Fleming (1991) emphasised how the dominant group can exercise political and social control so that no other way appears possible. Hegemony describes the way in which people may come to view and understand their worlds in ways that are themselves repressive or constraining (Gramsci 1971). Traditionally within nursing, the medical model has been dominant, with the concept of the nurse being seen as handmaiden in a paternalistic structure - in that the nurse is seen as the perceived adjunct to the doctor through stereotyping and historical roots of socialisation (Roberts 1983; Lovell 1981). In this way domination is through unquestioning consent rather than open coercion. Sohier (1992:63) believes history appears to show that change may be unlikely when the patriarchy and men traditionally have been perceived as strong, and the matriarchy and women have been perceived as weak.

Reinforcement of the concept of hegemony, therefore, has been through the process of the socialisation of nursing from Nightingale to the present day with rules, regulations and bureaucracy controlling their practice within institutions. Nightingale highlighted this as early as 1852 by emphasising that women had the

passion, moral standards and intellect but had no place in society to show these features explicitly (Chinn 1989). The description of silent, received, and subjective knowledge (Belenky et al 1986) supports this preponderance with rules, hierarchy and subservience. Through accepting the dominant mode of thought as the only possible way to think, nurses can come to participate in their own domination without realising it. Connell (1987) emphasised the concept of hegemonic masculinity and sees it as the source of power that retains the oppression of women. Fleming (1991:153) believes that hegemony must alter according to the social conditions and expectations of the time. Explicitly exposing the hegemonic influences through critique can free the oppressed and lead them towards recognising their own worth and place in the society within which they exist and work. This is one of the main thrusts of critical social theory and has guided the researcher's thinking during this study.

Power and Control

Hegemony imposes power and control over the perceived powerless or the oppressed person. Power generally infers that someone has the ability to influence the behaviour of another; along with having authority and/or control over others to bring about obedience (Fay 1987; Doering 1992). Within health care nurses have been and still are subordinate to physicians (Brooten et al 1988, Doering 1992). The dominant power model, shows a process that involves holding power close, keeping dominance and maintaining a social hierarchy in the every day activities of the individuals in that society (Mason et al 1991; Doering 1992). Doering (1992:28) describes how there is evidence to support the idea of the expert and the presence of forces in maintaining the dominance of medical knowledge over nursing knowledge. She goes on to say that there was a prevailing view that nursing did not have a claim to scientific knowledge as it was the domain of medical knowledge. In fact nursing was seen as an extension of the mother role and any intelligent, not necessarily educated woman can carry out the skills required from the physicians' directions (Lovell 1981; Doering 1992). The routine of tasks has been stressed as important and as a result has stifled initiative, creativity, reflection and the development of nursing knowledge. The rules, tasks and procedures have all been accepted as part of institutional culture and nurses, as do other health professionals, look for the boundaries. Friere (1970) believes that oppressed groups show the characteristics of self-deprecation that results from internalising the dominant group's viewpoint. In empiricist (positivist) and to some degree interpretive science, power is seen as having a behavioural focus which reiterates the

traditional control and authority (Carr and Kemmis 1986; Cull-Wilby et al 1987; Fay 1987). Through a critical social theory approach the people are encouraged to have reciprocal dialogue that detracts from the power over interpretation and leads to the power to or with, resulting in empowerment. Reciprocal dialogue encourages collaboration and involves sharing of information between the researcher and participant - a two way process of sharing. Sohier (1992: 164) has developed the point of view that because nurses have undervalued women and nursing knowledge, they have unwittingly deprived society of their strength. By speaking up about the concept of power embedded in control and authority, nurses can be empowered to use the principles of reciprocity, caring, partnership and collaboration that demonstrate the value of nursing knowledge. Gaining new insights into themselves and their professional lives can be the key to effect change and emancipation. Fay (1987:160) further supports this view:

> *A critical social theory wants to encourage a group of people to free themselves from the hold which expected ways of behaving, perceiving and feeling have over them, to reject any and all of traditional arrangements and activities which do not meet their needs as it defines them, and to restructure their lives on the basis of their own abilities of rational reflection and will to establish for themselves the sort of social order they wish.*

Ideology Critique

Ideology, in Habermas' terms, appears to refer to the beliefs which the agents in a society hold (Geuss 1981:7). An ideology critique is seen as a process that enlightens the people about their own true interests. In the context of this study these people are registered nurses. Power, emancipatory knowledge and hegemony all link to ideology critique which is the key concept of critical social theory. Analysing the perceptions and beliefs of nurses is an attempt to uncover the ideology, (ie values, beliefs, ideas) that guides their practice as a nurse. The ways in which these beliefs and values are controlled by other power relationships are explored. Ideology critique is one means of exposing the hegemonic nature of professional socialisation and its practical effects on nursing practice (Clare 1991:74). Within ideology critique, we open ourselves and our world to scrutiny. Street (1992:2) describes this as a

> *process by which - patterns of shared social meanings are subject to scrutiny with an explicit aim of demonstrating the internal contradictions and false understandings inherent in them.*

Critical social science helps to show the society and registered nurses, in this study, what they really want and a realistic, rational way of getting it (Fay 1987). However, it is important to note that ideology-critique is not only a negative activity but also provides the vehicle for uncovering hidden meaning, providing alternatives, overcoming resistance, stimulating self reflection and self growth and promoting reciprocity and mutual negotiation (Fay 1987; Habermas 1971; Geuss 1981). For example, exploring the perceptions and beliefs of registered nurses towards the theory-practice gap is one way an ideology critique can identify discrepancies and contra-indicators between what a nurse believes and what actually happens in the social context. Carr and Kemmis (1986:38) believe the purpose of critique is to provide a form of therapeutic self knowledge which will liberate individuals from irrational compulsions of their individual history through a process of critical self reflection. Ideology critique attempts to show individuals how their erroneous self understanding nevertheless, intimidates, in a disguised form, their real needs and purposes. In identifying the issues of theory and practice in this way strategies to decrease the domination of nurses may evolve.

Limitations of Critical Social Theory

Limitations of critical social theory are addressed in relation to the practicality of its use and its integrity as an ideal (Fay 1987; Clare 1991). Fay (1987) points out that there are epistemological, therapeutic, ethical and power limits. Epistemological limits include those that are inherent in the very essence of human reasoning and doubts the feasibility of autonomy and emancipation in the form of beginning with rationale self clarity. Therapeutic limits involve the human ability to reflect in an uninhibited way when the inherent traits, values and beliefs gained through socialisation and internalisation override the ability to reflect rationally. Critical social theory involves change and transformation and as Fay (1987) emphasis is crucial to critical social science. Ethical limits result from the change evolving from the critical reflection which may result in negative consequences when liberation does not occur. The expectations of autonomy, change and transformation in itself can create ethical limits in that the person may not be able to reflect on self and be self determining. Fay (1987:207) points out that

> *changing a peoples self concèptions may not be enough to change those perceptions, feelings and dispositions which are deeply incarnated into their muscles, organs, and skeletons.*

The above limits in themselves, create power limits in that the ability of the person, to be self determining, therefore autonomous is restricted. Fay (1987) goes on to support critical social theory with adaptations that consider the limits discussed and are able to distinguish between the utopia and the process of knowing self and the context within which one lives and works. Critical social theory does provide the framework for research and participant to examine through critical reflection and dialogue the values, ideologies, patterns, rules, characteristics, contra indications, oppositions, tensions and ethical dilemmas (Ray 1992). A theory of body, tradition, force and reflexivity would add the dimensions that would give critical social theory the scientific, practical, and critical base required for epistemological credibility (Fay 1987). The potential of critical social theory for nursing is the development of nursing knowledge that has been analysed during the process of development and can provide some vision for the future.

Ethnography as a basis for Critical Ethnography

Ethnography is the research process for describing a culture and aims to understand another or a particular way of life and people's actions, events, and reality (Spradley 1979). Culture is seen as the individual or group's way of life and involves discovering the shared customs, patterns, beliefs, values and interpretations that arise from their reality. It is important to remember that often what you see can be perceived and interpreted in many ways therefore assumptions can be made through what is seen. The ethnographer will examine what is seen or observed in order to gain meaning, understanding and a clearer interpretation not clouded by assumption. The ethnographer learns about the culture by observing the participants, listening to them and making inferences from what they say and from the way they act (Spradley (1979). The researcher is the main tool and Sandy (1979) believes that the ethnographer who becomes immersed in other people's realities is never quite the same afterwards in that perceptions and understanding have a new breadth and depth. Ethnography is characterised by in depth examination of a particular group of people with resultant detailed description and analysis of cultural knowledge (Street 1989). Ethnography is useful for the practice of nursing in many ways in that the extant world of nursing can be explored, as can the world of nursing theory (Aamodt 1991).

With this study's emphasis on field work, the specific use of ethnographic methodology may differ from researcher to researcher. Central to the process is

selecting an appropriate field and gaining access to the participants. Data are collected through observation, interviews, records, and/or reports and results in a compilation of descriptive field notes.

Ethnography is a research method of the interpretive science and requires a paradigm shift to critical science in order to become critical ethnography.

Critical Ethnography

The emergence of critical ethnography occurred in education in the 1970's and has spread in popularity to the United States, Australia and New Zealand. Critical ethnography develops from an emancipatory critical social science designed to empower the research participants and to engage in a process of collectively developed emancipatory theory building (Lather 1984). A central element of critical ethnography is the collaborative process, in which the participants share in the discovering of the phenomena under study. Therefore the major difference from ethnography is in the paradigmatic shift and the role of the researcher who Street (1989) describes as a "militant observer". She uses the word "militant" to explain the openly ideological nature of the role, in that it leads to and supports active intervention in the field setting. The registered nurses in this present study, therefore, became active in and conscious of the process of change through ideology critique and self reflection (Street 1989).

Angus (1986:59) believes that critical ethnography is capable of bridging the gap between macro and micro analysis, because it addresses the dialectic between broad issues of social structure and issues of social interaction which involve human agents. The overall goal is to create the conditions for open communication. Ethnography is regarded as a science of cultural description of subjects and the context within which they exist and results in the production of knowledge. Critical ethnography has both pedagogical and political dimensions and the ways of learning and knowledge development are ideological in form (Simon and Dippo 1986). Critical ethnography extends ethnography by taking both historical and structural perspectives that 'support an emancipatory as well as a hermeneutic concern' (Habermas 1971). Anderson (1989:249) stresses that critical ethnography is sensitive to the dialectical relationships between social structure constraints on human actors and the relative autonomy of human agency.

Therefore the overriding aim of critical ethnography is to emancipate individuals

from oppression, power over situations, powerlessness and give power to them. Lather (1986 a) believes that within emancipatory research self reflection is critical and is attained through full reciprocity in that the interviews should be interactive and require self disclosure of not only the participant but also the researcher. Negotiation of meaning should be sought, along with follow up interviews and freedom to engage in ideology critique.

Critical ethnography in the present study enabled the researcher to collaborate with the registered nurses in identifying the key issues involved in theory-practice, the influences on their interpretations and the action they might take to free up their thinking and create a process of reflection. Reflection is action oriented and historically embedded (Carr & Kemmis 1986). The reflection process reconstructs actions and experiences which are analysed and the nurse is confronted with the experience and knowledge from the interpretations. From this process of reflection the nurse can make choices about future actions which are new ways of thinking about and understanding nursing practice (Street 1989).

Critical ethnography has an important part to play in the development of emancipatory knowledge that contributes to social change. It has a role, through its dialectical reciprocity, of emphasising that praxis is produced through interaction that is active and is between theory and practice.

Nagle and Mitchell (1991:23) believe it would behove the nursing profession to move beyond rigid practice environments, support diverse practice methodologies, and strive for the co-existence of paradigms. Such co-existence may bring a new richness to practice, accelerate the discovery of new nursing knowledge and, therefore, advance nursing praxis.

Conclusion

Critical ethnography offers the researcher the opportunity to engage in reciprocal dialogue with the participants to promote reflection that is active, bring new richness to practice and encourage choice for the future actions involved in nursing practice.

The methodological approaches of this study, which are congruent for critical ethnography will be discussed in the next chapter.

CHAPTER 4

THE PROCESS - METHODOLOGY

In this chapter the methodological approach of this study is discussed. Ethical considerations in relation to the methodology are included, along with rights and privileges of the participants. The use of interview, observation and journaling will be discussed both as a strategy to gather data and a process used to travel on this journey of discovery.

This research explores the beliefs and perceptions of 12 registered nurses: 6 nurse educators, 6 nurse clinicians - in relation to the theory-practice gap in nursing and the way in which these beliefs and perceptions shape their practice. "Nurse clinicians", in this study, refers to those registered nurses who work in clinical practice in the metropolitan hospital chosen for the study. "Nurse educators", in this study, refers to those registered nurses who work in a polytechnic educational institution. In using a framework of critical ethnography, the aim was to uncover some of the ideology that guides these participants' practices as nurses. In providing a vehicle for uncovering hidden meanings, the processes of critical social theory will show people what they want and a realistic way of achieving it; resulting in personal and professional growth.

Context of the Study

This study was undertaken in two sites - an educational institution and a large metropolitan hospital. Each interview was conducted in a private room previously organised so that it was quiet, free from interruption of people and telephones and had ventilation that helped ensure the comfort of the participants and researcher during the process.

The educational institution was a polytechnic that had within the Health Studies Faculty, a School of Nursing and Midwifery. This was chosen by the researcher as the routines, structures, and processes were well known and this would enhance the negotiation of access. There was an opportunity to have access to a room that was private and quiet. This was negotiated through another department. Accessibility to potential participants was enhanced as the researcher was a teacher within the Health Studies Faculty and was known as a colleague, peer, and teacher with past experience in research. This had the potential for both positive and negative consequences. As Field (1991)

emphasises being perceived as a nurse by the participants assists the use of language in communication, aids credibility, and access. It was essential that the role of the researcher was clearly stated, the researcher - participant role clarified and the mutuality of the research process recognised within the paradigm used (Conners 1988).

The metropolitan hospital was a large acute and long term care institution that offered service to the total age span. The researcher chose this setting as it had a large staff from which to invite participants to join the study, was easily accessible, and key people were known who could be approached in negotiating the entry process. It should be noted, however, that none of these key people were participants in the study.

Negotiating Entry and Access to the Field

Negotiation was required with both the Area Health Board and the Polytechnic.

Within the Polytechnic structure, formal permission to undertake the study was negotiated with the Head of School as she was, in field work terminology, the gatekeeper of the setting (Wilson 1985; Field & Morse 1990). Informal permission was gained initially to assess whether the study would be considered appropriate so as to prevent time being expended unnecessarily on the formal proposal. Prior to this occurring a research proposal was presented to the supervisors of this study to ensure the process being undertaken was within research protocol and the questions to be explored, feasible, relevant, researchable and significant for nursing. After permission was gained from the Head of School, the Research Ethics Committee of the Health Studies Faculty was notified of the study. Ethical permission had at this stage been granted by the Area Health Board.

Entry negotiation with the metropolitan hospital was first informal, through an approach to the Director of Nursing to seek support for the study and clarification of the process for ethical clearance. Formal application with a full proposal of the research study was then forwarded to the Area Health Board Ethics Committee who approved the study (see appendix 1). Following this approval, the researcher was then required to formally apply to the specific metropolitan hospital for access. Once this was granted Senior Nurse Managers were approached and explanation given on the proposed research. They had already received a copy of the researcher's proposal and were enthusiastic and

supportive of facilitating access to potential participants.

Field & Morse (1990) support this process in that the more key people, contacts and support gained the more likely access, acceptance and commitment will be achieved. The way the researcher approaches this and presents is crucial to acceptance and credibility.

Contacting the Participants

The participants from each setting were gained differently but the researcher was committed to gaining participants who were keen to go on this journey of discovery and had not been coerced into doing so. Guba and Lincoln (1982) emphasised the importance of using a method to obtain participants that maximised the scope and range of information to be obtained. For the purpose of this study purposive sampling was used in that it is seen as the most useful method in field studies (Field & Morse 1990; Bogdan & Biklen 1982; Wilson 1985). In this way participants were chosen who were best able to meet the informational needs of the research study, were willing to put the time in to examine the theory-practice debate critically and share these reflections with examples from their practice. Roberts & Burke (1989:218) point out that

> *this type of sampling is designed to select subjects who are most likely to facilitate further development of the emerging nursing knowledge, concepts, or theory.*

The criteria for selection were that the participants would have a minimum of five years post registration experience. This was decided on by the researcher in that initially following registration, registered nurses are novices still adjusting to their role change from student to registered nurse and full appreciation of the theory-practice debate may not be possible. (Benner 1984) Proficient and expert nurses (Benner 1984) will have had a wider experience, be settled in their role, have used analytical processes widely in their practice and perhaps give a wider more experienced view of the debate. Perhaps having developed greater understanding of nursing, these registered nurses may have formed some theories in use or thought through more clearly in the use of theory in practice (Schon 1983).

Within the Polytechnic setting the researcher spoke to a full staff meeting explaining the research proposal, answered any questions and asked for participation of registered nurses meeting the above criteria. There was some

obvious enthusiasm for the proposed research and in order to remain anonymous to each other potential participants would leave a message in the researcher's mail box to contact them. This was achieved over a fortnight and a range of experience, seniority and time as an educator was evident in the participants. All nurse educators had come from a variety of practice settings which indicated that they had all been nurse clinicians in the past, and chose to become nurse educators. However as part of their nursing education practice they do work in clinical settings with students and develop collegial relationships with the nurse clinicians in the specific areas. This clinical practice with students assists educators to maintain up to date contact with clinical practice. This is not always the case with nurse educators overseas where separate clinical teachers are employed which may breach the close link between nursing education and service that we have in New Zealand, eg. USA and Australia (Mauksch 1980).

Within the metropolitan hospital the Senior Nurse Managers approached their staff within the proposal and again potential participants gave their names to their specific nurse managers.

Once given the names of both groups the researcher contacted each potential participant individually, made a time to meet, and gave them the information sheet (Appendix 2) and consent form (Appendix 3) to read and ask any questions. The research proposal was also available for them to read. Once questions had been answered and clarification made, participants signed the consent form and the avenue was open for the first interview. Only one potential participant withdrew. This was because it was felt her own study may interfere with the process to be followed.

Each participant agreed to being interviewed, audio taped, and observed and discussion occurred on the potential of the journaling process for the study.

Interview and observation times were negotiated that were mutually convenient. For each participant in the clinical setting, the researcher approached the Charge Nurse involved to seek entry to the area. Trust, rapport and open communication were seen as essential to establish and the researcher recognised the importance of this within the first meeting (Field & Morse 1991). The participant-researcher relationship receptivity through dialogue and reciprocity is crucial to discover meaning of the world (Field and Morse 1991; Connors 1988).

> *The informants (participants) are the key to sound ethnographic research and may supply the majority of the information needed, or complement data provided through observation, interviews, chart analysis or other techniques. Because a researcher cannot be in all places at all times, the informant helps fill in gaps in the data and act as a culture broker explaining the cultural rules, values and norms within that setting. (Field & Morse 1991: 58).*

Data Collection

Initially the study was planned and a process of how the research would be implemented was developed. Wilson (1989) calls this mapping in that the dimensions of the research setting, including the objects, people and events that reside within it are explicitly outlined. This is ongoing throughout the research process in that social and spatial mapping assist the researcher in setting times with participants, organises the venue for interview or observation and ensures equipment such as tape recorders and lighting are in working order. Temporal mapping assist in organising the schedules for interview and focuses in on the rhythms of the participants (Baker 1992).

Ethical Issues

The ethics of research, especially considering human rights, are crucial to consider in all research and includes the right to freedom from risk of injury, right to privacy and dignity and the right to anonymity. Roberts & Burke (1989) point out that all aspects of a study that impinge upon the social and moral aspects of society must be considered in the ethics of research.

Risk of injury in this study was the vulnerability of potential participants and therefore it was crucial to ensure that individual freedom was protected with all information given. All participants were given the right to decide with no coercion whether they wanted to participate or not in generating new nursing knowledge and recognised the right to withdraw at any time (Appendix 2 and 3).

The right to anonymity was respected in that all data were collected under a code name chosen by the participants, and nowhere on the data did their true names appear.

As previously stated ethical approval for the study was given by the Area Health Board Ethics Committee (Appendix 1) and by Massey University, through the Department of Education.

With the use of interviewing and observation in this study there were the potential risks of interaction for the researcher to consider. Respect, sensitivity and confidentiality were inherent throughout the study, with the researcher's heightened awareness of potential issues evolving related to embarrassment, mis-understandings, conflicts in opinions and values, catharsis, anger and violation of privacy (May 1991). Within the interviewing process, the researcher planned, reflected and consciously endeavoured to ensure a process of negotiation and reciprocity remained the focus. No participants explicitly experienced difficulty with the process, in fact many stated how much they had enjoyed and gained from it.

> *Toni Yeah, I have really enjoyed it and as I said before I have got a lot out of it, so it has been just good for me.*

> *Emma It's been revealing for me. I was starting to think I know these are the areas that I need to do work in, it has been stimulating and I'm very pleased to do some work and have some discussion on nursing, with the capital N, and that is really theory and the practice isn't it?*

Data Collection Methods

Within ethnographic studies the major mode of data collection is generally the interview and observation with the added dimension of journaling in this study.

Following the initial explanation and consent being gained, the first interview was conducted. A schedule for the following observation was set up at the end of the first interview and again this was arranged to mutually suit both the researcher and the participant. Prior to the second interview the participant had had the transcript from the first interview to read, comment on and make alterations as they saw fit, in that they could refute any of it that they believed did not truly reflect their theory-practice beliefs or give clarification of any data. Lather (1986[a]:268) supported this in emphasising that

> *submitting concepts and explanations to the scrutiny of all those involved sets up the possibility of theoretical exchange - the collaborative theorising at the heart of research which both advances emancipatory theory and empowers the researched.*

This process allowed the participants to reflect on the data, and negotiate through the clarification process, to which they were all enthusiastic and

responsive.

Interviews

The interview method involves asking people questions and can be structured or unstructured. This method was considered most appropriate for this study as one to one communication was important to gain information in an active way because the participants believe in the issues presented. Each interview was tape recorded with the consent of the participant. In this process flexibility, adaptability in questions and the opportunity for active participation enabled information to be gathered quickly, information could be checked against non-verbal cues and the researcher could check at once if there was a possible mis-interpretation of questions. Lather (1986[a]:265) points out that rather than being made objects of research, participants can become "active subjects empowered to understand and change their situations". Dialogue between the researcher and participants encourages critical reflection and helps to ensure that research will result in the production of relevant knowledge, and in the empowerment of the participants. Tape recorded interviews captured the detail and expression that would not be seen in the field notes.

Interviewing within this study was the main method of data collection. The interviews were both unstructured and semi-structured. Unstructured interviews have little or no organisation and do not reflect preconceived ideas about content or flow whereas semi-structured or focused interviews are organised around particular areas of interest while still allowing flexibility in scope and depth (May 1991; Wilson 1989). Initial interviews were basically unstructured, giving broad topic guidance to elicit the participant's story. However at each initial interview two questions were asked of all participants to elicit a beginning to the dialogue and included words such as:

> What do you understand by the word theory?
> What do you understand by the word practice?

Once some information was gained through interactive interviews, stories heard, and ideas put forth from the participants, the researcher was able to more actively guide the interview process, balancing the flexibility and consistency within the data collection itself. Consistency within qualitative research requires that questions which are important to be asked at a given point in the process, should be asked of as many participants as possible (May 1991). This

consistency is helped by preparing for each interview. The researcher made notes about specific areas/questions that should be asked, reviewed the previous interview and observation so as to focus in on particular aspects raised and worked within the critical social theory framework. Lather (1986[a]) believes that within emancipatory research, self reflection is critical and is attained through full reciprocity in that the interviews should be interactive and require self disclosure, of not only the participant, but also the researcher. During the process it was evident that the use of language influenced questions and the participants would ask for interpretation and clarification would be asked for.

> *Rusty Run that past me again.*
>
> *Toni I am not sure exactly what you are saying. Are you saying that the nurse themselves needs to have a good self esteem to be able to initiate and interact at a deeper level?*
>
> *Judy Can you just re-run that?*
>
> *Wattle Which theory-practice?*

Having verbatim transcripts and taped interviews allowed some of these issues to be clarified or validated by the participant in alterations or by the researcher in the following interview if it was not identified at the time of interaction.

In this study twenty four taped interviews were completed lasting from one to one and a half hours. These interviews were conducted with six nurse educators and six nurse clinicians and extended over a period of six months resulting in 24 transcripts ranging from 25-38 pages per transcript. As soon as possible after each interview the audio tapes were transcribed and given back to the participant, as already mentioned, for clarification and acceptance as data to be used. Trust, rapport and confortableness appeared to exist throughout this process.

Observations

Using this method the researcher works as either a participant or non-participant observer in order to obtain information about activities, interactions, events, procedures or day to day work in a particular setting. Observational studies allow the researcher to experience the total sequence of events in order to help understand them and involves using the senses of hearing, and seeing, taking field notes, interviewing and participating. These studies can be structured or

unstructured and observations are used when the researcher is interested in behaviours, actions, and patterns that are unable to be described through self report or as one method in the validity measure of triangulation when some quality is examined by several different methods. There is no single way to do observational study and the researcher designs the process which will best focus on the purpose, equate with the resources available, and record the data having a neutral observation language. Observation may be used either in an exploratory way, to gather supplementary data or be the primary data collection method.

In this study observation was used to gather supplementary data and as part of the triangulation process which will be explained below. Observation was mostly participant in that there was some interaction and in some instances assisting the nurse when requested. In Spradley's terms (1980) this would be termed moderate observation when the researcher is seeking to maintain the balance between participation and observation.

> *Thea I'm nervous with you watching me. Could you begin by helping me as I need help with Mr....*

Observation identified some issues that surfaced in the first interview and could be explained in the second interview.

> *Researcher Going back to the observation and looking at that, you were assisting and supervising - how do you see your role as supervisor?*
>
> *Emma I see there are a number of things....*

Observations were mainly in the clinical setting with participants. Two participants chose to have an observation with students in a classroom/tutorial setting as this was part of their work. It was difficult to take notes while observing as it could be considered inappropriate and obtrusive. Notes were made when time was taken out from observing.

Where patients or colleagues were involved in the setting consent was obtained prior to commencing the observation and the researcher was prepared to withdraw if that consent was not given or the situation appeared inappropriate for her to be present. The researcher withdrew in two situations that were considered ethically inappropriate. One being a student-teacher interaction with a new psychogeriatric client. In this instance the observation was made from a

distance so conversation was not heard. The second instance was with a new admission who was a suspected meningitis patient and it was considered not appropriate to be present and continue with the observation..

Observational notes were taken and were a description of what occurred through watching and listening.

For example:

Assessed decrease in urinary output to less than 30m/hour, Notified Doctor,
T6/T5 sensations with epidural pain relief and said it would be Ok but did not give knowledge of why it was Ok,
Tried to bring the topic to her colleagues in manageable chunks and encourage success,
Involved students in labelling the model to identify the inter-relationships of immunology system,
Talked openly with patients and appeared to recognise importance of communication.

Theoretical notes evolved that attempted to derive some meaning from the observational data (Baker 1992). Schatzman & Strauss (1973) suggest using methodological notes or instructions to the researcher to act as tactics or reminders about issues. These tactics were extended by Wilson (1980) who called them personal notes about experiences, reflections and reactions to the observations.

Journal Writing

Journal writing or personal log was encouraged by the researcher to allow illumination of the participants lived experiences. The format was to be as the participants wished and would allow for personal reflection. Journal writing allows the writer to be spontaneous, say what they feel, and not to have any worry about the style or literacy eloquence. It could be used to provide a record of the participant's personal journey of discovery as a basis for continuing reflection on the theory-practice gap debate. It has the potential for providing

> *rich descriptions of how the people who produced the material think about their world. (Bogdan & Biklen 1982:97).*

The participants were not asked to write full diaries but asked to make notes and record any other issues, feelings, or events that would add to our discussions on

the theory-practice debate. They were also told that they could share what they wrote as they chose as it was their journal. Some participants kept good notes and shared with me their discoveries both at observation and interview time. Wilson (1989) believes that journal writing is useful as a method of gaining more information from the participants on their beliefs and values and that if triangulation is employed validity is increased.

Issues of Reliability, Validity and Triangulation

When examining issues of reliability and validity it is important to recognise the issues in relation to qualitative research. Rosenthal (1989:115) believes "the qualitative-quantitative debate must be laid to rest." as different ways of seeing issues are valuable in developing new knowledge. Naturalistic research is an alternative paradigm to the positivist and is driven by the lived experience as it is, with no manipulation of any variable. Feminist research, neo-Marxist critical ethnography and Freirian empowering research all stand in opposition to prevailing scientific norms through their transformative agendas and their concerns with research as praxis (Lather 1986^{b}:64). With this in mind it is critical to examine reliability and validity issues from the trustworthiness and credibility of naturalistic inquiry (Lather 1986^{b}; Guba and Lincoln 1982).

Issues of validity that evolve in relation to critical ethnography are argued well in Lather's work (1986^{a};1986^{b}) that rigour is applied in planning, gathering and checking data through face, construct and catalytic validity along with triangulation. Lather believes triangulation is critical in establishing data trustworthiness. Triangulation is a method of increasing reliability and validity of research data, therefore credibility and research precision, by measuring the same quality with multiple techniques. Denzin (1989) suggests different modes of triangulation:

- Data triangulation,
- Investigator triangulation,
- Theory triangulation,
- Methodological triangulation.

In analysing any research method it is important to recognise that each paradigm is a way of knowing and defines reality in that context. Depending on the philosophical stance taken by the researcher, triangulation can be a defence for an eclectic approach and/or a substantiation to assist in generalisability. Mathison (1988:13) emphasises that

> *Regardless of which philosophical, epistemological or methodological perspectives an evaluator is working from, it is necessary to use multiple methods and sources of data in the execution of a study in order to withstand critique by colleagues.*

Triangulation is therefore a strategy for increasing research validity by assisting in eliminating or decreasing bias. It can involve measuring the same quality with multiple techniques; a variety of data sources or a combination of theoretical orientations on the same situation, ie. it can be between methods and within methods. Jick (1979:603) states that

> *Within methods triangulation essentially involves cross checking for internal consistency or reliability while between method triangulation tests the degree of external validity.*

Denzin (1989:24) believes that no research is free of rival factors which he describes as "time, situations, observers and observed." For this reason he believes that multiple methods should always be used in every piece of research.

An outline of the types of triangulation are as follows:

Data triangulation involves data sources and may include time, space and person. This may be for example a variety of settings/or different conditions looking at or working with the participants.

Investigator triangulation would involve using more than one investigator or researcher assistants remembering that the most skilled observers should be placed closest to the data (Denzin 1989:239). Denzin (1989:239) goes on to stress that triangulation in the use of observers removes the potential bias that comes from a single person and ensures a greater reliability in observations.

Theory triangulation is more difficult to achieve and Denzin (1978) in Mathison (1988:14) states "my use of theoretical triangulation must in no way be construed as a defence of eclecticism". In this mode, multiple perspectives/paradigms can be used to support or refute the research hypothesis/question/s. Different theoretical perspectives can be used to critically examine particular data. Denzin (1989:243) stresses that theoretical triangulation has two main components

1) a body of empirical data,

2) an ability to apply a number of paradigm/frameworks at the same time.

Therefore "the final framework should reflect the discriminatory power of each perspective."

Methodological triangulation can be "within method", "between method" or "cross method"triangulation. Within method triangulation, as already stated, emphasises reliability but as Denzin (1989) stresses this has limitations as only one method is being used even though multiple scales are being used to examine the same quality concept. This is potentially a biased approach and therefore will affect validity.

Between methods triangulation can further increase validity and also may uncover some unique variance which otherwise may have been neglected by single method (Jick 1979:603). It also allows for the weakness of one method being the strength of another. At least two methods should be used but in a completely triangulated investigation all research methods should be used. However it is also very relevant to use both within methods and between methods together and the triangulating investigator is left to search for a logical pattern in mixed method results (Jick·1979:604).

Triangulation, therefore, requires that a researcher obtains different slices of data on the same study question or hypothesis which gives "as many different perspectives as possible" (Wilson 1985:432). Therefore it is important to see triangulation not as a technological verification tool but as enriching device that gives depth, varying perspectives and credibility to the conclusions drawn, be that falsification or verification. With this in mind it is important to plan triangulation, not to do your research and think about it after the event and then try to get some validation. Denzin (1989:235) talks of triangulation and sophisticated rigour which

> *is intended to describe the work of any and all sociologists who employ multiple methods, seek out diverse empirical sources and attempt to develop interactionally grounded interpretations.*

Depending upon the methodological research approach, triangulation can have a

different focus. Some believe a "positivistic bias underlies the triangulation position." (Denzin 1989:24). He explains further

> *However, it's use, when coupled with sophisticated rigour, will broaden, thicken and deepen the interpretive base of any study. (Denzin 1989:24).*

Within this study, the following triangulation methods were used:

- Within methods - first and second interviews and checking out information from first interview in the second interview
- Between methods - observation
  journaling
  interviews
- Data triangulation - settings of educational and practice institutions

Lather (1986[b]) believes triangulation is especially effective and is critical in establishing what she calls data trust worthiness.

Guba and Lincoln (1982) talk of the following terms (Table 1) that replace validity and reliability from the positivist paradigm.

Table 1

Naturalistic Inquiry	Positivist Paradigm
Credibility	Internal validity
Transferability	External validity
Dependability	Reliability
Confirmability	Objectivity

Credibility refers to the truth value of the study under scrutiny. The study is required to have true or faithful interpretations of the data gained and that the participants would recognise as their own along with other readers recognising

the experiences when confronted with it (Sandelowski 1986). Within this study credibility is being enhanced when the audio tape transcripts are returned to the participants for validation. Triangulation was proposed by Denzin (1979) in order to ensure credibility.

Transferability in respect of Guba and Lincoln (1982) is that purposive sampling maximises the range of information gained. Purposive sampling was used in the study. Enough thick description is required to facilitate judgements on transferability. Guba and Lincoln (1982) also point out that fittingness is a criterion of how the findings will fit into settings outside the study environment and how meaningful that is to the individual/group in terms of their life experiences. With regard to this study, transferability will be evaluated on completion and dissemination of the thesis itself. Face validity from Lathers (1986^a, 1986^b) view is an integral part of establishing data credibility. Lather (1986^a: 271) states that

> *face validity is operationalised by recycling description, emerging analysis and conclusions back through at least a sub sample of respondents.*

Dependability is really interpreted as stability of data and design recognising that design may change as data emerges. Use of overlap methods and dependability audit can be done which judges all steps of the process. In the process of this thesis being born, the researcher's supervisors have carried out an ongoing audit of the process and the data.

Confirmability includes a prolonged engagement at the site, persistent observation, peer debriefing, reflexivity, triangulation, reference materials archives such as documents, audio recordings, and observational notes to be audited as appropriate, and member checks. Within this study triangulation was used as previously stated, audio recordings and observational notes are stored, member checks have occurred with regard to returning data at varying stages to the participants and to the thesis supervisors and peers as appropriate. Reflexivity was practised with use of the journals and within the second interview.

Construct validity contributes to the growth of critical social theory through what Lather (1986^a; 1986^b) calls systematised reflexivity which involves ongoing confrontation with peoples experiences in their daily lives. Catalytic validity

involves the research process being involved in reorienting, focussing and energising participants to know their reality better (Lather 1986[a]; Lather 1986[b]). Through this process occurring participants gain self understanding, and a positive drive for practice through being involved in the research process. This was certainly alluded to by participants within this study but it is also recognised that within critical ethnography there is no closure period and the emancipation or freeing up of participants is an ongoing process.

The Researcher's Role in Reflection

Using critical ethnography as a framework for this study changed the role of the researcher from the conventional researcher role of gathering unbiased data, to one of collaboration which is seen as a crucial element in a critical approach. As co-researcher, the participants share in the task of identifying and describing the phenomena, along with gaining insight and understanding to develop transforming theory. In this process all involved have their actions and understandings challenged. This is why the researcher alluded to this study being a "journey of discovery". Street (1989) explained the role as openly ideological in nature, leading to and supporting active intervention in the natural setting. The participants in this study demonstrated a commitment to sharing their beliefs and perceptions of theory-practice and found the thinking, clarifying and reflecting challenging and enlightening as they had not had the opportunity previously to think through nursing issues in this way. They shared with me freely and enabled me to learn from them their perspectives which changed and deepened my understanding of them in both settings; hence, the use of the descriptive phrase, "a journey of discovery".

The research was limited by the time frame of the thesis and the needs of the nurses. At the time of data gathering there were industrial contracts being negotiated and thus caused pre-occupation for some participants. However after initial listening to these difficulties they turned their mind to their commitment to sharing and discussing with me the issues related to theory-practice.

The researcher was aware that she was doing the research in her own professional culture and she tried to lessen the difficulties this might surface. As an insider, the researcher knew the broad language, the broad culture and was known as a lecturer in a tertiary educational institution. It was soon evident that there were many differences between the participants depending on the sub-culture they were from, eg a surgical; or medical area, teaching in different years

of an undergraduate programme and different roles in their areas of practice. Thus it was evident that one may need to learn the sub-cultural language of an institution, unit, or specialised area in order to conduct one's study (Field 1991). It should be recognised that the researcher had minimal work related contact with any of the participants.

In completing the observations, there were some difficulties in maintaining the observer role. To be a total observer was impossible as it appeared that the participants were ill at ease and in fact asked that the researcher converse briefly and informally with participants and patients as the situation demanded it. Participation of a moderate action, put the setting into a more normal context. Some of the activities involved the researcher in holding equipment, supporting a patient when no-one else was available, responding to patient or nurse questions or comments, and responding to nurse requests for help. On reflection, the activities the researcher was involved in created a normal situation which was still observable. In one instance the observer role became impossible as a situation became potentially unsafe. The researcher in this case intervened, followed up the nurse to continue and then resumed the observer role. The observational role was difficult and it was a learning process for the researcher. It was one of reciprocal relationships and open inquiry based on mutual respect and understanding. The researcher was very conscious of being an insider in the nursing profession but, because there is a broad scope of practice, was not an insider in the true sense. It was realised that acceptance as a "native" should not be assumed and the most important aspect was to gain mutual trust and respect from the participants.

The interviews were illuminating, exciting and were recognised by the researcher as a privilege to have the participants share with her. The challenge for the researcher was to consider the total context of the situation and interpret the concepts and categories that arose from the data. A conscious effort was made to ask questions from the data not from the researcher's expectations, eg

> What does this mean?
> Why?
> Do you see that relating to that?

The dialogue of critical research involves a reciprocal conversation based on listening to and hearing one another. Thoughts, perspectives and interpretations were shared and discussed that helped to promote the reciprocal sharing. My

reflections on the data, as researcher, shaped the direction for the next meeting - be that the observation or second interview. The negotiation for each meeting was mutual and no difficulties were incurred in that meeting - for interview and observation processes were met.

The termination of the research was difficult as the discussions were stimulating and the sharing of experiences and knowledge exciting, rich and illuminating. However, in the initial negotiation, it was agreed that the second interview would be the last in respect of the time frame for this thesis. At the end of the second interview each participant was asked to talk about the process for them. The researcher and the participant shared thoughts and ideas on this to allow each participant to debrief from the research process in an in depth way. The next contact was made with the participants when the transcripts were returned to the participants for their agreement of validity and use. Some participants have continued to initiate contact with me as they enjoy talking about nursing and want someone to listen to their ideas.

The process that evolved as a result of this research was empowering, enriching and professionally exciting for me as a researcher. To be privileged to share with other nurses their beliefs and perceptions was enriching. The sharing was empowering for each of us, in that the perspectives on theory - practice were thoughtful, challenging and dynamic in that they changed over the time of the research to an enlightenment of praxis. The thinking and new perspectives continue when the researcher meets with some in work related activities and the sharing continues - emancipation is ongoing.

Data Analysis Process

Data analysis in qualitative research is ongoing during the research and involves identifying concepts, patterns, categories and ordering of the data in order to make sense of it and use it in following interviews with the participants. The data analysis process is outlined in Figures 1 and 2 and will now be described.

Figure 1

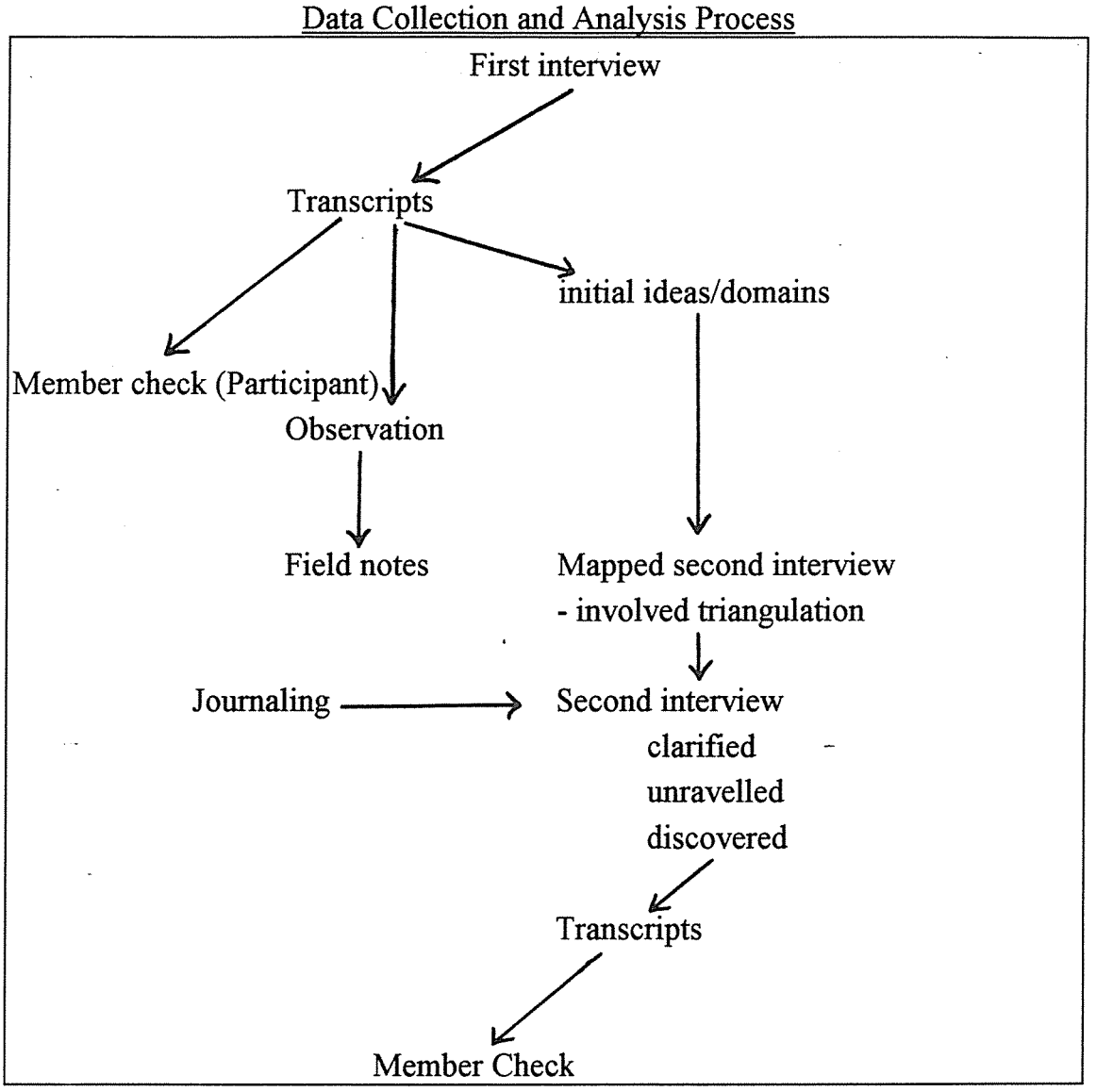
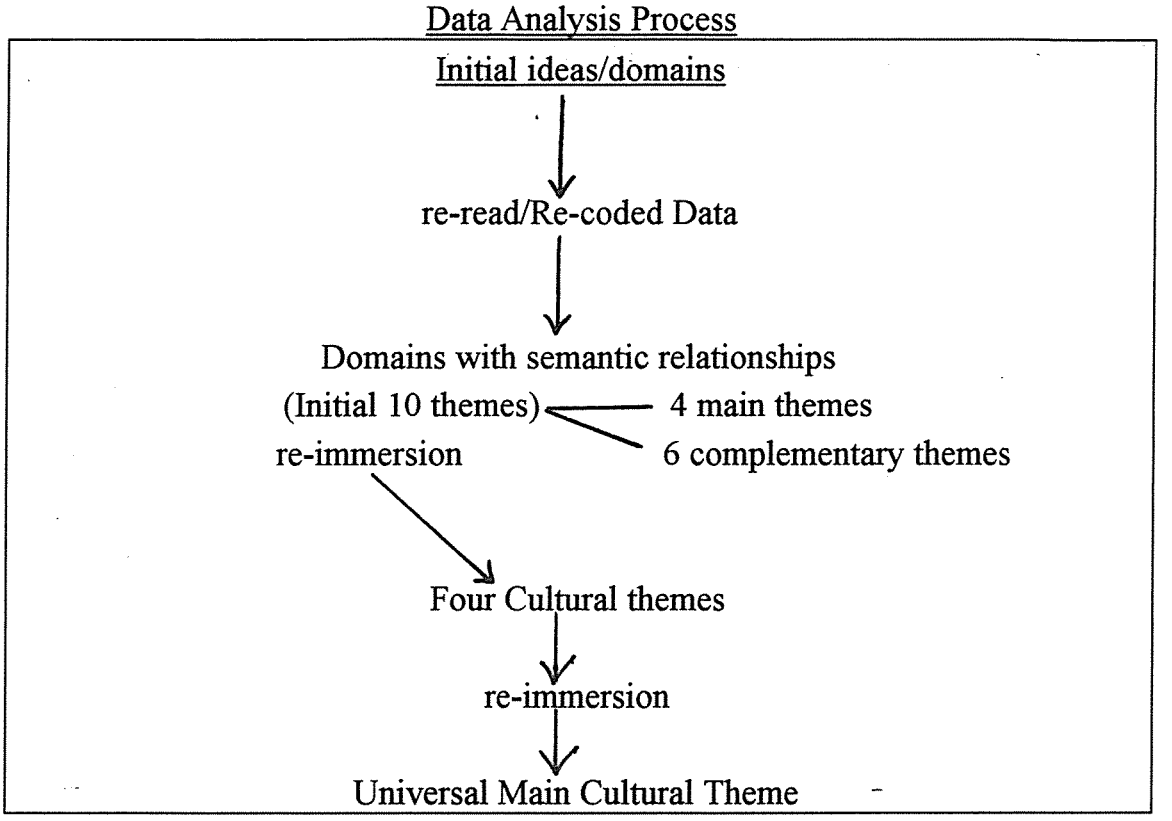

Data Collection and Analysis Process
First interview
Transcripts
initial ideas/domains
Member check (Participant)
Observation
Field notes
Mapped second interview
- involved triangulation
Journaling
Second interview
clarified
unravelled
discovered
Transcripts
Member Check

Figure 2



Ethnographic interviewing involves two distinct but complementary processes: developing rapport and eliciting information (Spradley 1979:78). Rapport involves developing trust that will allow the reciprocal dialogue of information exchange to occur. In gathering the data the researcher was conscious of using different types of questions to gain a richness of data. Questions can be of a descriptive type from broad to specific; eg "what do you understand by the word theory?" Questions can be asking for contrast or differences and help identify the different ways of thinking.

In completing the analysis for this study Spradley (1979 and 1980) was used as a guide with some adaptations which will be explained in the following description of the processes.

After the first interview; the researcher listened to all of the tapes and read the transcripts. As each transcript and tape was examined, the researcher looked to see if there were common ideas and listed these. Possible ideas, and domains came from the data.

Following the observation, the field notes and first interview data were examined and the second interview format was mapped out. Questions were formulated around the ideas that came from the data, that included the initial ideas/domains that came out of the first interview, and what the participant was thinking as they were observed in their clinical practice. All participants were asked questions on the same areas which was a way of triangulation within methods. It depended on how the interview progressed when each area was asked, as answers to some questions were very full and covered many issues whereas others did not and therefore required a next question. Information from journaling was merged into the data as it was shared by the participant during the second interview. Questions which were used, helped verify previous data collected, clarified issues raised, and compared information. This process resulted in obtaining further clarification of the participants' beliefs and perceptions.

The researcher re-read all the interviews many times and re-coded the transcripts into the broad domains (see example Appendix 4) through colour coding for each domain. This process involved immersion in the data for the researcher. Each domain was examined for the semantic relationships or commonalities that linked them into one domain. Through this data reduction process, the data was brought into a manageable form.

The same domain areas from each individual transcript were joined together in a domain transcript, which were read, re-read, re-examined and then included themes of the domain highlighted by memo stickers (see Appendix 5). This stage of analysis was then left for a few weeks, following which the researcher returned to and re-read to check the initial interpretation through re-immersion into the data.

To assist with dependability and credibility the researcher then asked a peer to sample and read the interpretation of the data and to critique and challenge the interpretations already gained. This was a valuable exercise that clarified the researcher's thinking and ratified the interpretations as being dependable and credible in the sample selected.

From this interpretation of the data, the areas within the domain, were then put in a worksheet form (see example in Appendix 6) to prepare for writing the first analysis chapter. These initial domains that arose from the data are described as main categories and complementary categories in Chapters 5 and 6.

In re-examining the domains, the researcher searched for any similarities with the same semantic relationship. The researcher asked the question: Are any of these domains similar in that they can merge together? As a result four sub-cultural themes emerged (see Chapter 7) that evolved from and integrated the main and complementary categories already identified. In this way themes not only recur throughout the data but also connect different sub-systems of the culture (Spradley 1980). These four sub-cultural themes, through ongoing data analysis, merged into one major cultural theme (see Chapter 7).

At this stage of data analysis, the data were returned to a sample of participants for the checking of the interpretations being congruent with what they had stated. Six participants examined and discussed the data with the researcher. Due to the time frame of this thesis six participants (3 nurse educators and 3 nurse clinicians) were chosen. As no incongruencies were noted, this data check did not go to the other participants. This stage of the research assists with the true/faithful interpretations of the data gained and that the participants recognise the data as their own (Sandlelowski 1986). It is also in line with Lathers (1986[a]; 1986[b]) face validity in that, she sees recycling description, emerging analysis and conclusions back through at least a sub-sample of participants. Credibility and confirmability of data was assisted with this process.

The final step in the data analysis was a re-immersion in the data and a universal or main cultural theme being identified - that of shaping nursing praxis (see Chapter 8). The researcher then went back to the data to reconfirm the end process. The processes described aimed to establish trustworthiness.

Table 2

Summary of Strategies with which to Establish Trustworthiness

Strategy	Criteria
Credibility	
	Prolonged and varied field experience
	Time sampling
	Reflexivity (field journal)
	Triangulation
	Member checking
	Peer examination
	Interview technique
	Establishing authority of the researcher
	Structural coherence
	Referred adequacy
Transferability	
	Nominated sample
	Comparison of sample to nominated data
	Time sample
	Dense description
Dependability	
	Dependability audit
	Dense description of research methods
	Stepwise replication
	Triangulation
	Peer examination
	Code re-code procedure
Confirmability	
	Confirmability audit
	Triangulation
	Reflexivity

Source:

Krefting L (1991) Rigor in Qualitative Research: The Assessment of Trustworthiness **American Journal of Occupational Therapy**; 45 (3) 214-222

All of the participants involved were assured they would have an opportunity to read and discuss the final report.

Conclusion

This chapter has outlined the methodologies used, the issues related to triangulation, credibility, transferability, dependability and confirmability of the study. The data analysis was described in relation to the above and exhibited the rigour of trustworthiness (Table 2).

The next two chapters will share the discoveries found in the data.

CHAPTER 5

THE DISCOVERY - PERCEPTIONS AND BELIEFS SHAPING PRACTICE

The following chapters five and six draw directly on the data in order to provide a description of the ways in which registered nurse participants (nurse clinicians and nurse educators) perceive their beliefs and perceptions of the link between theory and practice in nursing and how these shape their practice. Interpretation of the data is provided in Chapters 7 and 8. Extracts of dialogue with the participants will be included to allow the participants to share their journey of discovery as it occurred during the research. The data gained through observation provided cues for the second interview and, as a result, the observation, interview, and personal log data is merged with the dialogue extracts. An important issue that arose from the observations made was that assumptions could be readily gained but could end up being incorrect. When the researcher checked, through interview, the assumptions made from the observations there were many situations where incorrect judgements could easily result, for example tasks being completed in relation to intravenous additives involved clinical decision making not evident on seeing the task completed. The registered nurses who participated in this study were from both educational nursing practice and clinical nursing practice in the belief that this would provide the multiple dimensions of the theory-practice debate.

Chinn and Kramer (1991:162) talk of nursing practice as being

> *the experiences a practising nurse encounters during the process of caring for people.*

Interpretations of the words "process of caring for people" are wide in that it may include education and different settings where practice occurs that leads to caring for people.

The richness of the data was given depth and breadth by the inclusion of the participant mix. There was very little difference between the two types of participants overall responses except in the area of language where educators were more familiar with some terminology and were used to articulating information and, therefore, appeared more comfortable in doing so in some cases.

In gaining an overview of the cultural scene being studied, codes evolved from the data and were further explored in the second interview (see Figure 1 Chapter 4). From the participants' realities of the theory-practice debate, categories or domains emerged initially through domain analysis. Following refining of these domains the following four main categories were identified (see Figure 1 Chapter 4). Each main category was made up of the codes that initially evolved from the data and are outlined as follows:

- Ideal versus Reality
  - What is theory?
  - What is practice?
  - There is a gap,
  - A gap does not exist,
  - Expectations - are they unrealistic,
  - Importance of Role Models.

- Culture of Nursing
  - Variance in what is nursing,
  - Recognition of a culture,
  - Culture in practice,
  - Accepted cultural practices,
  - Need for acceptance by cultural group,
  - Need for support from peers.

- The Development Process
  - Growing Process,
  - Know what/know how,
  - Ongoing education,
  - Automation comes with experience,
  - Thinker or doer.

- Professional Judgement
  - Impact of history and tradition,
  - What is professional judgement?
  - The place of reflection,
  - A developmental process,
  - Integration of theory-practice.

Six further complementary categories evolved which impact on the effectiveness and perception of theory-practice which in turn shapes the nurse's practice. These categories, with the codes that constitute them, will be described further in

Chapter 6 and are as follows:

- Image of Self and Nursing
  - Personal self esteem,
  - Effects of history/tradition in being a minority group,
  - Self versus patient/client focus
  - Stereotype effects,
  - Showing you make a difference.

- Valuing in Theory-practice
  - Ideological base including history and tradition,
  - Varying interpretations of theory and practice,
  - Effect of Bureaucracy,
  - Effect of Societal issues,
  - Effect of contextual issues,
  - Interpretation of political activity.

- Language Affects Interpretation
  - Power of dialogue,
  - Varying interpretations,
  - Difficulty in articulation,
  - Effects of language on confidence.

- Power in Theory-Practice
  - Interpretations of Power,
  - Power in knowledge,
  - Impact of change,
  - Effects of feeling threatened,
  - Accountability/Responsibility issues,
  - Time constraints.

- Horizontal Violence
  - Effects of patriarchal structures,
  - Oppression of women,
  - Non supportive to each other,
  - Personal versus Professional behaviours,
  - Disillusionment.

- Shaping Practice
  - History/Tradition,
  - Role of Preceptors,
  - Collaboration of educators and clinicians,
  - Developmental process,
  - Change in thinking and practice.

Each of these themes are now explained in detail with extracts from the interviews and observations to allow the reader to be part of this journey of discovery.

Ideal versus Reality - the beliefs and perceptions of the registered nurses within this category were encompassed within the following codes:

- What is theory?
- What is practice?
- There is a gap,
- A gap does not exist,
- Expectations - realistic or unrealistic,
- Importance of Role Models.

Each of these codes evolved to highlight many issues from the participants' perceptions of reality.

What is theory? What is practice?

Varying interpretations were given in the answers to the questions - What is theory? What is practice?

The variations appeared to reflect the participants' experiences both in clinical practice and ongoing education. Theory was seen as being separate from practice and guiding practice. However some participants saw it as synonymous with knowledge, being the ideal, part of knowledge, interwoven with practice. When asked - "what does the word theory mean to you?" - some comments were:

> *Kim 20 The ideal I guess, what you were first taught, I mean you are taught the ideal in your training, what the books say you should be doing. It guides your practice all the time.*

Researcher So how does it guide your practice?

Kim 20 It is constantly there all the time. When I come to a person who has had a cholecystectomy or whatever operation I think to myself this is how it should be, and this is how you do the dressing.....

Theory was seen as the rationale behind practice.

Mary 1 Well in a nursing context I think theory probably gives you the rationale behind your practice work. Knowledge is something learned and acquired so therefore is theory acquired, it must be knowledge.

Mary 21 The trick might be whether it is good knowledge or bad knowledge.

The knowledge behind nursing practice was described as being theory when asked 'What does theory mean to you?' Theory, therefore, was seen as guiding and explaining practice. It was seen as essential to practice and some of the comments participants shared were:

Ann 1 When you are trained the knowledge that has been gained from their learning. The background they need to practice nursing.

Emma 2 I see theory explaining what is. I think of people like Watson and Benner. People can have a vision of nursing and as a result formulate theory.

Carol 1 I guess for me it is things you learn in books, things around theories of practice, or it is a whole range of things that help put a framework to something I guess, in a way of some sort of learning.

Carol 2:16 So the Clinicians will have skills and ongoing practice based on some theory, but they may not actually recognise it as that.

Some of the participants believed theory can be the knowledge base for practice but it can also come out of practice. There is discussion on how difficult it is to separate theory and practice as Judy explores:

I guess for me it is the knowledge base that I actually bring to my practice, upon which I am basing my practice.

Judy.2 I think a lot of what we actually do in practice has been based on theory. Because some of it has been with us so long it becomes ingrained into practice.

Judy.17 A lot of theory comes basically out of practice.

Theory was described by the participants as being different types of knowledge interwoven with practice. It was recognised that technical and practical knowledge were considered important but that reflection on practice increased the strength of our personal knowledge. Wattle acknowledges this in the following excerpt:

I guess it means the different types of knowledge that we use within our role. Its interwoven within what we practice - its part of you and you can't practice without theory and you can't have theory without practice so its all knowledge. Its quite a dynamic changing state.

Practice was seen as technical skills, and a safe way of doing things. Some participants saw practice as all inclusive, and the "doing" of nursing. Mary saw it as the appropriate care being given:

Nursing practice is just carrying out appropriate care for the patient.

When asked what practice was, Kim believed it was the ideal, but it involved a variation of skills depending on your client (Kim2). Some other participants comments were:

Kim 3 It is your work that is done every day.

Judy 9 Nursing is often seen to be a practice, the practice of doing caring and there doesn't have to be any theory to do that and I still think it is equated with that image or mothering.

Ann 2 Practice - it's doing things in a safe way - doing it the best way for the patient.

Emma 6 Practice is how I nurse - the doing.

Nursing education was seen as part of practice. In fact practice was described as being all encompassing in that theory was meshed with practice. Some of the

participants' views were:

Ann You can't teach nursing if you are not a nurse, you can't teach it effectively unless you are a nurse and practice as a nurse.

Beatrice 1 Practice is what the nurse actually does and to me that is actually like a set thing, using knowledge, and nursing theory for decision making in clinical judgement.

Rusty 14 I think practice is all things rolled into one I guess. I see everything, like education as part of a theoretical background as part of that, as knowledge, as technical skills, as communications because all of those things - I see all of that as practice.

Rusty 2:6 Practice is assisting people to reach their full health potential.

Carol 2 Practice is much broader and it probably incorporates what you do in a nursing way and what you do in the way of things with people and other parts of it is how you incorporate bits of your knowledge base, your theory, and integrate that through into your practice.

Judy 2:15 I guess for me there is a practice in nursing that is grounded in certain theoretical bases that we have which are held.

Wattle 14 Nursing practice is all encompassing. And if I'm a clinician pure that is my whole practice. At the moment education is my practice but it incorporates all the interactions with the community in different ways, and part of that is the interaction in clinical settings.

Is there a gap?

Some participants saw every day work as an "ideal versus reality" issue while others saw there was no gap, especially after experience was gained. The concept of development and acknowledgment of allowing the growth in practice was seen as important by the following participants:

Thea I think the gap is there but it decreases as you become more experienced.

Thea 2:6 Mmm, I think we do expect too much. Like a new grad you think, right because you are a staff nurse, you should be able to do this, that and the next bit, but you may not have had the

experience to actually to do it, so it will take us a year or two to actually get in and do those kind of things until you are experienced.

Beatrice 4 There is a gap but I don't think it is so wide as some people believe it. Because we are also talking about the reality of practice and how one has to perhaps match beliefs and assumptions and ideals to actually fit the reality of the practice in recognised blocks, of why that is not occurring. I mean, that is my focus, I mean that is my assumption and how I teach.

As a result of a previous interview it was suggested that the gap may be an excuse for coping with threats and change. When a situation in practice is not comfortable or knowledge is not known, it was thought the nurse rationalises what is happening in the practice setting in such a way that it can be seen as a valid excuse. Beatrice explains:

Beatrice 6 I think it is definitely an excuse for what's happening and its a way of rationalising.reasons, other reasons of why nurses perhaps don't fulfil their role as to what their potential is, is able.

The possibility of ideal versus reality being used as an excuse was extended by the participants with another view being offered that the ideal was often a label given to required practice as an excuse for a decreased standards of practice that existed.

Toni I think what (pause) they talk about is that we teach the ideal, and they do the real, and that is the gap that they perceive. I actually don't take that on board as being valid (pause) because I believe that is an excuse for not doing the ideal.

Researcher So why then do they say there is a gap between the ideal and the real?

Toni 6-7 I think they're probably in a different generation, a different school of nurses, maybe hospital trained like myself that haven't furthered their thinking about nursing and learning about nursing and that have learnt theory through a set way, of patterns of practice and I suppose one of the ways I see the gap between theory and practice is the lack of catch up with the development of nursing understanding.

Beatrice 2:8 Yeah I see it definitely much as a scape goat therefore it becomes an implied gap it has become a gap. I think it actually, I

think in a sense there is a reality but that reality is not formed on like there is a perceived gap. I think there is a real perceived gap there, but that perceived gap is not actually based on the reality of a gap but more on the continual scape goating, do you know what I mean?

With the ideal versus reality concerns, it was felt by the participants that perhaps the problem solving and critical thinking skills being taught in today's education setting, might see the ideal-reality issues becoming less marked.

Researcher Some clinicians, and I am bringing to mind one that just said to me the other day around "you lot teach the ideal and here is the reality and that is why we have a gap". Do you believe that?

Carol 14 Sometimes it is true but I also believe we teach in a way that we are teaching the ideal to some extent sure, but that we are also teaching problem solving and adaptability so that the ideal may be a little way off from the reality of what practice is happening here and now, but certainly it is not being compromised by being altered if you like a little.

Subsequently, in the second interview with the participants the influence of different perceptions and beliefs became evident along with valuing practical knowledge.

Researcher so when people react and say things like "it's the ideal reality, they will never learnt anything here, because you know it has to be in a hospital setting" there will always be a gap...

Wattle And they continue to make that gap happen by valuing that type of practical knowledge I talked about last time that the graduate cannot have because it is culturally bound to the area and therefore they can maintain that you can never have a new person coming in that can manage....

Researcher Quite powerful!

Wattle 2:15 Very very powerful. You or I would struggle with years and years of experience.... if they chose for that to be so, if they have got a thing about the graduates and where they're coming from etc and um, yeah... it is extremely strong.

Participants acknowledged that there were different expectations of nurse

colleagues and this would influence how people might see reality at that time and space. This could be interpreted as a perceived theory-practice gap. Perhaps a continuum of development was the actual reality of nursing practice, with an emphasis on situational and reactive aspects at specific times and in specific situations, that highlighted areas of knowledge or practice deficit through having certain expectations of the new person.

> *Beatrice 6 So it is the gap between the basic needed care and real quality care.*

> *Lou 19 So when they come out of the course. So we have done the complete opposite and it is quite upsetting because you have large numbers of nurses who did the hospital training and have expectations that way, and you have large numbers who have done comprehensive training and are basically at sea quite often, the poor things. So this chasm is between expectation and reality I think. The senior staff, (and senior at the moment is experience, it's years of service, it isn't because you are good). The senior staff have expectations of the new graduates, that the new graduates can't meet. And new graduates have expectations of the senior staff of explanations perhaps behind procedures and things that they are doing, which the experienced people can't meet because they have never learnt it, they didn't know it and they have never looked it up.*

Expectations - realistic or unrealistic

Within this concept of development continuum, expectations of both the new registered nurse to an area and incumbent staff arose as an issue that affected the perception and belief about the ideal/reality situations in practice and the chasm perceived. On the subsequent interviews, expectations of the new person continued to be mentioned in that the ability of the registered nurse was not concrete and the developmental process of becoming more competent was an important consideration. Thea explains:

> *Right. Mmm, I think we do expect too much. Like a new grad you think, right because you are a staff nurse, you should be able to do this, that and the next bit, but you may not have had the experience to actually to do it, so it will take us a year or two to actually get in and do those kind of things until you are experienced.*

> *Thea 2:6-7 I think that we tend to forget that um the more experience you get and what you find is, (pause) normal to do and just because you label that person staff nurse, they can do this. You*

don't sort of think that right they've had the theory to do this but they haven't had the practice to do it, and that is something we all need to remember that, if the theory is there good, but you have to develop the theory into practice to actually get it reinforced into the fact that they can do things properly.

Along with expectations it was recognised that the complexity of care had increased, the demands of competent practice existed at a higher level than traditionally acknowledged, and the staff patient ratio had decreased. This appeared to cause frustration in that Kim could not practice and use her knowledge as she would wish to:

Kim 2:6 I think yeah, when I first started back on the ward, there was, we did have, we seemed to have more staff. It has always been a very busy place but we did seem to have more staff. Like in room three is our special room as such, and there is four patients in there, and there was always two nurses in there and yeah, you did work differently. You could deal with the smaller not only psychological things, but just the little things for the patient, the comfort needs and not just be task orientated. So like instead of now, like you go around you do your hourly urines, you do your blood pressures and you do all those mechanical things and then you think about the comfort needs and the psychological needs. You are doing, you had maybe two patients and you could do all of them together at one time for that one patient and then move on to the next person.

With the expectations being identified as another facet of the perceptions of the ideal/reality dichotomy it was stressed that rules had an impact on the perception of effective practice.

Wattle Sometimes I think it is rule driven.

Researcher By whom, driven by whom?

Wattle 10 Within our own practice between us as nurses. Its expected that, and I think we are very good at toeing the line sometimes, we have learnt. Those of us who survived were those who could toe the line in many ways.

Importance of role models

However perceptions and beliefs of theory-practice were very much affected by the role models seen in the practice settings. Role models were seen to set the

standard therefore expectations of nurses in their practice. In most cases the charge nurse was seen as pivotal in setting the standard, expectation and reality for nurses in practice.

> *Lou 18 I think the charge nurse is pivotal in nursing practice in the ward, her opinions, and what she lets happen.*
>
> *Toni 2:27 The charge nurse can really be a catalyst to raise the quality of care.*
>
> *Carol 2:14 I think being role models and certainly the role modelling in the practice setting is one of the best ways of learning anything and as people stand up and begin to show an expert way of articulating particular things, a way of dealing with conflict, a way of you know working through some of these situations that we talk about.*
>
> *Rusty 2:22 With some charge nurses, I believe they are very good practitioners but sometimes I wonder whether they have been assisted with the extra skills it takes to become a charge nurse and I think that sometimes they have been dropped in it.*
>
> *Thea Right well, hopefully, (pause) the preceptor should be a role model, that is the first person you are in contact with when you come on to the ward. You have got the charge nurse as a role model, whatever that charge nurse does then you will do, if she has her hair hanging down below her shoulders, and why can't you, she is a role model and the level three should be an excellent role model on the ward as well.*
>
> *Thea 2:12 I mean the clinical specialists are definitely role models.*

Theory and practice were seen generally as interwoven and inseparable but with varied interpretations ranging from frameworks to knowledge for practice. Any perceived gap was seen as a temporary state and was part of development of knowledge and practice. How nurses practice appears to be greatly influenced by the role models present in their practice settings. There was some recognition of the importance in acknowledging the developmental process of nursing practice through experience. It was recognised that the staffing levels, expectations and complexities of care, affected how the nurse practiced and helped other nurses adjust to a new setting. This was seen as a major influence on how theory and practice were perceived.

Culture of Nursing

This category encompasses the perceptions and beliefs of the registered nurses in relation to culture and nursing highlighting the following codes:

- Variance in "what is nursing",
- Recognition of a culture,
- Accepted culture in practice,
- Need for acceptance by cultural group,
- Need for support from peers.

Variance in what is nursing

In exploring the culture of nursing, the shared values, beliefs, expectations, attitudes and norms were highlighted by the participants in many different ways. The very essence of nursing was given varying meanings with a commonality of caring that mirrored most participant's perceptions of what nursing is for them. Typical comments were:

> *Mary 2:16 Nursing is really making a contribution to a person's wellbeing, something, you know and if possible restoring them and that would probably cover in hospital and the community as people see you but that would be the thing. It is about combining knowledge and practical skills to improve somebody's quality of life.*

> *Lou 6 Nursing is an art and a science and it has a philosophy of caring. It is very difficult to describe isn't it? We haven't defined nursing adequately, - I don't think we have found ourselves yet as a profession.*

> *Beatrice 2:3 I think people at the workface really just think of nursing as what I am doing today or this week.*

> *Judy 9 I think nursing is often seen to be practice, practice of doing, caring and that there doesn't have to be any theory to do that.*

Recognition of a culture

The culture of nursing was recognised in different ways but indicated that perceived realities are individual, unique and complex. Participants commented:

> *Ann 2:6 Oh every ward has its own culture. I know at Christmas time when they used to combine two wards, it can actually have a bit of strife because everybody has got their different ways of doing*

things. And you stick to the way of your culture.

Carol 2:6 Sometimes but I also think that the students acknowledge that they're still trying to get into the culture of the nursing workplace but everywhere they go there is a basic culture that's the same but the individual culture is different in every area.
I wonder if staff forget what its like to be a new person and the expectation laid on them is unrealistic.

Ann 2:8 when I first started here there were hospital trained people and tech trained people and the hospital trained people fitted in quicker but now they are all tech trained you have to adapt to that and fit them in to how things are done. So you recognise it and you help them fit in.

"The way things are done around here" was a way the participants described fitting into the practice setting. The power relationships, culture of other groups and the complexity of the work setting all needed to be acknowledged. In dialogue with the participants it was recognised that perhaps a culture gap should be acknowledged, more than a theory-practice gap. It did not matter where the new people come from to their ward, they needed to learn the culture. Examples of such comments were:

Toni 2:17 It makes a lot of sense - the new kid on the block, new person in a new area, and unfamiliar ..... are likely consequences of enculturation of that person and socalisation ..... the new, the working relationships.

Lou 2:10 You just have to know about it, how to do it and how it is accepted in the place because they learn to follow the protocol of the place.

Beatrice 2:9 The culture changes. Because with hospital based training you see you were encultured into it over three years so when you actually graduated you knew the system inside out - and that's the difference between the two systems. And new people coming from different hospitals, they have the same problem - they have learnt a culture from somewhere else that is totally different.

Rusty 2:12 Going from ward to ward in a hospital and all the same sort of area - there is a huge difference in the culture of each ward - probably stems from the charge nurse and it is interesting to watch a ward change with new staff - new charge nurse. I believe the culture is very strong. We don't teach them any survival skills.

Accepted culture in practice

The accepted culture in a specific practice setting often became evident when the nurses in that culture appeared to try and change the way new people fit in and made sure they 'learn how to do things around here' properly. This restricted the new person in how they might practice and increased the pressure on them that they had to conform.

> *Judy 12 If they start to shift from that, the system may not allow the shift and that could be on restriction on them.*

> *Wattle 2:7 Now there is culture stuff that you can't just rely on your principles because you can't go against a local belief - Say taking out a redivac. They are culture based decisions - the new grad is trying to find her feet and be accepted etc they are not going to want to break those local rules. They have got to establish their credibility in the area - they don't want to carry a label - 'they never get taught anything'.*

Need for acceptance by cultural group

Within a culture there is a need for acceptance. This view is exemplified by such comments as:

> *Emma 2:17 She appeared laid back, she asked questions in a way that seemed to indicate that she didn't know, but she did, or she asked questions in a way that seemed to indicate that she had less knowledge than she did. And she was a very competent nurse, she had worked, was skilled at nursing in other areas coming into a specialised area and for a while she felt as though she wasn't accepted.*

> *Mary 2:9 Yeah, because they are waiting to see what the culture of that area is? Now this particular girl when she came you would say to her 'oh are you familiar with that' and she would say 'oh yes I have done it but I don't know how you do it here'.*

> *Emma 5 I believe strongly that we need to treat each other with respect.*

> *Emma 2:16 And also until I felt that they trusted me because there was an element "she comes from a foreign country, she doesn't know the way we do things, we have got to see what her practice is like, is it up to our standard."*

Lou 2:4 I think they are so anxious to please and so anxious to be accepted into the group that they actually will go against their own feeling and I wonder if that is where a lot of the dis-satisfactions come in because they find themselves unable to be themselves and to be creative and to stand alone.

Beatrice 2:6 They are trying to find their niche in that new culture and it is quite important, that each area does have its own culture and it takes a while to learn. To learn a culture and because they are training there have been only like short periods, they've never ever really developed a way of actually surviving the enculturation process.

Kim 2:16 Another comment was 'they don't teach us how to deal with this in school' which sort of makes you think well perhaps there is a gap, but really it was just that they didn't know how to deal with it, because they were new to the area and new to nursing.

Need for support from peers

However along with the acceptance and fitting in to an area there was discussion of the need for support to help adjust to the culture and gain confidence. The new person to an area especially wanted to 'fit in' but also needed to be able to practice how they had been educated to practice. Support and understanding were seen as key issues to consider:

Ann 2:6 They might not feel confident doing it and they just want you to watch them doing it to see if they are doing it OK.

Lou 18 'Why aren't you practising it, why aren't you doing it' she said, 'well you just follow what others do'. And that I think is the crux of theory and practice. They come in and they get straight into the culture of the organisation because they want to follow their peers and I find that incredibly sad because they have got so much to offer other nurses there.

Carol 6 I think it is very much the individual in that practice role to be getting on board and picking up those issues again but that is where the blocks sometimes come in and that they might be starting to work in a more confident and integrated way, and as long as the environment they are working supports their integration of that practice and theory that will happen.

Rusty 2:24 They are probably lacking direction they are probably lacking some knowledge of the culture of the area.

The culture of nursing was identified by the participants as being all inclusive of practice, beliefs, knowledge and acceptance by the majority. It is affected by the different practice settings and expectations made of nurses in each individual practice setting. This acknowledges that nursing is formed through historical and contextual meanings that can be seen as ritualistic practices. These rituals, myths, beliefs, norms and knowledge patterns reveal the culture of nursing that changes within the context in which nursing occurs.

The Developmental Process

The beliefs and perceptions of registered nurses within this category highlighted the following codes:

- Know what/know how,
- Thinker or doer,
- Ongoing education,
- Automation comes with experience,
- Link between theory and practice,
- Growing Process.

Knowing what/knowing how

The importance of finding out what nursing and professional judgement are interpreted as, was described by the participants as being important in being able to articulate what the nursing profession is. The inter-relationship with the culture of the work setting was evident in that the nurse might know how to practice differently to meet standards, but practices in a way that is acceptable to the rituals and beliefs of colleagues in that work setting. Personal, professional and organisational goals may conflict with the goals of the individuals within each practice setting resulting in incongruency between what they know and what they do. Participants emphasised:

> *Lou 2 I think we have to take ourselves aside and say what are we, where are we going, why do they need us, why does the manager need registered nurses.*

> *Lou 13 That frightens me to death. So I think that we won't do it and I think that is why we are failing, but we have to educate those nurses who know so much practically but don't know what they know and why they know it.*

> *Wattle 4-5 Its that linking that we talk about with the students and*

making sense of the reality of practice. It was the difference between knowing what to do and how to do it and knowing that.

Emma 2:1 So sometimes the basic things like, taking rings off when they are washing hands before they are doing sterile procedure or washing their hands properly, they know... if you say to them "what are you doing here" "oh yes I know I should wash my hands in this way, or I shouldn't be going like that because of the possibility of taking bugs up towards the clean area". They know the things like that, they know, but they don't do it.

Thinker or doer

In knowing what and knowing how, thinking or doing was discussed as being critical to identify in clarifying the developmental stage of knowledge development of each individual nurse. Until nurses can think nursing, it was seen as a block to the integration of theory and practice becoming one (Perry 1985).

Thea 2:9 Well I try and always make people think, why am I doing this. Keep always asking yourself why, why, why, if there is no reason for it, or what you are doing is not making any difference to the treatment, don't bother doing it. Save your time there.

Mary 23 People need to develop skills, personal skills are one thing that I think people need to be very conscious of, I think they are very important. And I also think people need to be able to think things through and I think that some people need help to train themselves to be logical, you know and to reason a thing. So that if somebody says black is white you need to be able to reason it out for yourself and not accept somebody else's word, particularly in the clinical setting. Today I think you have to be able to reason and not just accept that what somebody says is right.

Lou 2:24 But in the, what I call my 'good wards' they will sit down and have a subject, they will pursue it, they will talk and discuss it.

Thinking was acknowledged as being complex and changed depending on the paradigm of thinking the nurse was using. As already stated (refer Chapter 3) ways of knowing and paradigms of thought available were varied and would account for the complexity in how theory-practice is perceived.

Ongoing education

Thinking was seen as being assisted by ongoing education, which was important

in expanding skills, opening the mind and bringing nurses together legitimately to share their realities of theory-practice. Inservice education as well as ongoing tertiary education were seen as essential for the ongoing development of the personal and professional self, as well as nursing knowledge. Some of the views shared by the participants are:

> *Ann 19 Certainly in the hospital there is lots of little lectures about all different subjects that you deal with, it is up to the nurses to get more education outside of nursing. I mean like with techs or with the diploma or university education that is up to the nurse. We certainly need people doing that even if everybody doesn't do it. And people also go off and do specialty courses, I think that is quite important too.*
>
> *Kim 2:20 Through courses at tech and university I have to get into more adult education, learning for myself how to deal with people, educating people, how to educate people.*
>
> *Mary 17 The programme for surgical areas is quite extensive for all surgical areas. Places are limited but all can apply. Study days include practical skills, anatomy and physiology, professional development. A nurse has to be accountable.*
>
> *Judy 5 Unfortunately I don't think that the system always encourages you to keep on growing in terms of knowledge base. Knowledge is grounded on theory but they don't see that, because the theory is not actually given is it.*
>
> *Lou 2:18 We don't give her some avenue or at least not actually responsibility to expand her knowledge but you don't know, what you don't know. I think that we're wrong in not expecting nurses to have a certain number of education hours a year to retain their registration.*

Accountability was seen as being important by participants and ongoing education was one way of expanding the knowledge to help accountability develop. However the participants' comments reiterated the variance there is in the interpretation of theory. Within the region in which this study was conducted there is a career pathway which has within it educational requirements to move from level to level. This was in itself a motivator to join the inservice education that was provided within work time.

Kim 13 There is quite an extensive levelling system in the area. When a person, no matter how experienced they are, comes into the area they go into the familiarisation programme which is ten weeks.

Kim 15 If I want to carry on being level 3 etc, I need to put more education, outside education, into my career.

Mary 15 Because you see there is an audit attached to all those programmes. Familiarisation and levels of practice programme for RN's and EN's.

However it was also seen that a nurse could be over-educated for the position she or he held. This appeared to be seen as a disadvantage to some degree.

Mary 21 I suppose you could be over educated in a certain situation - meaning people might have knowledge greater than necessary for a particular job.

Education was seen as opening the mind and bringing people together legitimately to share knowledge and gain more understanding of each other's practice. It was discussed that by broadening perspectives of nursing the nurse could also gain greater understanding of self.

Lou 16 With education comes self image because you realise what you are and what you can do.
Everybody is pinning their hopes on the degree becoming part-time so we can do it otherwise we can't.

Beatrice 2:16 I think education is important in the sense that it brings people together, to chat, to talk nursing.

Lou 2:30 I think we need to teach experienced nurses. In this hospital most of our nurses are only probably under five years experience.

Opportunities to talk nursing were seen as a contribution to personal and professional growth. Educational forums were seen as an important setting for this to happen.

Automation comes with experience

It was recognised that automation is a result of a habit of doing something in a particular way over a period of time and internalising the process to such a

degree it does not require thinking about. However, there was concern expressed that automation could also put the patient at risk if the rationale behind the action was not evident or known.

> *Mary 2:12 In an area where patients can change quickly I do see some staff like that you know its automatic.*
> *So yeah there would be that automation to a degree but again in the area I think you do at the patient's risk quite frankly.*

> *Judy 2:1 Automation for me is when you get into the habit of doing something that you have learnt from theory but you get to the stage where you stop thinking and therefore stop applying the theory. They are not relating to the client at all, they are doing a task.*

The distinction of tasks instead of caring for the client as a person was of concern to many participants. However tasks as a major focus without thinking about why practice was occurring continued to be described as an issue of automation.

> *Ann 20 and Ann 2:2 I think now it comes automatically and you don't really think about it. - its a gradual process.*

> *Kim 2:1 I did have a set of tasks in the back of my mind, I also had a lot of other things like assessing patients.*

> *Researcher So have you got a sort of global feeling of that person?*

> *Kim 2:1 You mean the patients? I hate to say it but probably more of the tasks at that time.*

On reflection Thea believed that automation of a task allowed more time to assess the patient and the context more globally.

> *Thea 2:10 Right, I was reading through what I said the other week, um, we mentioned that about the task and yeah that is true. I sort of thought about that again and thought well you do need to do the task so that you get into doing it, the more and more you repeat the task the less you have to concentrate on that task, you can look around more.*

Automation in practice, especially in performing tasks was seen to have both negative and positive perspectives. Experience resulted in being able to

complete tasks more easily allowing for other ways of thinking to occur.

Link between theory and practice

There was great variation in responses to the integration of theory and practice. The changes within the health care system were seen as a deterrent to integration, as with less staff, tasks were emphasised more than the process of learning.

> *Kim 2:22 Oh, it's going to be difficult, I think, to keep it (nursing) intact because there is quite a shift, everything is orientated to money rather than people and how they deliver a service. I really am not sure how we can keep it intact because the shift of, sort of, hospitals becoming more businesslike is getting away from the patient.*

Orientation/familiarisation programmes were seen as a facilitator of linking theory and practice and as well as helping them learn the culture of the unit.

> *Mary 6 That is for anybody. Anybody that is newly employed by the hospital regardless of when they trained. They have three days inservice and when they come on to a ward there is 10 weeks familiarisation programme.*

There was a strong support from the participants for the belief that theory and practice cannot be separated - it is meshed and interwoven. However within this belief was the reality that the interpretations of theory were different as already stated.

> *Ann 1 Well the theory is the background that you need to combine that with your experience. Because every patient reacts differently, if you have got knowledge, then you can apply it practically.*

> *Carol 2:2 It links in some ways particularly - I think the most important linking that I see for that theory-practice bit, that linking, is where the student has a particular focus or need that day in the linking and the theory that might be associated with that comes into play.*

Frustrations exist at not being able to practice as nurses are prepared to do. This often could be used negatively to excuse the reality of practice at that time and relates back to the issues, already highlighted, of ideal and reality. However the

ideal here is unachievable due to staff shortages combined with the requirements of more complex patient care.

> *Emma 15 I think that, when nurses say, you know, there is theory, when they imply a theory-practice gap, they are usually feeling quite frustrated about something and recently I can think of three or four nurses on a particular ward who are frustrated because they can't give the care that they want to, that they are used to giving and the sort of care that their personal nursing philosophy demands.*

Frustration was shown in that there appeared to be a time lag between current clinical practice and educational practice of nursing. This could hinder the linking of theory and practice in that knowledge is not always gained by educators at the time of new practice innovations.

> *Toni 2:15 Yes I wrote, I have just written two things down and it was after our first interview, in the car on the way home, stopped at the lights - we all have gaps in our knowledge or theory, that was the first insight I had, that whether we are a practitioner or a teacher there are, there has got to be lots of gaps in the knowledge. I would say that is a basic assumption. Secondly the gap is, the gap between clinical and education is it is just a time lag.*
>
> *Researcher Can you talk about that a bit more?*
>
> *Toni 2:15 Things are happening so quickly, with technological advances, drugs, just procedures that nurses are doing, there is lot of research is happening in the clinical area and nurses are thinking and changing practice constantly and that time lag is education catching up, finding out about that.*

This highlighted the need for closer collaboration and communication between educators and clinicians to assist in developing currency of knowledge. This was emphasised by Rusty:

> *I think perhaps, I think we are perceived by the clinical areas as being too idealistic and without our feet on the ground. We teach the students all these things that don't relate to reality and the other way I think we sometimes are extremely critical of clinical practice out there.*
>
> *Rusty 5 I guess just by having a better liaison between tech perhaps and the clinical area, I don't know.*

Along with this it was seen that theory was a blueprint for guiding practice (Emma 2:20). There were instances in practice where intuition was used as a reason why experience automatically or unconsciously assisted the nurses decision making for patient care.

> *Ann 5 It was probably just because she knew him she had had him as a patient before and she knew that he wasn't himself. It's your instincts with people I think.*

> *Rusty 1 I guess because I think we have to acknowledge or treasure the knowledge that is generated through practice, and I think nurses aren't good at doing that.*

The theory-practice link was well supported by the participants, even though they interpreted theory differently. Knowledge was seen as critical for practice as was closer collaboration of clinicians and educators.

Growing process

All of the descriptions that developed this theme overall lead into a concept of the growing process. The blueprint and guiding role of theory to practice was seen as developing over time and led to consolidating practice. This acknowledgment of growth was in itself a valuing of all nurses regardless of their experience and length of time in practice.

> *Thea 2:9 So I think it is a growing process really.*

> *Thea 2:7 I think that we tend to forget that the more experience you get and what you find is, (pause) normal to do and just because you label that person staff nurse, they can do this. You don't sort of think that right - they've have had the theory to do this but they haven't had the practice to do it, and that is something we all need to remember that, if the theory is there good, but you have to develop the theory into practice to actually get it reinforced into the fact that they can do things properly.*

> *Toni 2:28 I think nursing is at a developmental stage to, of where we are describing where nursing is.*

> *Judy 2:3 Yeah its developmental - I see that just fitting so closely with what you were saying with Benner's model.*

Benner's model (1984) was discussed by some participants as being very important in understanding nurses' practice in all contexts whether they were a

new graduate, transferring nurse or an experience nurse.

> *Rusty 2:13 No its not a gap - it is just a different way of approaching things.*

Descriptions emphasised the importance of recognising that the new person in an area needs time to consolidate practice which facilitates the growth process of professional nursing practice from novice to expert. Ongoing education was seen by the participants as crucial in the developmental process to consolidate and extend practice.

Professional Judgement

This category has surfaced issues related to professional judgement and encompasses the following codes:

- Impact of history and tradition,
- What is professional judgement,
- The place of reflection,
- A developmental process,
- Integration of theory and practice.

History and tradition

The impact of history and tradition on nursing and the perception and beliefs of registered nurses in relation to theory and practice was expressed by many participants and will be revisited as an issue of image in Chapter 6.

It was seen that educators and clinicians need to learn to sit down and talk about their perceptions of each other. Through clarifying roles and clarifying historical assumptions there would be a clearer road for collaboration. It was recognised that the change from the apprenticeship system of education to the student based system of education left incongruencies of practice to be dealt with. In the past nurses practiced in an environment that was dependent on medical and hospital systems. These beliefs still exist but along with them nurses are more critical and independent thinking in their practice. Some participants views on these incongruencies were:

> *Beatrice 14 It is also trying to prove that it is a validated nursing practice to actually sit down and talk about nursing, because that is how you actually provide quality of service.*

Emma 22 I think for a lot of people working in the clinical area, theory has not guided practice.

Researcher What has?

Emma Tradition. What has worked for us in the past.

The effect of the military and tradition on the role of the nurse as more subservient was seen to still be present and reinforced the dependence on the medical and hospital systems in a positivist approach.

Judy 18 That was a militaristic foundation of nursing, hierarchical structures.

Rusty 2:3 I believe basically our health care system is medically driven and nurses are certainly oppressed in nursing as women because nursing is 90% female. And I think it is just really a sign of society, that nursing is like that.

It was evident that, as each participant shared their perceptions and beliefs, different paradigms of thought and knowing were coming into the descriptions. These varying interpretations accentuated the complexity of examining the theory-practice debate:

Beatrice 2:22 And once you can work beyond the black and white stuff and see more into the grey, I think that is when you tend to be able to do it (practice) more on your own. Concrete = black and white and theory-practice gap is evident. In the grey this is not so and a developmental process is recognised.

Wattle 5 I'm looking back and really a lot of my initial responses were task related more than to a global practice theory justification. Yes we were reinforced for knowing how-when, and that is only a small part of knowing. There is so much more knowing that makes your practice so much more exciting and beneficial.

Professional judgement was seen as having different interpretations depending on the paradigm of thinking that was used by the participants (refer to Chapters 2 and 3).

What is professional judgement ?

Professional judgement was a term used by participants and was mostly

described as being based on experience which included intuition. It was a term that appeared to be used without fully understanding its meaning.

> *Kim 2:8 I just do things now with experience, do things off rote, I mean not off rote either, its just experience coming through. This is what is happening to the patient, this is what is going to happen to the patient, this is how I have to deal with it.*

> *Rusty 2:10 I think you need to encourage them (students) to talk to the staff and ask them about those frameworks they have and why they decide to do that. I believe when Benner's work came out that nurses were able to read that and it was almost like an 'ah ha' to them.*

> *Lou 9 Well you made them (professional judgements) based on your knowledge, based on your experience, which is what I have seen before in similar circumstances or a variety of circumstances that came together.*

The discussion with the participants led onto the issue of intuition and whether that was part of professional judgement.

> *Judy 2 I don't believe in intuition - I don't think its anything hidden or that can't be explained; I think it is experience, its just the ability to see things and make decisions because of experience and understanding.*

> *Rusty 2:11 Intuition I believe is based on experience.*

Intution overall was seen as part of professional judgement, in that it evolved through experience and was more than a sudden insight when reflection on the decision followed.

The place of reflection

In using professional judgement, reflection was seen to have an important part to play in the professional development and practice of a nurse.

> *Beatrice 2:29 I had to be made to reflect before I realised the value of it. I used to think 'oh yeah what a waste of time really'. We are doing that with our students, actually making them reflect and actually seeing the value of it.*
> *I guess most people do reflect but it is unplanned and it is intuitive reflection.*

Judy 14 Also the fact that one of the things you can do to bridge the gap is reflection.

Reflection in action came from two participants while driving home following the first interview, with the researcher:

Thea 2:12 I sort of thought you can't sort of, the practice and the theory, the practice won't be any good if the theory is not of a good standard and you can't sort of say that someone's practice is bad if they haven't had a good standard of theory.

Thea 2:28 Its just that you have sort of opened up something that I hadn't thought about before and its made me more conscious to look at what people have been taught instead of just thinking right they should know that.

Kim 2:8 I think I reflect a lot of mine on the way home in the car.

Developmental process

With reflection and recognition of the impact of history or tradition, professional judgement within nursing practice was seen as a developmental process or process of growing as already stated. Nursing practice was seen on a continuum of development that came with experience and further knowledge and the word gap was not a clear description of what happened.

Beatrice 2:25 There are so many issues and things in this gap and therefore the gap, it is not actually a gap on a line, it is actually a continuum, but its a (pause) I sort of picture it like a universe. You have actually got to take in all those different contextual factors.

Toni 10 I think its (the gap) definitely part of the developmental process of nursing.

Judy 2:15 I don't believe there is really a gap. We are talking about developmental aspects.

Wattle 17 I don't see a gap in me, in whatever I am doing. Knowledge and practice is interwoven.

The gap could be part of the assumptions nurses make about colleagues who appear on the surface to be "doing" tasks. The process of thinking that lies behind the task is not known if not explored with the person or reflection on the

judgement is not instigated.

> *Wattle 2:4 What confuses students sometimes is they see an expert in practice and they don't see the framework the same. Its the difficulty in recognising it is happening, to call it a label such as a post natal check, because it is being delivered at such a high level of skill.*

In transferring from one area to another, eg. having worked in acute surgery and then going to oncology -

> *Ann 18 I would expect to have a theory-practice gap there. In fact I would have a knowledge gap going there. But I would expect to go there and learn about it so I can close that gap.*

Integration of theory and practice

Integration of theory and practice was emphasised as being what should happen as professional practice. There was a recognition that this was not always evident and that more knowledge and a recognition of nursing's ideological base may facilitate or inhibit this integration. The different paradigms of thinking already addressed in this thesis, impact on the interpretation of theory and practice and is evident in the participants' comments:

> *Thea 2:3 New grads will be frustrated because the ideal and theory and the practical um, there is a bit of a gap there at the start, both in theory you learn, the ideological way things should be and that is interrupted a lot by the workload.*

> *Emma 2:13 Alright. If my belief says that patients and families are capable and should be involved in the process of their care and their healing, that they should be totally involved, and therefore sharing in decision making and if I... if I don't practice like that and if I go ahead and organise care without consultation and fail to give education, and information, then there is obviously a theory-practice gap.*

> *Lou think we need more scientific knowledge so that we can care, we can interpret, observe accurately and report on our observations accurately.*

> *Beatrice 11 We actually haven't given them (students) the skills or strategies of how to use theory in a very much deliberate way.*
> *Theory and practice - they are sort of like a never ending circle in a*

sense. Both are shaping nursing.

Carol 4 I don't think nurses in practice always apply theory to their work. I think they do in very simplistic terms. I think they cling on to the easy to remember, easy to apply sort of theories rather than actually integrating a lot of depth of theory into practice.

Conclusion

Professional judgement from the participants perspective was influences by history, tradition, reflection, intuition and the paradigm of thinking being used. With experience, professional judgement was seen to develop as a process and could be misinterpreted through assumptions made on observing colleagues in practice.

The four main categories identified in this chapter are not discrete in that they relate closely and overlap in many areas. These categories will be further clarified in that six complementary categories evolved that influenced the above categories. These six complementary categories will be described in the next chapter.

CHAPTER 6

THE DISCOVERY - THE INFLUENCES THAT AFFECT THE PERCEPTIONS AND BELIEFS THAT SHAPE NURSING PRACTICE

This chapter continues the description of the ways registered nurses perceive the link between theory and practice in nursing. The following every day realities of theory-practice are the issues that are seen to impact on the beliefs and perceptions of theory and practice. Contextual issues such as setting, socio-political, historical and organisational influences need to be considered within the reality described as nursing and nursing activities are embedded within these issues. Exploration of theory-practice within the nursing context discovered the ways registered nurses act, react, value, believe and view the reality of the theory-practice debate and in doing so shape the practice of nursing. The opportunity of participation with registered nurses gave insight and understanding of what occurs for them in their theory-practice reality, acknowledging that their descriptions highlight the important relevant issues for them.

The six complementary categories (refer to Figure 2 Chapter 4) that impact on the ideal/reality, culture of nursing, developmental process and professional judgement main categories will now be identified and then described.

- Image of Self and Nursing
  - Personal self esteem,
  - Effects of history/tradition in being a minority group,
  - Self versus patient/client focus,
  - Stereotype effects,
  - Showing you make a difference.

- Valuing in Theory-Practice
  - Ideological base including history and tradition,
  - Varying interpretations of theory and practice,
  - Effect of Bureaucracy,
  - Effect of Societal issues,
  - Effect of contextual issues,
  - Interpretation of political activity.

- Language affects interpretation of Theory-Practice,
  - Power of dialogue,
  - Varying interpretations,
  - Difficulty in articulation,
  - Effects of language on confidence,

- Power in Theory-Practice
  - Interpretations of Power,
  - Power in knowledge,
  - Impact of change,
  - Effects of feeling threatened,
  - Accountability/Responsibility issues,
  - Time constraints.

- Horizontal Violence
  - Effects of patriarchal structures,
  - Oppression of women,
  - Non supportive to each other,
  - Personal versus Professional behaviours,
  - Disillusionment.

- Shaping Practice
  - History/Tradition,
  - Role of Preceptors,
  - Collaboration of educators and clinicians,
  - Developmental process,
  - Change in thinking and practice.

Image of Self and Nursing

The beliefs and perceptions of registered nurses in this category were highlighted through the following codes:

- Personal self-esteem,
- Effects of history/tradition in being a minority group,
- Self versus patient/client focus,
- Stereotype effects,
- Showing you made a difference.

Personal self-esteem

Gaining knowledge and having the need to be accepted were two issues that were seen as being very important in increasing self esteem. Self esteem was seen as how positive the participants felt about themselves, their practice and their ability to confront issues of practice.

> *Ann 8-9 Having more knowledge also helped the recognition. It has given me more confidence. Just having the confidence of my knowledge to be able to confront doctors, more than nurses, and saying this needs to be done for this patient.*
> *I guess because they see you as clinically competent.*
>
> *Wattle 8 Well, there is a need to be accepted, there is a need for credibility with peers. And credibility in practice tends still to be based on some areas of technical knowledge.*
>
> *Wattle 2:13 I would like to think that your self esteem would be high, we feel good about ourselves because we are using knowledge in a way to facilitate others.*
>
> *Lou 2: 30 I think confidence comes from knowledge.*

Credibility of practice was considered as being gained through visibly using knowledge in their practice. Nurses were seen as skilful people but some of them were not seen to always stand up for their rights. This was seen as being linked with self esteem and self awareness and the difficulty in thinking and articulating nursing along with not valuing the role. This appeared to stem from the positivist way of thinking that stressed the importance of medical and institutional systems which saw nurses in a role that assisted and did not complement the role of doctors.

> *Beatrice 9 I can't be right I'm only a nurse.*
> *I think we actually have to support nurses and actually try and build their self esteem up and say hey you are doing a really great job.*
>
> *Emma 2:6 She has always been very nervous about being on the ward, when people are looking very sick, she has come down here worked five days a week and has just developed out of sight. It has been really... you can just see the confidence grow.*

Effects of history and tradition

The effects of history and tradition were seen as being crucial in the way women

feel about themselves as a minority group in society and the image that creates. Historically doctors have been seen as the most important people in health care and nurses have been predominantly women.

> *Ann 15 No there are still females who because they are women, they won't fight hard enough for what they want.*

> *Thea 2:16 In the old days, if you came up with anything that was new, no way, the charge nurse has been doing this for 20 years this way and that's it. And all the senior ones would just push you down, nowadays it's more into democratic society if anyone has got an idea well put it forward to whole ward will vote on it and see what they think.*
> *Oh yeah, the history of women, definitely always being put down all our lives and they get that across on television that women are inferior.*

This socialisation process of women as a minority group as well as being nurses who were initiated into nursing through routines, rituals and tasks oriented nursing practices was highlighted by Lou in that she had changed her way of thinking but contemporary colleagues could not see the need:

> *Lou 2:10 The fact that when they trained they were at the same time as me, you stood up for everybody else, you were secondary - you worked for doctors and they haven't quite cottoned on to the fact that you are accountable for your practice.*

> *Beatrice 10 It is easier to shift, to fit in with the dominant image of nursing than to actually go it alone.*

Nurses were seen as more defensive as they have been encultured into being less than men thus womens' and nursing knowledge is seen as less valid than men's or medicines knowledge (Beatrice 2:13). Some participants saw that it was more important to identify shared knowledge and validate shared practice as well as recognising the separate nursing knowledge. Confidence and self esteem needed to increase along with changes in thinking for theory and practice to be seen as one. The positivist way of thinking perpetuated a constraining organisational structure and facilitated the separation of theory and practice.

Self versus patient/client focus

Within the image of self, some participants saw that there appeared to be difficulty in separating out self interests and career development from patient

care and what motivation actually existed for nurses to value each other. Competitiveness was present in relation to some people looking for power and others were just looking to improve their status in their nursing career (Kim 2.10).

> *Carol 9 I don't know whether nurses always value nurses and that is what bothers me. It's the professional valuing of individuals and groups within nursing that I don't believe actually comes together very well.*
>
> *Nurses mostly have a valuing about what they do for their clients.*
>
> *A lot of competition out there right now is a new element that has come in.*

The changing environment of health care in New Zealand, was seen by the participants as having an effect on their perceptions of the world of nursing. Competition, wage claims and restructuring of the health care system had some influence on what they believed was valued by the organisation. The discussion of the issues of self esteem, the effects of history and tradition and self versus client focus, led onto the effects of stereotypes and how it was seen as impacting on nurses and nursing's image today.

> *Lou 14 I didn't have a child for nine years. Now I am working full time so I didn't fit into the mould, some people thought I was the most dreadful person in the world and of course my woman's guilt agreed. My super ego told me I was bad.*
>
> *Beatrice 8 I think the public has two images of nursing - they have the media image and then when they come to a situation of actually receiving nursing, they then have another image. There is a lot of cognitive dissonance then.*
>
> *Rusty 6 I think nurses are socialised to believe that they have nothing to offer. Nurses don't value what they have because it is not valued by society, it is not valued within the nurse/doctor relationship which is still hierarchical and male based.*

The public and other health professionals' views of the nurse can perpetuate the dominated role of the nurse as Judy explains:

> *Judy 2:24 I think that nursing has been demeaned in New Zealand*

in a sense. I can remember being shattered when a student social worker came and asked me why should a nurse be in a crisis team.

However, if the stereotype view is to change, it was seen that nurses needed to act in a professional way as Thea emphasises:

Thea 10 Nurses get upset because a lot of people don't think we are professionals and I think we throw that on ourselves sometimes - the image that we are not because we are not acting professional. You will see a lot, sort of yelling down the corridor or drinking their cups of tea at the desk and it is not giving an image of someone who is professional.

In discussing these perspectives with the participants, it was seen as important to value self both personally and professionally, in order to change the way of thinking that sees theory and practice inseparable. This was incorporated in the demand by the managers of health care of - show how nurses make a difference.

Showing you make a difference

The need for nursing to show how they make a difference, has put a demand on nurses to think more clearly on what it is they do and to actually to be able to show and articulate that. Increased self esteem and a recognition of self worth were seen as essential components in being able to clearly justify how nursing makes a difference.

Thea 2:16 I think the more confident you get - the job satisfaction comes from you knowing you have done the right thing and standing up and saying look this is the right way to do it, and hopefully people are going to say, yes that's right and do it with you.

Affirmation of being able to use one theory that works was seen as important for the image of a nurse as well as within the valuing of nursing.

Beatrice 2:22 I would really want to set them to have one recognised nurse theorist as the framework in that structure for them - a blueprint.

Rusty 10 Sometimes I think we could do better by really looking at nursing practice, especially with the health care system as it is undergoing change at the moment, and really looking at nursing practice and saying what it is that we actually do that makes a difference. Like, let's say patient education for one thing, I believe

> *we could really make a difference to health care in New Zealand if nurses were really good patient educators. And yet you go out there in the clinical areas and its not done well, its very poorly done. A bit of a hit and miss chance. And yet I believe it is so easy to do, and we could really actually raise our profile in doing it by saying to doctors for example, this patient can't go home because he doesn't really know enough yet about his medication to use it properly so he doesn't need to come back in again.*

The image of self and nursing was seen as having an effect on the perceptions and beliefs of theory and practice through history and tradition, stereotyping and showing how nurses make a difference. It appeared that when a positivist way of thinking was evident, valuing perceptions and beliefs were centred around structure, hierarchy and nurses in a less dominant role. The issues of valuing were seen to be part of this category and led on to the next category very effectively.

Valuing in Theory-Practice

The beliefs and perceptions of registered nurses within this category were centred around the following distinct codes:

- Ideological base of nursing,
- Varying interpretations of theory-practice,
- Effect of bureaucracy,
- Effect of societal issues,
- Effect of contextual issues,
- Interpretation of political activity.

Values in this context varied greatly in the depth of interpretation but in general referred to the set of personal beliefs and attitudes that give direction and meaning to life. Values were seen as guides to behaviour, standards of conduct that one tries to live up to and providing a frame of reference through which ideas, events and relationships are integrated, explained and appraised.

Each of these codes highlighted many issues from the participants perceived reality in relation to the valuing in theory-practice.

Ideological base

For many of the participants the realisation that valuing was interpreted differently by nurse clinicians and nurse educators became a new insight for

them. Emphasis by the nurse educator on some aspect of nursing, eg. communication, is different from the nurse clinician, eg. practical skills of managing three clients per day in first year of the programme - each of these were valued as a priority for practice.

> *Wattle 2: 19 That is where I say that the value is different and that is where we might put emphasis on therapeutic communication, they (nurse clinician) may want the student to be able to carry out some practical skills or practical knowledge in a certain amount of time or to be able to manage three clients during their first year of nursing practice.*

Along with this, the different ideological base of the nurse clinician and nurse educator can be emphasised in that valuing differently what people thought important, can in turn result in a divisive relationship between nurse educator and nurse clinician (Wattle 2:44).

> *Wattle 13 (refer to Chapter 5:62) concern was expressed that some students find dissonance with the different values evident and how difficult that was to move within, when the patient was no longer the focus, but the time the work should be finished.*

> *Wattle 13 If you are not sitting down by 7 o'clock at night having cups of tea for the evening what were you doing stuffing around.*

The difference was highlighted by some participants valuing tasks and rituals compared to a valuing client focus, along with a new nurse practising compared to an experienced nurse practicing. This led to reinforcing the value of practical and technical knowledge that partially comes from experience. The new person, who comes to an area, cannot possibly have all the practical and technical knowledge required of an expert nurse. This expectation was seen as a powerful tool of isolating a neophyte.

> *Wattle 2:15 And they continue to make that gap happen by valuing that type of practical knowledge I talked about last time, that the graduate or new person cannot have because it is culturally bound to the area. It also made new staff frightened to explicitly use their knowledge, in that practical knowledge was more valued by nurse clinicians.*

Ongoing education was seen to shift the ideological base and give new

dimensions to thinking and practice.

> *Lou 2:9 However it was also made clear that change had occurred in some nurse clinicians thinking through education and reflecting on practice.*

> *Lou 5 Well that was the time I fell in love with nursing, that is the time I found out what nursing was because I didn't know before and I remember to my shame now, saying to somebody nursing is a series of tasks and I believe that because that was all it was. I was lucky enough to be on the ward with a very forward thinking charge nurse who was very unpopular because she was bringing in things and challenging people.*

Change was seen as threatening and affecting the routines of practice which were comfortable. It would appear that this involved professional valuing in the eyes of another participant in that nurses do not always value nurses.

> *Carol 9 Its the professional valuing of individuals and groups within nursing that I don't believe actually come together very well and assist in that process.*

> *Thea 2: 23 You look at people, if you don't value yourself, you don't value other people, number one. If you don't value the profession, then you are not going to value any other nurse for what she can do.*

Comments were made such as 'nurses are their own worst enemies' and 'nurses are always shooting each other in the foot'. Some participants believed this was because of the past traditional role of where nurses and nursing was not valued and the medical dominance continued.

It continued to evolve from some participants, that nurses need to value self first.

> *Beatrice 2:15 I think it comes back to the self. It is really hard to actually value beyond yourself unless you actually have some firm stable measure of your own value. I think to actually look at individual valuing of me as a person is too much, but if we just perhaps may be focus on the valuing of you as a nurse, because then there is a lot of commonalities that we can perhaps do.*

> *And once you start thinking nursing, I think you know that's good, and hopefully people will start to see the values and dialogue come to realise the values.*

> *Carol 9 I don't know whether nurses always value nurses and that is what bothers me. It's the professional valuing and of individuals and groups within nursing that I don't believe actually come together very well.*

Undervaluing of nurses and nursing came as an explanation of ideology by some participants in that hierarchy and patriarchal bias was still evident. The traditional view of nursing was seen as being linked with undervaluing. This equated with medical knowledge being valued over nursing knowledge or even being recognised as nursing knowledge.

> *Rusty 6 And nurses don't value what they have because it is not valued by society, it is not valued by, within the, nurse/doctor relationship which is still hierarchical and male based. Anyway they have 24 hour contact with the central focus of health care, which is the patients and yet nurses aren't involved in decision making at all, they are not involved in any of it.*

In undervaluing, the question remained unanswered about whose choice it was that nurses were not involved in decision making. Professional behaviour was again mentioned by Thea in relation to valuing and being valued.

> *Thea 2:19 you find a lot of people that gossip are just frustrated and bored and may be they're not very valuing of people because no-one values them.*

In exploring what influences nurses' values, one participant believed that our history, our social context and beliefs greatly influence personal and professional values (Toni 2:26).

Some participants believed this was connected to the historical position of women in feeling under valued and oppressed (Thea 11: Carol 11: Rusty 7: Lou 8)

> *Carol 10 I think it has happened for a long time - there is a historical bit to it and also there is a lot of competition out there right now.*

The ideological base of nursing showed the influence of tradition and the positivist way of thinking was still strong and would account to some degree for the next code that evolved from the data.

Varying interpretations of valuing in relation to theory-practice

This has already been eluded to (Wattle 13) (refer Chapter 6:89) however the value of communication in interpreting values was seen as being relevant to their perception of reality related to theory and practice. Nurses have a difference in values in relation to nursing and the rights of patients as Wattle 2 explains:

> *The value of communicating with the client, the empowerment, the form of consent, the right, the who is making the decisions etc. Now that is a big shift area that is pretty important and that was not valued by the majority of the nursing staff through that experience (student - staff nurse experience). I don't think all sides were making non judgmental informed comments and so the valuing was being passed on and it was almost like if you didn't follow and foster that negative approach within that working situation it was not ok and that is the same experience I have experienced out there where I challenged on an ethical basis. From then on that patient could never do anything right. So I call it mob behaviour - common values.*
>
> *Beatrice 2:10 we all offer something different to and lets value that.*
>
> *Thea 2: 21 I think that the charge nurse in the other areas too is afraid to let go and give anyone else power, because she has to hold on to everything herself.*

This was extended into what is accepted in communicating on one ward is not accepted on another ward and it was described as:

> *Lou 2:29 On my "bad ward" you find the nurses if they haven't got much to do, which is quite rare, they will be in the treatment room chatting to each other, they'll be in the office chatting to each other, they don't talk about nursing by the way, its the social things that they are talking about. They are often putting management down because they are into blaming management for their situation. They don't go out and talk to the patients.*

Whereas in another ward this would never happen. It was explained that perhaps they were frightened of the consequences of being human to the patient and this could be interpreted as involving issues of self esteem and different values related to using theory in practice.

In order to explain how the participants used the word values and valuing,

tradition was often seen as the underlying belief or perception. Tradition included how anything should be done as well as the perceived worth of something. However one participant saw this as having another negative effect in that:

> *Beatrice 2:13 We have actually made people go on the defence by saying you know the medical model is not right. We are really articulating some valuing - valuing medical knowledge which in part is nursing knowledge.*

It seemed evident that blaming occurred without thinking about the actual reasons behind actions. Being able to articulate what valuing really was appeared difficult for some participants.

Commitment to the patient was seen differently by some in that the focus of nursing, indeed the nurse, might be more valued.

> *Ann 2: 15 Some of them when I see that they like to be off on time all the time, whereas that is not always a priority for me if the patient needs something to be done, that is the priority for me.*

> *Beatrice 8 I think that if a nurse actually just does what we were talking about - the situational stuff, that is valued and that if she doesn't do it, she is not valued.*

When theory or new knowledge was discussed by some participants it was not perceived as having any value.

In relation to theories Rusty believed that even when they were produced

> *Rusty 9 They were perceived as no value because they were unrealistic, unworkable and all those things.*

Some participants acknowledged that what you brought with you into your work affected what you valued in relation to theory and practice.

> *Mary 2:20 You just don't come to nursing isolated you have all got something from your domestic situation which reflects how you actually treat your job or how you perform.*

Theory and practice have been identified as being valued differently by the

participants in this study, but what has appeared constant in the data is the effect of tradition and the positivist way of thinking which includes hierarchy and bureaucracy.

Effect of bureaucracy on what nurses value has already been discussed (refer Chapter 5) (Rusty 6; Thea 2:19; Carol 11; Lou 8) and appeared to be returned to by many of the participants in relation to theory and practice.

> *Carol 7 I think until there is some valuing of where they are coming from and what they believe in, yeah, a lot of those things don't come together.*

In ongoing discussion Carol believed that the hierarchical system had had a marked effect on nursing and how nurses function in practice. Within the hierarchy rule bending was discussed as happening, but the actual rules never got changed.

> *Rusty 7 it was interesting that nurses bent the rules constantly and yet really didn't actually try to change the rules.*

Effect of societal and contextual issues along with political activity Political activity, societal and contextual issues were seen as a group of concepts that the participants saw as having impact on what was valued in and about nursing. Overall the participants believed the health care system was medically driven and that the culture of nursing evolved from the society of the time. It was considered important that nurses should value and build on the strengths of each other and value each nurse's expertise.

> *Rusty 2:18 lets build on each others strengths and therefore make nursing richer.*

Nurses with long experience need to learn to recognise that they are very knowledgeable with an expertise that helps ensure quality care for clients.

> *Rusty 2:18 I mean the knowledge they have is absolutely amazing.*

> *Carol 7 I think valuing is actually a very important part.*

The devaluing of nursing was made worse by the contextual changes within the health care system. The perceived lack of control appeared to demonstrate a

feeling of helplessness.

> *Toni 2:26 I think there is a big negative mind set about nursing, its like dooms day stuff and the health service is doomed and it is never going to be as good as it was and that that you actually need to get in there and have some action to change those attitudes.*

In elaboration of this, blocks to valuing by other nurses, were seen as issue of power and could be interpreted as a power relationship of experience. In relation to students it was seen that

> *Carol 2:3 when they experience practice that they disagree with or have difficulty acknowledging as something that they value in their practice it often causes confusion*

It appeared that societal and contextual issues resulted in disempowering of nurses if valuing of self was not seen as paramount.

> *Beatrice 2:15 I think it comes back to the self. It is really hard to actually value beyond yourself unless you actually have some firm stable measure of your own value.*

It was suggested if nurses perhaps focussed on valuing the role of nurse - the professional self - perhaps more people would see valuing as a positive strategy for growth. Overall it was believed that valuing of themselves and of the knowledge they have gained, might change some of what they, as nurses, are doing in practice. However in exploring the issue of valuing with the participants, it became evident that another central component of what was valued was inter linked with the language used both in written and oral communication.

Language Affects Interpretation

Registered nurses beliefs and perceptions of language, and the effect it had on knowledge development and use, was evident in the codes that made up this category:

- Power of dialogue,
- Varying interpretations,
- Difficulty in articulation,
- Effects of language on confidence.

Power of dialogue

Placing the language nurses use under scrutiny allows the words used to be analysed along with how we construct the dialogue. Language was considered a tool of power by some participants and jargon was entrenched to such an extent that it was not always recognised by the user. This could create barriers which could accentuate self perceived inadequacies and distance the educationalists and clinicians unintentionally.

> *Beatrice 13 We actually have to talk about our perception of us and their perception of us and vice versa.*
>
> *Lou 2:27 You need the confidence to say you don't know. We need better communication.*
>
> *Carol 2:17 At a meeting recently someone said get off the jargon and I didn't even see it as jargon. I was talking about energy.*
>
> *Beatrice 2:5 I actually have fears, that is where my doubts are, that I am not sure that we can talk straight. Women often use double level communication to protect ego/self.*

With the recognised medical dominance being evident within health care settings, language was seen as disempowering. It was thought important to give nurses the opportunity to use language to express their views in a safe environment. Lou describes one situation in her practice.

> *Lou 2:25 We recognise that we weren't confident, we weren't happy about speaking out and we decided that we would talk about something fairly non-threatening for a start.*
>
> *Lou 2: 27 I think nurses often verbalise, there is so many of us, we have got so much power, all we have to do is get together and agree with each other.*

The power of language both written and spoken was seen as a positive means of communication and with added knowledge - confidence grows and networking may prosper (Carol 2:18). Nurses were described as being reluctant to articulate their knowledge to colleagues, doctors and other health professionals unless it was to describe a clients' condition or progress.

> *Toni 24 This fear of articulation - is a lack of confidence, probably a New Zealand characteristic.*

> *Lou 2:30 I know that from the knowledge I've gained on a couple of science courses it has helped me a great deal, its given me the confidence to talk to Doctors, use their language and understand the way they think.*

> *Lou 2:24 You actually have to learn how to be specific, you have to learn how to be articulate and be succinct and accurate.*

The participants believed there was a reluctance of nurses to document their knowledge and this appeared to limit the development of nursing knowledge. Whether this was an issue of self confidence was not known.

> *Lou 2:32 She had a huge storehouse of knowledge which she had difficulty articulating, refuses to do teaching sessions, hates new grads because they are useless as they can't immediately do practical things and she has to do half their work for them. I think if you look at nursing documentation particularly their evaluations - nursing progress notes you will see the theory-practice gap. Good documentation reveals knowledge or lack of knowledge.*

Documentation in its many forms is recurring throughout the discussions as being a difficulty for some nurses. Use of written care plans was varied and in some instances opposed. New graduates who come to a new unit with the skills of documenting care are often opposed and over time loose these new skills. Other participants saw it as useful to talk and discuss issues as experienced in the researcher-participant role. This equates with traditional oral culture of nurses and the belief that instead of documentation, verbal expression saves time (Chapter 2:13).

> *Carol 2:18 Until people challenge each other I guess, and talk about things and start exploring where their base is, and what they are actually doing, we won't know if we are talking the same language.*

Varying interpretations of language

Language was discussed by the participants with varying interpretations. Thinking nursing requires the physiological and cognitive ability of the nurse to derive meaning from what is seen, heard and sensed and define it as belonging to nursing (Perry 1985). Thinking nursing was one way of examining the language concept. This could be done through discussion.

Beatrice 13 I mean I think it is time to start actually moving toward thinking nursing more, more than thinking about patients needs, because that is not necessarily nursing. I think what we need to do is try and identify people in the clinical area who are on the same wave length and get them to be the motivator of it and educators can provide all the support and resources.

Beatrice 17 We have really got to talk about nursing here and to make sure we are all talking about nursing in the same sense.

The creation of forums such as 'nursing rounds' to allow nurses to discuss issues was seen as a way of improving dialogue and gaining confidence in communicating knowledge of nursing.

Toni 2:21 I would like to see nursing rounds developed in the clinical area where the nurses are presenting on a monthly basis what they are experiencing. Discuss the issues for that client and gain contributions from different nurses.

Bringing language to the level of the person you are talking to was seen as a challenge - this was with students, clients and colleagues (Toni 2:22; Carol 9; Ann 4). This was often difficult to achieve and feedback was required to see how effective the communication had been.

Role modelling was another way of how language could be interpreted and transmitted.

Carol 2:12 I think being role models and certainly the role modelling in the practice setting is one of the best ways of learning anything and as people stand up and begin to show an expert way of articulating particular things, a way of dealing with conflict, a way of you know working through some of these situations that we talk about and also writing more about them.

Beatrice 12 I think we've actually got to talk about, well, what do we as nurses in New Zealand really believe we can do.. We need to use the same language and sort of feel that as if that some people aren't talking down to you.

Difficulty in articulation

Difficulty in articulation has already been identified as a common issue for nurses. Within the study there was discussion on how there was difficulty in

stating exactly what was meant.

> *Toni 16 The problem of articulation is that is where the developmental stage of nursing is. We are still having problems articulating what nursing is.*
>
> *Judy 2:17 We need to encourage and allow nurses to express themselves.*

During the dialogue in gathering data for this study many participants reflected on the usefulness of the discussion and how they had never had to talk or think about nursing in this way before. The difficulty level varied but the discussion in the interview was seen as positive learning experience (eg Kim ; Emma; Toni; Ann; Thea).

> *Toni 16 I have experienced colleagues saying they have difficulty in articulating the principles and ideas of the curriculum. Its developing a clear understanding of what we are talking about.*
>
> *Beatrice 13 It is when you start talking about nursing that you actually do start to become more conscious of your own ideas.*
>
> *Beatrice 12 I think just talking about the perception of the gap, and actually trying to identify well what do nurses really want. We haven't talked about well what do New Zealand nurses really want and really believe we can do.*

Language was seen as having a profound effect on the way theory-practice was perceived. Different interpretations, difficulty in articulating, and the effects of language on confidence are seen as important issues to consider in exploring the theory-practice debate. The power of language was seen both as a positive and negative tool and could perpetuate the self perceived inadequacies.

Power in Theory-Practice

The beliefs and perceptions of registered nurses within this category were centred around the following codes:

- Interpretations of Power,
- Power in Knowledge,
- Impact of Change,
- Effects of Feeling Threatened,

- Accountability/Responsibility issues,
- Time constraints.

These codes focused on the many issues that arose from the exploration with the participants of their perceived reality of perceptions and beliefs related to power in the theory and practice debate.

Awareness of the power issues related to theory and practice were considered as being very important. How power was used and the impact on performance were highlighted by the participants.

Interpretations of power

There were many interpretations of power described throughout the study but all participants saw it as a critical aspect that affected how and why nurses practice in any setting.

Peer pressure was seen as being extremely powerful and could isolate the nurse involved.

> *Lou 19 I think peer pressure is the single most important thing. People are quite frightened to stand alone, because when they stand alone they are shot down. The charge nurse who introduced me to real nursing, who had the primary nursing model in the ward, was shot down by her peers.*

Power was later described as setting people up for failure when their ideas/theory was to be used but was not wanted by the nurses in that area. Sometimes when a new graduate had had a bad experience, they would give the next new person a bad experience (Lou 2:18).

> *Beatrice 2:10 Lack of choice was a powerful political strategy that kept the status quo.*
>
> *Wattle 2:22 recognises that there is enormous pressure for some expectations in a clinical area and they come from the power, the hierarchy, the doctor nurse relationship still, male female relationships etc. And they are very very powerful out there.*

This also indicates that very power of the medical team/medical model still exists with status and power over others and that people are rule driven. This is

a perpetuation of positivist paradigm which is epitomised by a patriarchal society.

> *Wattle 11 That people are rule driven and that they make some assumptions about what it is that you have learnt in a different way and that there is some threat because of that, that that in itself will perpetuate that theory is there and practice is there.*
>
> *Judy 27 What I'm aware of though is the way that doctors keep their power and I think that the medical field is one reality we should look at to understand.*
>
> *Rusty 2:3 The doctor gave her a script and the woman said "is this going to cost me". "Yes - you have to pay for all prescriptions now" they said to her. "Well I haven't got any money" "Well that is your problem." I really cringed I thought, you know, what the hell is that nurse doing, why isn't that patient getting a lot more education. The nurse didn't seem to care. It was almost, the power the nurse and doctor had was immense over that patient.*

Power over others was seen as a concern and when followed up as why this type of power was needed, it was thought that it was to do with the structure of our society (Rusty 2:4) Power over students was sometimes seen as a result of frustration on the part of the senior person (Carol 8). Power can also be a security within a rule driven environment.

> *Thea 2:21 I think that the charge nurse in the other areas too, is afraid to let go and give anyone else power, because she has to hold on to everything herself.*
>
> *Researcher Why do people want to hold on to power?*
>
> *Thea Because she hasn't got the confidence or the self esteem to give anything to anyone else and you find that it's is the people with the most intelligence and knowledge and ability that are the ones that aren't as up themselves so to speak,*

Power was seen by some as the main focus being a way to improve status or career. Patient and quality care was not the priority in one participant's view.

> *Kim 2: 11 some people are looking for the power to, you know, just a (pause) yeah, to, for the power and other people are just looking to improve their status in their nursing career.*

The varying interpretations of power could be seen as part of the development process and appeared to depend on the way of thinking and self confidence that was evident.

Power in knowledge

Power from knowledge was described by several of the participants both from a positive and negative perspective.

Some people appear to be concerned about their own base of their practice, the knowledge behind their practice and which gives them power (Wattle 2:16).

Knowledge, especially the practical and technical, can also be used to oppress others and perpetuate the power over status of the patriarchal dominance model.

> *Lou 2:8 She is a bit afraid, doesn't realise that she has got all this knowledge that she just needs a little top dressing. And she actively but subtly suppresses some of the young nurses and the new nurses - "oh you don't need to do that, we don't do that here, that is rubbish, we don't do care plans here"*

The power of status appeared to be used in this situation and was described as having a negative effect on a new nurses development.

There appeared to be a see-sawing of holding on to knowledge on one hand and blocking creativity on another.

> *Carol 8 It always seems to me to be issues of power, issues of almost a holding on to knowledge of some people or not willing not a willingness to change sometimes, and being threatened by people who may or may not have innovative and new ideas coming through.*

> *Lou 2:8 It hides her knowledge deficit and fear of this being discovered and articulated. I suppose she is defensive because she doesn't know.*

It was thought that nurses have lost their voice perhaps in the political, power arena in the health care system and nurses have to get it back somehow.

> *Beatrice 16 I am always thinking well I've always got to continue to sow the seeds, to continue to talk about it to sort of try and put ideas there and then when the next person comes along perhaps and they*

add their bit more to nurses minds, you know that things are slowly germinating in there.

Implications of change and effects of feeling threatened

A general comment from many of the participants was the threat of change and the impact that was having on nursing practice at this time.

Emma 18 I feel sometimes that people just want to carry on with what they know works for them.

Thea 2:18 You need to sell an idea to the group, trial it, and everyone agrees then you have done something to improve the standard of nursing and definitely a confidence boost.
There is one charge nurse there who is stopping everything and no-one is going to do anything, when you think oh, all get together do something, get rid of that person, get someone in and work as a team, but no-one is willing to do it, so they are just putting up with what they are putting up with and they sit in it, and they deserve it really.

This overwhelming threat of change was described in many different ways but came down to new knowledge, new ways and new people being the main areas of threat. Changes in how knowledge is transmitted from one shift to another with a change in the hand over process was also seen as a threat.

Emma 19 We haven't got enough information, we don't feel safe. We need to respect what they say and I also wonder whether part of their anxiety is the change.

Lou 2:9 I think there still persists the hospital trained versus tech training and hospital is better naturally because (so some people say) because they get the practice skills and that is what we need isn't it? Well if you tap into these people who have been through comprehensive training, and they have this enormous knowledge base, which they are too frightened to share, you know.

Knowledge from new staff has already been mentioned by Carol and is described by Toni that it is a threat to staff who have been in the unit for a period of time and used to routines and processes of the work schedule.

Toni 7 Its really threatening (pause) to have students coming in with more theory, have more knowledge. They perceive that and its very threatening.

This new knowledge makes some nurses feel inadequate and gives a lot of pressure to conform and study. Its having to, needing, wanting to keep up with current knowledge and understanding (Toni 7). This pressure of having to conform to keep up with the changes in practice can often create new stresses for the nurses involved.

> *Wattle 2:6 You have got to have sufficient knowledge to be able to make choices. Some people look highly efficient and competent but can't make choices because they are working on automation or are learning in practice but not gaining a knowledge base that gives them choices.*

> *Lou 12 Quite honestly, I think a lot of them are frightened because they don't know. They are frightened to let on to people - younger and recently trained. They are frightened to let them know they don't know the basis of what they are doing.*

Value judgements get made and are concerned with power, power roles and getting threatened (Wattle 2:12). Pressure of time constraints, and work are powerful and can exaggerate the situation. Participants felt that time was a huge factor in power issues, knowledge versus automation and prioritising of practice. In a follow up with Kim after observation there was a situation where consent along with pain relief requirement and intravenous antibiotics all happened at once, and with the pressure of many demands at once the Doctor's role in consent was almost overlooked.

> *Kim 2:2 In a way I suppose at that instant because time was such a big factor I didn't really take a lot of notice. Doctors do that role unfortunately and I know we should be the patients' advocate but in times when you are busy you tend to sway away from it. I sort of lost my train of thought there.*

> *Lou 2:32 Nurses have huge difficulty with documentation, it is often seen as a time user when time is precious. Good documentation reveals knowledge or lack of knowledge.*

Power issues in theory and practice were perceived by registered nurses in varied ways but overall there was more power over and control issues described than those empowering nurses and patients.

> *Rusty 2:23 Patients really I guess are at the bottom of the pecking order, nurses are powerful over them, the doctors are powerful over*

nurses and so it goes on and on.

Beatrice 2:10 How can we empower nurses more and I know that is a key word that people are using, its jargonistic, but what can we do to help.

Emma 4 The whole principle of knowledge empowering people, whether they be nurses or patients and so seek to help people obtain information, look at things critically and then take action from there.

Power was described by the participants in many ways. It was seen as maintaining the status quo and in perpetuating the traditional model of practice, medical power could be unwittingly supported and maintained by nurses. By continuing to value medical knowledge nurses were in reality decreasing the value of nursing knowledge which leads to an interpretation of horizontal violence.

Horizontal Violence

The beliefs and perceptions of registered nurses within this category were centred around the following codes:

- Effects of patriarchal structures,
- Oppression of women,
- Non supportive to each other,
- Personal versus professional behaviour,
- Disillusionment.

This category emerged from the data showing the strong effect of patriarchal structures being evident in the discussion with participants. This has been a recurring issue in all the categories identified. In relation to the theory-practice gap one participant explored the issue that a theory-practice gap does exist.

Rusty 2:19 I believe it exists for a lot of reasons really, and I think one of them is the fact that nurses or nursing as a profession does not have a high status and so you get a bit of the horizontal violence.

The high status of medical dominance was seen to accentuate the minority status of nurses.

Toni 8 I think status is definitely part of it, that nursing, I think is an incredibly competitive profession, that there are a lot of Indians and

not many people, like in the clinical area, getting many opportunities for professional advancement and I think that creates horizontal violence between groups of people. Like it is really competitive and yet you try to work and remain colleagues as well.

Oppression of women

The idea of women being oppressed was thought to contribute to the horizontal violence. Nurses were considered to be easily oppressed and that they in a way actually perpetuate that oppression by not valuing what they have and through not recording their practice (Rusty 7).

Rusty 2:2 I think it is just really a sign of society, that nursing is like that.
I believe we are prevented from putting nursing on the map because of the medical profession and the belief that the medical profession has the knowledge and they are not willing to give it up.

Non-supportive to each other

This violent attitude towards each other appeared to show lack of collegial support and perhaps a lack of trust between nurses.

Thea 2:26 Nurses run each other down, and slam them in the back, and stab them in the back, it is disgusting. I always wonder whether men sort of do the same thing at the office.

Lou 2:8 And she actively but subtly suppresses some of the young nurses.

Toni 11 I think in effect it could be that you hold on to your knowledge and you could almost use that against other nurses. In the clinical area some staff nurses or charge nurses won't share knowledge freely with students, they'll use it against students and yet students make mistakes and fall over.

However in reflecting on this statement it was recognised that

Toni 20 Educators can appear arrogant and patronising to clinical people because we have had the luxury or the opportunity of study. We may use this knowledge if we are not careful against them rather than <u>with</u> clinical people.

Rusty 17 I get really disturbed sometimes when I hear clinical practice being criticised as much as you do hear it criticised and I

think to myself I was out there and I used to do some of those things and I guarantee they did as well. I sometimes think we look through rose coloured glasses.

Beatrice 16 I think even in the educational institution we actually have to support each other and actually talk about nursing. Yeah, if we, are not supporting each other, how can we expect to support in clinical.

Personal versus professional behaviour

Consideration of the personal knowledge affecting professional practice came across as important in considering before making assumptions of people.

Mary 2:20 You usually find that people who feel threatened, underneath there is a very stubborn streak because they refuse to recognise that some of the problem might be in themselves.

Thea 2:27 A person's attitude might be different to yours but nursing wise, they are excellent and performing to standard. Nurses need to remember this especially when doing appraisals, it is practice that is being looked at.

Disillusionment

Disillusionment is seen as an outcome from insecurities and feelings of inadequacies within the system.

Judy 2:9 I think nurses do feel threatened frequently in the situation and I think the dynamics of units tend to be reflected through the nurses and I don't think we have separated ourselves out sometimes from that. I mean I have seen some people who have become disillusioned and it gets compounded from high above or from other dynamics occurring within a system.

Horizontal violence can be perceived as being a direct effect of the patriarchal structures in that the status quo is perpetuated opportunities for advancement are less, and frustation and job satisfaction decreases. Within a positivist way of thinking, structures exist that appear to keep theory and practice separate and nursing knowledge less powerful.

Shaping Practice

This category described perceptions and beliefs of the registered nurses in relation to how practice had been shaped for them and the following codes emerged:

- History/tradition,
- Role of Preceptors,
- Collaboration of Clinicians and Educators,
- Developmental Process,
- Change in thinking and practice.

History and tradition played a large part in the development of theory and practice for the participants. This merged with the theme of culture in that history and tradition helped acceptance into the culture along with being part of each category that has evolved. It helps to show that the context of the time helps shape the practice of the time.

> *Kim 2:17 I trained where hierarchy had a lot of impact and was regimented to a certain extent. So I think that sort of moulded me into the way I look at things, I do tend to look at things with a task oriented perception of the work. As experience came I adjusted my way of thinking to a more personalised approach to the patient.*
>
> *Judy 8 Why you come nursing shapes your practice, the class background and I think the attitude of others around you.*

Just because the tradition and history was real did not make it acceptable practice (Judy 18). The impact of history and tradition on the perceptions and beliefs of theory and practice has been marked. However Beatrice had another view to offer:

> *Beatrice 2:11 In fact we actually do have some commonalities, lets really identify those and then we can identify your differences with more safety.*
> *Maybe we start being honest and say well we really do work to some degree within medical model. Identify shared knowledge and validate shared practice then identify separate knowledge that supports practice and this will decrease the gap.*

The role of preceptors was seen as an important part of the process of shaping practice. How a new nurse was first introduced to the practice setting moulded the practice that followed.

> *Emma 2:22 We have preceptors who will take the new person through the orientation phase, or familiarisation phase, which is 10 weeks, and at the 5 week mark there is a appraisal of how it is going*

and what do we need to aim for so that at the end of 10 weeks you are not standing there not having achieved important things.

Preceptors should be aware of the strain that a new person is under when they come into an area otherwise they shouldn't be a preceptor - this was a belief of some participants. In helping new graduates, Rusty explained that preceptorship did not appear to achieve the goals she thought it should:

Rusty 2:16 I guess that is what the preceptorship scheme is designed to do out there in clinical. I don't know that it does because it seems to exist of a huge check list which needs to be ticked off.

In this process of preceptorship new nursing staff were encouraged to reflect and look at the 'whys' of practice. Collaboration of clinicians and educators was described as being critical in shaping the practice of nurses. These were descriptions of students being taken away for tutorials when there was still work to be completed. An expressed need for discussion of a students' role in clinical practice, was seen as critical to prevent misunderstanding and to ensure a quality clinical learning experience for the student.

Mary 2:12 The tutors want to take away the students to discuss something and the message the ward staff get is that the work environment can be left and other staff can just be left to carry whatever you were doing.

The developmental process of practice is enhanced through valuing individual differences and acknowledging the strengths of each other in practice.

Beatrice 2: 15 You can look at it in manageable chunks in that first I actually value myself as a nurse.
And once you start thinking nursing, I think you know that's good, and hopefully people will start to see the values and dialogue and come to realise the value.

Many strategies were suggested that may help make changes in how nurses think about theory and practice.

Emma 2:24 There are a whole host of things. You know in the future... hopefully not too distant. There is a whole host of topics that could be discussed, seminars that could be run. Some may be

interested in hearing a particular way of practicing and they might be interested in that learning and in the translation of that learning into practice. It is something that we as a group of specialists are looking at, and we should be starting very soon.

Emma 2:24 and the problems that may arise from job sharing or joint appointments I think they could be resolved - yes joint appointments.

Beatrice 2:11 I mean nurses need to learn how to be supportive to our colleagues as well as identifying our differences.

Carol 17 Little exercises or triggers to get to express what they have absorbed or used of those particular theories or processes. A bit of using coat hangers of how when where and what.

Toni 2:21 I would like to see nursing rounds developed in the clinical areas, that the nurses are presenting on a monthly basis and wider discussion of issues for the clients can occur.

Carol 12 The ongoing leadership role of clinical nurse specialist as a resource person for several groups of wards.

Generally the participants thought that challenging where nurses are coming from, giving nurses more responsibility and room to grow would help the integration of theory and practice and therefore praxis.

Conclusion

Image of self and nursing was seen by the registered nurses in this study as the beginning of professional development. Valuing, language, power and horizontal violence interacted together to affect the perceptions and beliefs of registered nurses in relation to the theory-practice gap. History and tradition impacted on the way nurses think, interpret and act. All of these complementary categories must be considered in context with the main categories of ideal versus reality, culture of nursing, the developmental process and professional judgement.

This study has identified the categories that evolved from the content analysis process. Ongoing analysis facilitated the merging of the categories to gain cultural and sub cultural themes which will be discussed in the next chapter - the reality of theory-practice.

CHAPTER 7

THE REALITY OR MYTH OF THE THEORY-PRACTICE GAP

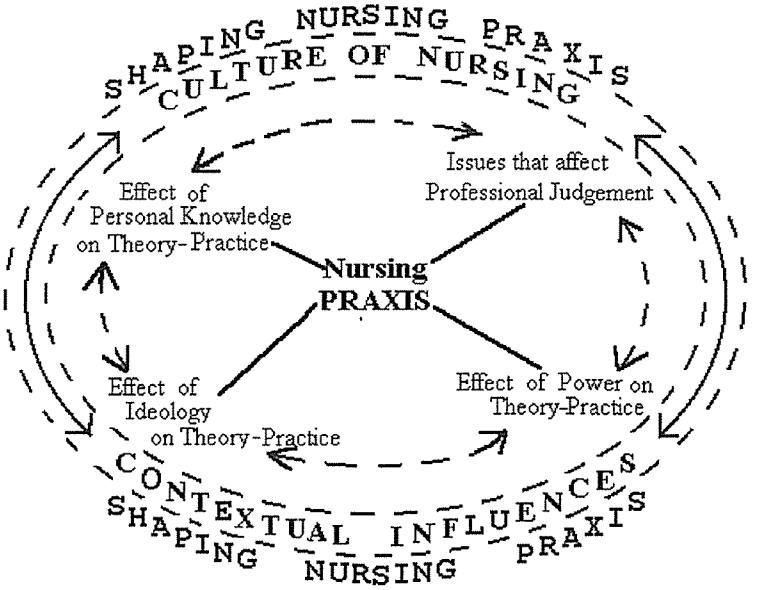
The categories arising from the data, analysed in chapters 5 and 6, explain the ways in which the registered nurses in this study act, react, value, believe and view the reality of the theory-practice debate and in doing so, shape the practice of nursing. The data analysis and examination of the emerging main and complementary categories revealed one major cultural theme. Theory-practice perceptions and beliefs of registered nurses transformed from a gap to a developmental process revealing a major cultural theme of shaping nursing praxis. Praxis indicates the dialectical, interactive process of theory-practice which involves reciprocal shaping of theory and practice (Chinn 1989). Four sub-cultural themes merge into one major dynamic cultural theme of shaping nursing praxis. The four sub-cultural themes which evolved from and integrated the main and complementary categories should not be seen as sequential. The sub-cultural themes are:

- Effect of personal knowledge on theory-practice,
- Effect of ideology on theory-practice,
- Effect of power on theory-practice,
- Issues that affect professional judgement in theory-practice.

These four sub-cultural themes need to be considered in the context of Chapters 5 and 6 where the categories that constitute the sub-cultural themes addressed previously.

Before explaining these four sub-cultural themes, it is important to present them in the context from which they arose. Through the analysis of the data it became evident that the culture of nursing and the context in which nursing occurred has a major impact on the perceptions and beliefs of theory-practice shared by the study's registered nurses. This culture which needs to be considered in this dynamic transformational process, results in shaping nursing praxis. This is outlined in Figure 3 which was developed from the data and incorporates the sub-cultural themes that led to the major cultural theme of shaping nursing praxis. Each section of Figure 3 will be described in detail, beginning with the culture of nursing and the context in which it occurs.

Figure 3 **SHAPING NURSING PRAXIS**



The Culture of Nursing in Context

The sub-cultural themes are impacted on by the culture of nursing which affects the perceptions and beliefs registered nurses have on theory-practice. The categories which evolved from the data and contributed to the culture of nursing include:

- Language/Dialogue,
- Need for acceptance,
- Peer support,
- Unknown new area of practice,
- Thinking nursing,
- Role models.

Each unit/department or hospital was acknowledged by the participants in this study as having its own way of doing things and this impacted on their beliefs and perceptions of theory and practice. Culture involves shared social meanings, social practices, beliefs, knowledge, myths, habits, rituals, language and customs (Deal and Kennedy 1988). In nursing practice, there are certainly such shared dimensions with the language, or jargon, often being a predominant issue that causes nurses who are new to a specific unit or hospital environment to feel

isolated, devalued, less confident and less effective in practice.

Language and the culture of nursing

In examining the language which nurses used to describe nursing experiences, this study found nurses did not always say what they mean. In order to unravel the very nature of what lies behind or within language, nurses need to question motives, values, desires and assumptions behind the language which nurses use. Beliefs and myths related to nursing have changed since the transfer of education from hospitals to tertiary institutions. Over the last twenty years a new language in nursing has appeared. This includes terms such as paradigms, models, theories, justification of practice and qualitative/quantitative research (Henry et al 1987). Language is socially constructed and can provide a subtle and powerful tool for controlling the behaviour of one person to another person's advantage. Lovell (1980) emphasised this point in regard to controlling and withholding information. This can be a powerful tool of paternalistic deception. Language, depending on how it is used, is very effective at controlling what happens at a particular time and place. The use of language as a controlling tool has the effect of disempowering nurses and recreating the hegemony of medical dominance (Street 1991).

Language can then perpetuate the theory-practice gap through a "them" and "us" mentality as well as through the jargon of nurse theorists who talk of, for example, self care agents, energy fields, and paradigms of thinking (Meleis 1985; Street 1992). Habermas (1973) suggests that language could be understood in relation to tradition but should also be recognised as being used as a means for domination and social power. This view was clearly seen in this study where language was considered a tool of power which could create barriers, accentuate self perceived inadequacies and unintentionally distance the educationalist and clinician.

Nurses in this study considered that more confidence was required to feel comfortable in articulating nursing, using the language and freeing nurses to collaborate and speak out. It appears there should be a recognition that a process of "unlearning" past socialised practices involving language is part of accepting there is more than one way of saying and doing. It is not a matter of a right and wrong way. There are many ways of using language that add depth, breadth and richness to practice. The challenge for nurses is that they need to begin to understand this point and concentrate on the broader issues of empowering each

other. This in turn, would lead to empowering those for whom they care.

Need for acceptance and peer support

The realisation that expectations of new people to a unit were unrealistic, was, for one participant (Thea), transforming. This realisation changed her way of thinking from a positivist to an emancipatory frame of reference, through reflection and action. Thea (2:19) was very keen initially to have more close liaison with education teachers so that new staff nurses could 'fit in better'. On reflection, although still believing in the close liaison, she recognised that her expectations of their practice were not allowing for growth and adjustment to the new role and culture. She began to explore new ways of facilitating this growth in nurses and was very positive about this point in her second interview.

Unknown new area of practice

The unknown new area of practice was a category that emerged from the data and was seen to affect the perceptions and beliefs of nurses in relation to the culture of nursing.

One participant (Toni) believed it was possible that a culture gap rather than a theory-practice gap should be explored as the reality. This was supported by Lou: Beatrice and Rusty (refer to Chapter 5). As already mentioned, the historical and social contexts from which nurses have come, impact on the way they act, react and practice. The relationships between medicine and nursing and between nurses, patients and physicians have historically been symbiotic (Lovell 1980:73). Nurses often express a sense of disquiet about the way in which the practice of nursing reflects an unbalanced emphasis on the biomedical and technological concerns, neglecting the concern for humanistic dimensions in the lived experiences of clients. Street (1992) believes that culture is never static. Culture is in a constant state of tension, shaping our actions, understanding and relationships. Therefore culture must be seen to affect interpretations of theory-practice. As nurses interact with other people in multiple settings and in different ways, they produce and reproduce the culture of nursing. Another way of examining this may be that the messages given explicitly through education and clinical practice may not be what is actually experienced. The gap, therefore, may not be actual lack of knowledge or skill but it may be one of expectation. The gap occurs in part through assumptions and the culture in which nursing occurs. Participants in this study suggested that the gap may be an excuse for coping with threats and change. A theory-practice

gap may be either an excuse or a reason that gives permission unconsciously for the power imbalances to remain.

Thinking nursing

Acceptance of "thinking nursing" in a particular way can add to the richness, depth and breadth of practice if we are open to listen and not judge others through our assumptions. Perry (1985[a]) suggested that nurses do "think nursing" but in different ways - medical, physical, technical, historically and humanistically. Ways of thinking change within the context - socially, politically and ideologically along with the paradigm shifts which the nurse may or may not make in his/her professional pathway of development. The registered nurse participants in this study acknowledged thinking was complex and changed depending on the paradigm of thinking the nurse was using.

Nursing occurs in a social environment in a particular culture. In the technical positivist model where decisions by doctors, managers or nurse executives are often made separately from the action, fragmentation of total care can occur. This has the potential to create a separation of the actual work and health professionals from their social, cultural and ethical context in which the nursing occurs. This could be why the literature has abounded in a theory-practice gap instead of recognising that theory and practice are intertwined and that together they evolve within the cultural context. Smyth (1986:11) reiterates this point that in his view, by continuing to insist on using such phrases as 'the translation of theory into practice; closing the gap between theory and practice and integrating theory and practice', we are still fundamentally wedded to the idea that theory and practice are separate. Clark (1986) believes that the major problem confronting the nursing profession is continued separation of nursing theory and practice. A change in the way that nurses think nursing and recognition of the cultural context in which nursing occurs will impact on the interpretations and assumptions of the actual day to day practice of nursing. Thinking nursing was seen by the participants in this study to be assisted by ongoing education along with exposure to different ways of seeing the world.

Role models

The cultural category included within it the importance of role models, the support of peers and the ability to think nursing.

There was overwhelming agreement among participants that the charge nurse

was seen as pivotal in setting standards and creating the reality for nurses in which they practice. This in turn was seen by the participants as having a major impact on the culture of nursing in that specific unit or department.

In the past, rituals of the culture, such as bed making and sponging of patients were emphasised and role modelled. The expectations that nurses have of each other impact on how theory-practice is interpreted (refer to Chapter 5). The participants in this study recognised that the new nurse in a unit, department or health care setting needed acceptance from the culture of nursing in that setting. Along with acceptance, there was a need for support to help adjust to the culture, gain confidence, practice effectively and not have unrealistic expectations imposed on them. Nurses in this study, suggested that nurses need to examine the myths and rituals of nursing for their power and accuracy in the present, in light of their development in the past.

Having examined the culture of nursing and the context in which nursing occurs, the four sub-cultural themes (Figure 3) will be explained.

Effect of Personal Knowledge on Theory-Practice

This sub-cultural theme encompasses:

- The image of self and the profession,
- Tradition and expectations of nurses,
- Women as a minority group.

These categories inter-related and affect the development of personal and professional knowledge.

Image of self/profession

It is the thoughts and beliefs of people that determine their self image. Self image determines how people act, achieve and perform which in turn affects the image of the collective profession. In this study, the nurses' point of view was that they saw nurses in a role that assisted doctors and were not valued as independent. The participants in this study recognised that an increased self esteem and recognition of self worth were essential components in being able to justify how nursing makes a difference.

Moch (1990:155) sees personal knowing as essential to the development of

nursing knowledge - the discovery of self and other which is attained through reflection, synthesis of perceptions, and connecting with what is known. Moch (1990) identified three components of personal knowing - experiential, interpersonal, and intuitive knowing. Participants in this study saw the disparity of expectations of new staff between experiential and intuitive knowing. Experiential knowing involved knowing that was gained through participating in the world or in this study the practice setting. Interpersonal knowing incorporated the knowing gained through interaction or being with people. Intuitive knowing appears to happen without conscious use of reason. Practice was seen as technical skills, a safe way of doing the tasks of nursing. Moch (1990) believes that each relationship in the practice of nursing offers opportunities to gain knowledge about self and others through gaining experiential knowledge.

Gaining knowledge was seen by the participants as very important in increasing self esteem (eg Ann 8-9; Wattle 8; Lou 2:30). The link with personal knowledge, personal realities and political realities is seen by Chinn (1989) as a crucial inter-relationship that forges the patterns of practice.

> *We begin to recognise that if we change the political realities, the personal realities will begin to shift; if we change the personal realities, the political realities will shift. (Chinn 1989:73).*

Tradition and expectations of nurses

Tradition and nurses' expectations have of themselves and other colleagues, emerged in this study, as a strong, recurring, underlying basis for the beliefs and perceptions of the registered nurses in this study. The effect of language as a tool of power was seen as influential in how a nurse would be accepted. Lou (refer to Chapter 6:21) emphasised that increased confidence was required to articulate what was meant. This view was shared by other participants.

In the interviews, there was recognition from the participants that, because nurses had the title staff nurse, they can 'do' everything. In subsequent interviews, the participants began to recognise that automation and intuition come with experience and new staff nurses cannot automatically do everything. Smith (1992) believed that nurses choose nursing theories that fit with their own values, perceptions and reflections. History and tradition has been seen as crucial to the way in which women feel about themselves and the image that creates. One participant identified with this view and considered that it was

easier to comply with the dominant image of nursing than to actually act independently. This perspective could be equated to hegemony shown as domination through unquestioning consent rather than open coercion (Geuss 1981; Roberts 1983). Belenky et al (1986) refers to this idea as silence or blind obedience to the medical model traditions and received knowledge where learning was gained from listening to others and not through ongoing education.

Given that history and tradition have impacted strongly on nursing today, and the way in which theory-practice is interpreted, nursing can be compared with Belenky's "procedural knowledge" stage. This is characterised by many approaches to theory-practice development including positivist, phenomenological, feminist and critical approaches. However, nursing has not yet reached complete integration of theory-practice, or praxis, where all types of knowledge can be integrated (Valentine 1992). Until nurses explicitly acknowledge this stage of knowledge development, especially in relation to self esteem, culture, language and personal knowledge issues, it would appear that 'gap' language and ideal reality issues will persist. There was evidence that the participants in this study recognised these issues in their changed in expectations of new nurses.

Women as a minority group

Nursing has struggled for professional identity through attempting to separate from the medical profession dominance (Strasen 1992; Roberts 1988). This struggle has been through a need for a complementary role to the medical role, not a subservient role.

Nurses have the characteristics of an oppressed group which includes such traits as lowered self esteem, being devalued and having little power to make changes (Speedy 1987; Roberts 1988; Lovell 1980). It would appear from the participants in this study, that the past history of learned helplessness has arisen from the powerlessness and patriarchal hierarchical structures which characterises nursing and health care systems. Participants recognised that nursing is still bearing the scars of this oppression.

The powerlessness that exists leaves nurses as a fragmented group, and in a blame mode that allows patriarchal dominance to continue. Nurses see structural constraints as personal and professional inadequacies where nurses blame themselves and each other for failures in the system.

Integration of theory-practice is undervalued in the striving for personal and professional knowledge development. Nurses need to understand that myths, rituals, symbols and metaphors are intertwined in nursing practice. This personal understanding will help nurses to interpret and appreciate how other nurses think and act and it will help them make more explicit the actual personal knowledge of nurses.

Effect of Ideology on Theory-Practice

The previous statement leads into this sub-cultural theme well and demonstrates the inter-relationships of each sub-cultural theme. This incorporates the following categories that affect the beliefs and perceptions of nurses about theory-practice:

- Valuing in nursing,
- Ways of womens knowing,
- Ideal or reality issues,
- Socio political forces.

Many of the problems which face nurses are not straight forward. The issues of nursing practice are immensely complex and require systematic reflection to make sense of the history and meaning which is inherent in any nursing situation, to pose appropriate questions, and to make rational judgements on action (Street 1991:4).

Valuing in nursing

Valuing, within this study, is seen as the beliefs and attitudes that give direction and meaning to practice and recognising the worth of valuing. Valuing in nursing is integral to the self esteem issues that influence the beliefs and perceptions of registered nurses. Assumptions which appear to be made on little information, and with a different knowledge and value perspective, result in divisive relationships and disunity.

Valuing, as previously highlighted, was seen by participants in this study, as focusing first on valuing self.

> *Beatrice 2:15 It is really hard to actually value beyond yourself unless you actually have some firm measure of your own value.*

Traditionally, nurses have been socialised to have a self image that values giving, caring and dedication (Strasen 1992). Schon (1983) believes that, through reflection in action, professionals will make sense of value conflicts, current practice, uncertainties and uniqueness of self, colleagues and nursing practice. Values, beliefs, perceptions, reflections, and experience all contribute to develop the knowledge base of nursing.

Ways of womens' knowing

Belenky et al (1986) identified the different ways of women's knowing. The first two levels - silent and received knowledge perpetuated the ideological structure perceived by the participants in this study. This resulted in the nurses feeling undervalued. This under valuing equates with the patriarchal dominance and oppression of women already addressed within this thesis. Social and political conditions have influenced the development and image of nursing which in turn has influenced nurses values of self and the profession (Roberts 1983). Practical and technical knowledge appears to be valued by the nurses in this study. This knowledge reflects the importance of "doing" tasks that needed to be completed. The varying interpretations of nursing and knowledge were made very evident by the participants. Only through reflection, a positive self esteem and a recognition that nurses' actions, perceptions and beliefs impact on the reality, will theory-practice be seen as integrated. This integration involves using all types of knowledge made explicit by both Belenky et al (1986) and Carper (1978). There should be a recognition that all knowledge is dynamic. Knowledge helps create the discipline, gives direction for the future development of nursing and gives an increased awareness of the complexity and diversity of nursing practice.

Ideal or reality issues

The concept of "ideal versus reality" was seen by the participants as an excuse for some of the practices that may not have been the best way to nurse. However, there was an acknowledgment that expectations of some colleagues could be unrealistic and this was often through assumptions being made. The terms "ideal" and "real" are used by many nurses to explain and justify the apparent contradictions between beliefs and action (Perry 1987).

Socio-political forces

The amount of change that has occurred in the context of health care settings in relation to policy, law, technology and the complexity of care, impact on the

interpretations, assumptions, and beliefs of nurses on the theory-practice debate. The registered nurses, in this study, have the view that change, power and power roles are all affected by the socio-political climate of the time. Smyth (1986) extends this in emphasising that the stresses of running in the unwinnable race of nursing practice alienates nurses from their patients, their colleagues and themselves. Today's dominant, hierarchical social structures of health and education reflect a technical, positivist ideology that is reflected in control, competition, profit, efficiency and effectiveness. These features are not conducive to the reflection, challenge and critical analysis which are encouraged by some of today's nurses. Participants, in this study, believed nurses had lost a voice in the political arena. By recognising these explicit hegemonic realities, nurses may be able to transform some of the socio-political structures that inhibit growth, freedom and open communication which, in turn, will lead to praxis - the integration of theory-practice. As Clare (1991b:20) stated:

> *We must seize opportunities that the education and social legislation has given us and work together towards uniting and strengthening the professional voice of nursing.*

Effect of Power on Theory-Practice

This sub-cultural theme well demonstrates the hegemonic realities which were discussed previously and the theme incorporates:

- Threat of change,
- Oppression,
- Horizontal violence,
- Ongoing education,
- Dialogue between education and clinical practice.

Power is a concept that is integral to the socio-cultural world of nursing and health care. It can be interpreted as power over, influence over another or power to act in a particular way (Carlson-Catalano 1992; Cohen 1992; Doering 1992). The socio-political influences, as previously recognised by the nurses in this study, strongly affect the environment in which nurses practice, along with the history and tradition that a patriarchal society strives to keep the same. Nurses who would want to be autonomous and assertive are seen as threatening to the dominant group's hegemony (Cohen, 1992).

Threat of change

Change was seen as threatening by the participants in this study. This was evident through discussions which highlighted, in their view, a nursing practice fragmented by ongoing change within the health system.

Nurses often believe they are powerless. They have tended traditionally to internalise attitudes of subordination which are considered to have been historically imposed on them by the dominant figures (Lovell 1980; Cohen 1992). Participants in the study mirrored this point. In their view lack of choice was a powerful political strategy, to maintain the traditional doctor nurse relationship and the belief that people are rule driven. Power and knowledge are entwined in that knowledge is limited through power as well as being developed in response to power. Power and knowledge are mutually generative and are always exercised in relation to a resistance (Doering, 1992:25). The rules and regulations which are traditionally imposed from above in a hierarchy, have affected the development of nursing knowledge and nursing autonomy. With the extensive changes imposed over the past few years through the health reforms in New Zealand, nurses' vital energy has been diluted by needing to constantly respond to the ever changing external demands, leaving little time or energy to develop their own professional needs. This, in turn, has helped to perpetuate the perception of a theory-practice gap and, perhaps, to produce a greater concentration on tasks than the total person approach. Participants in the study certainly found that new knowledge, new ways and new people were the main areas of threat to the development of their own knowledge and practice.

Oppression

Roberts (1983) argues that problems of self esteem, initiative, assertiveness, feelings of worth and being valued in nursing result not from a lack of nursing leadership, but from the reality that nurses are an oppressed group that shares the characteristics of oppression. Freire (1971) expressed this view more clearly in that it can correspond to the position of nurses within health care today:

> *The oppressed suffer from the duality which has established itself in their innermost being. They discover that without freedom they cannot exist authentically. Yet, although they desire authentic existence, they fear it. They are one and the same time themselves and the oppressor whose consciousness they have internalised (Freire 1971:32).*

Is there fear of freedom, in the common statement that many nurses make in that:

We don't need that.
How we do it is just fine.

This is a view shared by some of the participants in this study.

Horizontal violence

Horizontal violence, as a concept, evolves out of the model of oppressed groups. The dominant group identifies the norms and values for the group, community of society. These norms and values give the dominant group power over the subordinate groups who develop oppressed behaviours. Lovell (1981:39) emphasises that

> *the silence of nurses throughout their history was initially imposed by physicians, but today nurses help perpetuate the silence. Nurses have adopted the characteristics of their oppressor.*

Within the oppressed behaviour of nurses, they exhibit self hatred and dislike for other nurses (Roberts 1983: 27). Thea 2:26 (refer to Chapter 6:29) described how nurses run each other down, slamming and stabbing each other in the back. Her view was supported by statements from other participants . These actions result in maintenance of the status quo. The powerful dominant group has a hegemonic influence, which in turn, controls knowledge development, curricula, position, status, dependency and monetary rewards. Oppression is thought to contribute to horizontal violence which is also known as passive-aggressive behaviour (Roberts 1983; Strasen 1992). Horizontal violence appears to be a result of suppressed aggressive feelings toward the dominant group. These suppressed feelings are exhibited through self hatred, a dislike of other nurses, a lack of self esteem and fighting with colleagues (Stasen 1992).

Ongoing education

Freire (1971) talks of an education that leads to a level of critical consciousness, in that it frees thinking and promotes critical analysis and reflection that is humanising. Participants in this study saw ongoing education as helping to change their ways of thinking.

> *Lou 2:16 With education comes image because you realise who you are and what you can do.*

This approach could help nurses to participate fully in the world of health care.

Recognising that all nurses have some expertise to offer, they would be receptive to new ideas, and avoid distortion of perceptions, beliefs and assumptions. This, in turn, would assist nurses to question the status quo and promote dialectical relationships and reflection on practice. This would result in a paradigm shift in thinking to a critical paradigm that establishes the conditions for open, unconstrained communication (Allen 1985). Nurses, initially, need to recognise the existence of oppression and blaming, and discover the new culture of nursing that values the worth of each person, and puts into perspective the impact of culture on a group which leads to a praxis orientation for nursing. However, some nurses are disillusioned about continuing education because of the lack of rewards and recognition they receive (Strasen 1992: 103). The education offered needs to promote critical analysis and reflection otherwise education in itself can be an important vehicle in maintaining the status quo (Roberts 193). While the participants in this study acknowledged eduction was important for ongoing professional development, the increased costs for education and decreased financial support from employers, limit some nurses' plans for continuing education.

Dialogue between education and clinical practice

Dialogue between education and clinical practice has been varied. The reciprocal dialogue of a critical social theory stance would help develop and maintain the integrity of the profession, liberate it and develop a profession that promotes autonomy, and complementarity to other health professions directed to improved, high quality health care. The registered nurses in this study saw closer collaboration between clinicians and educators as crucial for the development of nursing knowledge into the year 2000.

Issues that affect Professional Judgement in Theory-practice

This sub-cultural theme is a culmination of the previous themes and incorporates:

- Impact of history/tradition,
- Reflection,
- Knowledge of know how and why,
- Theory-practice issues.

Professional judgement is a concept which is not clearly described in the literature but it is certainly used regularly by clinicians and educators.

Judgement is based on the merits of something, using all the professional knowledge known to that person, a conclusion, a decision with specific action being taken - this is termed professional judgement. It is believed that judgement, preceded by perception and followed by reasoning, is the path to knowledge (Doona 1992:232). Reflection is seen as necessary for judgement to occur. Judgement is seen as a personal response and commitment to the perception and resultant reasoning and therefore is the responsibility of the person who judges.

History and Tradition

The effect of history and tradition has been well traversed in this thesis. The writer will return to it only in a context setting role. Recognition of the effect of history and tradition on change, practice and ways of being a nurse all affect the registered nurse's professional judgement. The myths and beliefs of educators and clinicians about their roles is one example of where, clarifying roles and assumptions, were seen as essential in setting the scene for more effective collaboration.

Reflection

Reflection refers to examining the largely unchallenged social, economic, and political assumptions, values and beliefs that underpin our actions, as well as the institutional practices around us (Smyth 1986:3). Reflection and reciprocal dialogue, help individuals discover the inter-relationships between facts and actions. This leads to understanding the hegemonic structures that support oppression and promotes social change (Freire 1971; Fay 177; Street 1989).

Reflection was recognised by the participants in this study, as being crucial in developing nursing knowledge and in shaping the integration of theory-practice.

> *Beatrice 2:29 I had to be made to reflect before I realised the value of it.*

> *Judy 14 One of the things you can do to bridge the gap is reflection.*

Reflection helps to develop self determination, self esteem, and confidence in such a way that it can be recognised as counter-hegemonic (Street 1989).

Schon (1983:290) argues that radical critique cannot substitute for (though it may provoke) the qualified professional's self reflection. Unreflective

practitioners are equally limited and destructive whether they label themselves as professionals or oppose professionalism.

Knowledge of knowing how and why

Knowing "how" constituted the practical knowledge and involved knowing the way the process, task, or skill was implemented. Knowing "why" involved the technical and empirical knowledge which gives the purpose or reason behind what is being done. Participants in this study believed that both types of knowing were crucial to safety in nursing practice. Participants in this study also believed that intuition was a result of experience, knowledge, patterns, and ways of knowing.

Benner and Tanner (1987) believe we undervalue intuitive judgement based on a deep background of understanding. Pattern recognition is often seen as the essence of intuitive judgement. Pattern recognition can develop through experience, case studies, constructive feedback, precepting, observing other expert nurses, and reflecting on practice. Benner and Tanner (1987) believe that intuitive knowledge and analytic reasoning can and often do work together.

Habermas (1974) argues that all distorting conditions must be removed to prevent coercive, negative communication. Nurses need to be able to articulate conditions that frustrate and constrain understanding. Through this articulation the emancipatory interests of nurses will begin to be addressed. Critical reflection or critique is concerned with how the forms and contexts of our thought shape and are shaped by the historical situations in which we find ourselves (Smyth 1986[b]). Thinking through the social and political aspects of reflection leads us to ask the question,

> What or whose interests are being served?

In answering this question through critical reflection, it would also assist in uncovering the knowledge of the 'know how and why' which was seen by the participants in this study as important.

Theory-practice issues

Different interpretations of "what practice is" affect the way in which nurses look at their world of practice. Many participants saw practice as all encompassing with theory being meshed with practice, whereas others saw it as technical skills - the doing of nursing. They saw that ideal/reality issues in

relation to theory-practice, could be used as an excuse, or scapegoat in order for nurses making the excuse, to feel less threatened and to preserve their own integrity. When nurses feel threatened or their self esteem is low, this type of reaction is not uncommon, especially in relation to a positivist approach to practice. To be able to reflect on practice critically and use the process as an opportunity for growth can develop a professional leadership model that values the work of each person's contribution to practice. Perceptions are a significant part of nursing. Meleis (1992) talks of a received view and perceived view. The result of a shift from the received view (objective, sensory data, free of values) to a perceived view (a view that accepts values, subjectivity, intuition, history, tradition, and multiple realities) is a view that is more congruent with nursing and its focus on human phenomena.

Theory-practice issues of professional judgement can be interpreted as the professional work of the nurse and therefore the totality of nursing in whatever setting. Critical reflection promotes praxis in that it is an expression of the power we possess to collectively alter and transform the nature of ideology and practice (Smyth 1986b).

Conclusion

In the context of nursing practice, nurse educators and nurse clinicians have identified many areas that they believe influence their beliefs and perceptions of the theory-practice debate. History, tradition, and the effects of a patriarchal culture have been recognised as having influenced how nurses see the world in which they practice. Ideology, power, and personal knowledge all impact on professional judgement and, in turn, on praxis. Where nurses put ideas into practice and move towards methods and activities that contribute to understanding more fully the meanings of every day experience they are trying to describe praxis. Whether we call it "practice oriented theory", "bridging gaps between education and practice", or "putting an idea into practice", we are trying to describe praxis (Chinn 1989:74). The co-existence of different paradigms of thinking affects how and what nurses perceive as being theory-practice and the influences on whether a gap actually exists.

Perhaps nurses need to think about Friere's words in relation to their own practice:

> *Reflection without action is verbalism;*
> *Action without reflection is activism. (Friere 1971)*

In the next chapter the theory-practice realities will be revisited, along with the implications of this study and some suggested strategies for praxis.

CHAPTER 8

SHAPING NURSING PRAXIS

The findings of this study, as in Chapters 5 and 6, were presented in the form of main and complementary categories which were derived from an exploration of the perceptions and beliefs of registered nurses from a polytechnic educational institution and a metropolitan hospital in New Zealand. Chapter 7 evolved from further analysis of these categories and the major culture theme emerged - 'shaping nursing praxis'. This major theme was explained through four sub cultural themes. Together these themes explain the journey of discovery which was traversed with the registered nurse participants in this study of their beliefs and perceptions of the link between theory and practice in nursing. These processes will be drawn together in this chapter emphasing this major cultural theme of shaping nursing praxis. The theory-practice debate will be revisited and the ways of thinking in relation to theory-practice will be examined. Recommendations and strategies for nursing practice will be addressed, along with areas for further research, implications and limitations of this study.

It is acknowledged that the co-existence of different paradigms in nursing knowledge can affect the assumptions and judgements made by nurses. In keeping with the philosophy of critical ethnography these different paradigms and the assumptions and judgements emerged during the participants journey of discovery as co-researchers in this study. Lather (1986[b]) supported this concept in that she pointed out that through the reciprocal, dialogical process, the researcher empowers the subjects by turning them into co-researchers.

Shaping Nursing Praxis - a hegemonic or dynamic process

Moccia (1992) emphasised the point that theory and practice should not exist in opposition as they depend on each other for their ongoing development. In reflecting the underlying premise of critical social theory, this dialectical relationship can be used to advance nursing knowledge and the profession as a whole. This relationship involves such basic assumptions as the following:

- Reality is only and always part of a larger whole,
- The whole is continually dynamic,
- The whole is made up of parts that have an internal network of dialectical relationships.

These assumptions reiterate some of this study's data in that reality for the participants was different, the context affected how theory-practice was perceived and discussion and reflection clarified assumptions and practice. Theory and practice share a co-determining interaction through which each grows, develops, and changes (Moccia, 1992:28). Practice says in action what theory says in words. Gramsci (1971:106) calls this link an ensemble of relations.

Theory - Practice - how is it seen?

While we continue to talk of theory and practice as separate entities, a difference between the two is created. 'Theory' has been a word that has been easily misused and confused in that interpretations of the term include formal teaching in a classroom, any knowledge, education, academia, and a framework for practice. Theory as a separate entity suggests a gap, an outcome, or a full stop, that then has to be reconciled with practice. Gap is defined as a blank, a break in continuity (Concise Oxford Dictionary 1990:485). By stating an outcome of gap, it appears that praxis is devalued, and a cycle of difference is perpetuated. Through this difference the separation of theory and practice is maintained. By using this language of there being a difference between theory and practice, an excuse is made by some nurses in that they do not need to change how they work or think. By not changing their autonomy is decreased, self responsibility for upgrading or extending knowledge can be ignored, and the potential for a hegemonic situation exists because what they do and how they practice is not perceived as needing to change.

By maintaining the status quo, in which a gap is perceived, nurses are discouraged from thinking about the theories that underlie their practice and the changes in society are often not accommodated. The context in which nurses practice and the ways in which society changes cannot be ignored by nurses. However difficult this may be for nurses, they need to be acknowledged, responded to, and accommodated by changes in clinical practice, ways of thinking and new knowledge. In using the word 'gap' it would appear that finality exists and growth is not encouraged. Energy is used in stating that there is a gap and it seems an insurmountable task to change. Nursing needs to delete the word 'gap' from its language and use an integrative model that sees theory-practice as part of a developmental process that incorporates praxis as a continuum of growth. 'Theory' should be a term used only to explain the framework used in clinical practice, as distinct from all knowledge gained about

nursing. This study identified the participants' view of nursing in relation to theory-practice. The data analysis process revealed the four sub-cultural themes:

- Effect of personal knowledge on theory-practice,
- Effect of power on theory-practice,
- Effect of ideology on theory-practice,
- Issues that affect professional judgement.

These four sub-cultural themes led to the main cultural theme of 'shaping nursing praxis' (Figure 3).

As a result of this study the writer developed models that shows the different ways in which nurses perceive theory-practice, where the participants moved to, and where nursing should move to. The identified changes promote a developmental process that allows for growth, individualism, and emancipation or freedom to grow. In developing the suggested model, a dynamic process is identified and the inter-connectedness of theory-practice is evident (Figure 5).

Ways of Thinking Theory-Practice

Figures 4 and 5 outline two models that identify the emergent theory that has evolved from the data and summarises the codes and categories covered in the data and literature. The traditional or hegemonic model (Figure 4) is one that is inclined to maintain the status quo and presents a 'power over' model that sees theory and practice as separate. This separation infers a gap which can be interpreted as an outcome set in concrete. This means that while the word 'gap' is used in nursing language, the separateness of theory and practice becomes an expected state or outcome. Prediction, authority, control, status, and hierarchy are all tenets of a positivist paradigm which is identified in the hegemonic model. Knowledge gained from a positivist perspective needs to be objective, scientific and rational. This in turn is reflected in the totality paradigm (Chapter 2:12) which focuses on cause-effect (Parse 1992). The traditional model denies the theory-practice link and maintains the potential for hegemony. Theory and practice remain separate and the influences on maintaining the status quo are many (Figure 4). These influences have arisen from the codes identified in Chapters 5 and 6.

Figure 4

Ways of thinking theory-practice

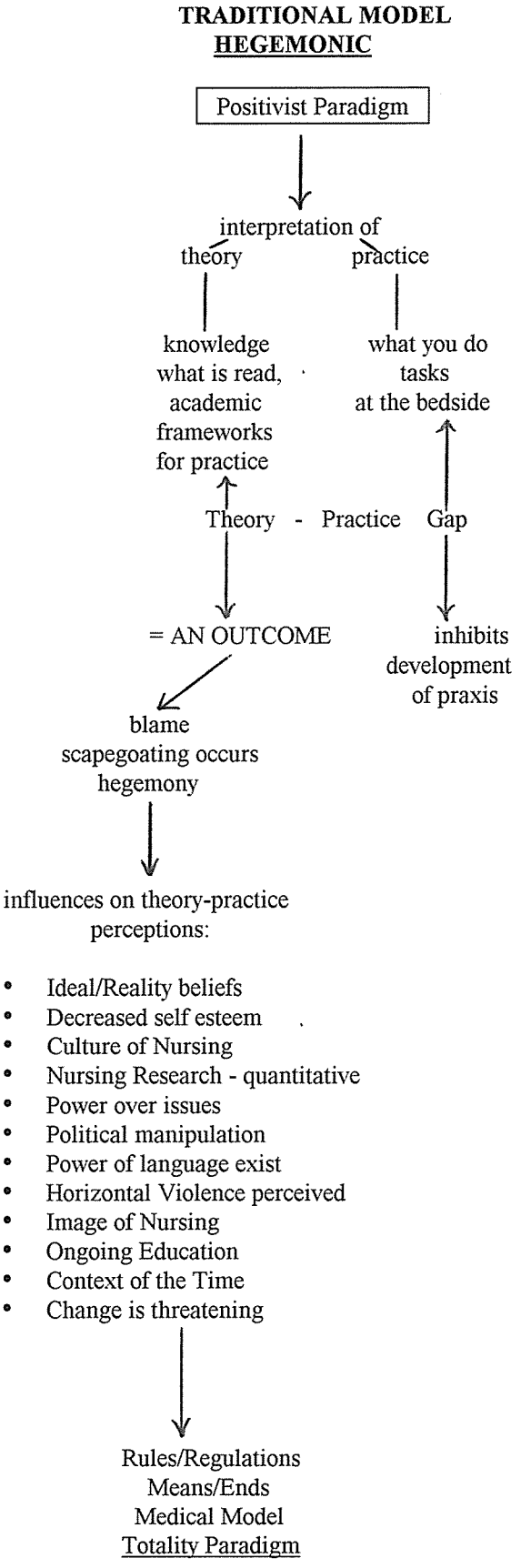
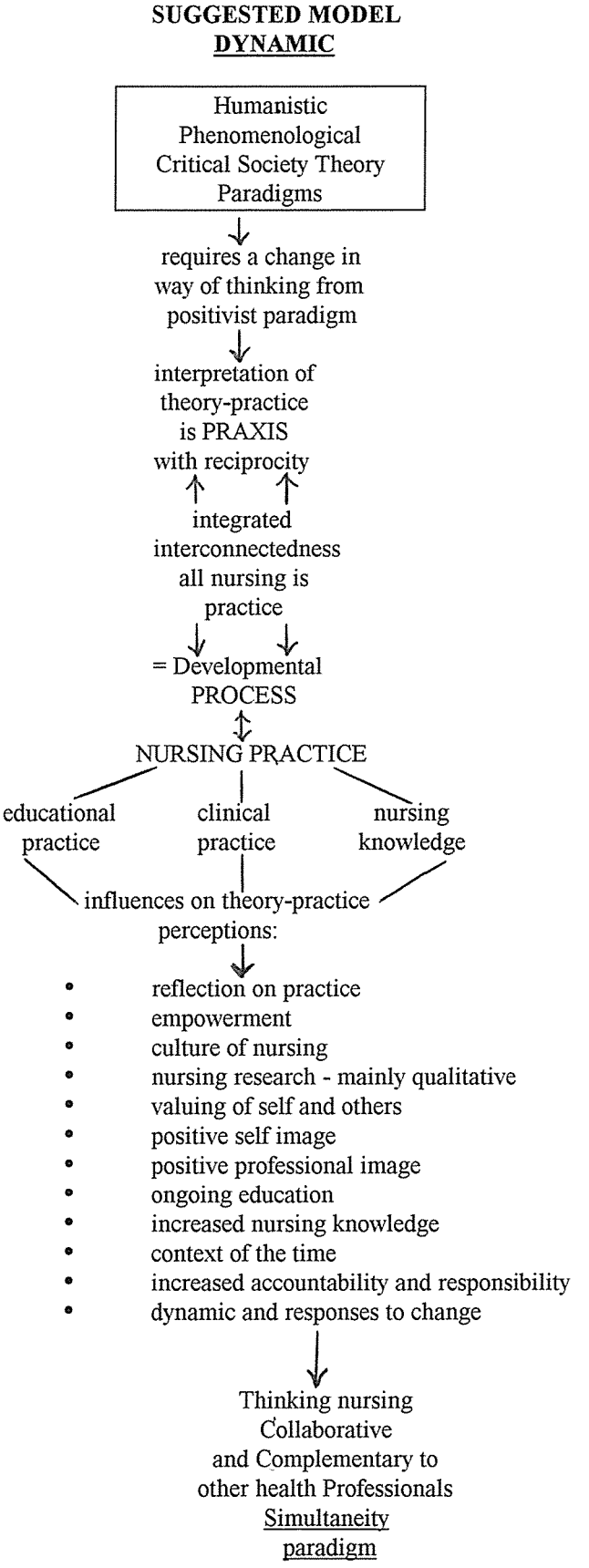


Figure 5

Ways of thinking theory-practice



The suggested model (Figure 5) which is dynamic, evolves from the humanistic, phenomenological and critical social theory paradigms. Inherent within this model is the act of seeing the world as a lived experience and discovering the reality of the time in context. The critical reflective basis of the model requires a willingness to see the world as a lived experience and involves reciprocal dialogue between the critique of the power imbalances and political structures that oppress people and prevent growth, autonomy and freedom (Allen 1985). A critical social theory approach has the potential to empower nurses to question the status quo and to consider possible alternative actions (Speedy 1989b) The simultaneity paradigm (Chapter 2:12) reflects the above in that it has a mutually evolving process with health as a process of becoming (Parse 1992:12).

In the dynamic model, theory and practice are one in praxis with nursing practice which encompasses

- Clinical Practice,
- Educational Practice,
- Nursing Knowledge including:
  - empirical knowledge,
  - personal knowledge,
  - ethical knowledge,
  - nursing theory,
  - affective knowledge.

The influences on praxis in this model are many and they indicate the dynamic reciprocal theme which is related to praxis. Praxis involves reflection in action in order to transform nursing (Figure 5). Reflection as an active process can be done alone or shared with others. These influences have arisen from the discussion, and reflections of the participants in this study which provided the data that was examined and analysed.

Nurses and nursing have to decide which model should be maintained in the future in order to sustain quality nursing care in a changing environment (see Figure 4). A theory is a framework or blueprint in which practice occurs and, as such it is integral to practice. Moccia (1992) believes that nursing theorists would do better to account for the dialectical relationship at the outset instead of perpetuating the never ending papers and conferences in which the gap between education and clinical service is detailed. Nurses in this study came to the

realisation that they must stop perpetuating the dichotomy of theory and practice as it ends with nurses 'going around in circles', not understanding what practice is, how nurses make a difference, or how nurses develop a unity of purpose that becomes the culture of nursing in a general sense. Within this view it is recognised that each unit of practice develops their unique culture of shared beliefs, values, myths, knowledge and processes of doing. This unique culture along with acquiring the affective, cognitive and behavioural skills as well as nursing knowledge, helps to give the nurse the capacity to 'think nursing' (Perry 1985). Perry (1985:37) believed nurses already 'think nursing'.

> *but from a variety of conceptual orientations - medical, physical and technological - which incorporate some nursing concepts. Differences between theoretical approaches should be seen for what they are, that is, a commitment to a particular way of 'thinking nursing' based on social, political and ideological positions.*

Thinking nursing in terms of the dynamic model would involve praxis, collaboration, and the recognition of the process of nursing on a developmental continuum (see Figure 5). Acknowledging nursing practice as a critically reflective and developmental process is a means of valuing the expertise of all nurses at all levels from novice to expert (Benner 1984).

Speedy (1989[b]:146) emphasised that the derivation of theory from practice and its reciprocal nature, is vital for developing multiple ways of understanding our world. In the dynamic model, collaboration is seen as interdisciplinary as well as intra disciplinary, recognising the strengths and expertise of each other in a common aim for quality care. By acknowledging praxis as a developmental process of nursing practice, thinking can be transformed. As previously stated, Chinn (1989:74) believes in discussing praxis whether we call it practice oriented theory, or putting an idea into practice - we are describing praxis. The participants in the study all showed some change in thinking during the interview/observation process and therefore showed themselves to be at different phases on the developmental continuum.

Nursing practice is nursing occurring in any setting, and its nature impacts on the outcome of quality care for the client/patients to reach an optimal level of well being. The issue is not one of protecting our individual status or power over others who are controlled by the management structure but, rather, one of transforming the professional thinking of nursing. Thereby, knowledge that

allows growth, freedom and different ways of seeing the world which, in turn, empowers those within our care, would be produced. Theory is not an end in itself, as to believe this would perpetuate a gap, and promote a separateness between theory and practice. This separation causes theory to be esoteric and fragments nursing educational practice and clinical nursing practice to the degree, that nursing as a profession could be decimated as nurses go into the 21st century.

Place of Reflection in Nursing Practice

In order to help change ways of thinking, reflection on practice can help nurses to recognise the imbalances of power, relationships and their domination by other groups (Speedy 1989[b]). By recognising that there are different ways of knowing (Carper 1978; Belenky et al 1986), reflection will help legitimate and justify the technique of reflecting on practice which is essential for understanding and analysing the theory which is embedded in it (Speedy 1989[b]). Critical reflection helps to assist the thinker to discover the historical, traditional, and ideological ways of changing and misinterpreting knowledge and action along with how these discoveries affect the processes of practice. Nurses need to ask themselves whose interests are being served here and how will it or did it affect the present situation?

Smyth (1986:24[b]) sees critical reflection as an expression of the power nurses possess to collectively alter and transform the nature of ideology and practice. Critical reflection uncovers the thoughts, feelings, beliefs, and knowledge which one holds about the social, political and professional dynamics of the settings in which practice occurs. It helps us to make sense of the world. Understanding the different dimensions of issues enables us to be constructive in our response, not negative and destructive.

Freire (1971) sees praxis as reflection and action upon the world in order to transform it. Nurses, through reflection, can develop new ways of looking at their world. They can explore all the ways of knowing, explore the knowledge base they are working from, and develop a new language through questioning the how, what, why of their world. Through collaborative, reciprocal discourse, hopefully, nurses will respond more effectively to their dynamic environment.

Street (1991:30) sees reflection as a journey which includes the past, future, and present as well as an 'inwards and outwards' journey. The inner journey

uncovers our values, feelings, language, embodiment and ontology, whilst the journey outwards challenges our findings with another perspective and enables us to challenge the situation with our findings.

Strategies and Recommendations for Nursing Practice

From the present study and the transformation which the researcher reported in the participants' perception of theory-practice, nurses need to consider ways in which the dynamic model could be a continuing reality. This would have 'praxis' as the catch word for nursing practice. Nursing practice would be a collaboration with nurses, in all nursing practice settings, for their expertise, which in turn can continue to develop the nursing profession as a whole. Some strategies that can facilitate the change in thinking needed for the dynamic model are empowering strategies that include:

- Education,
- Coaching and clinical supervision,
- Mentoring,
- Case Management,
- Faculty Practice,
- Joint Appointments,
- Reciprocal Advisory Groups,
- Research.

Each of the above empowering strategies are now discussed. A body of literature exists on each strategy, but only an introduction to each strategy will be given in a general sense.

Education

Speedy (1989[a] and 1989[b]) identified some strategies and recognised the importance of professional development needs through education to promote the concept of reflection in practice. Reflection in this sense requires action, active listening and dialogue that facilitates the uncovering process. Along with reflection, there should be education on the integration of nursing practice - nursing knowledge that encompasses research and theoretical frameworks in the reality of clinical practice. Education on each strategy is critical for their successful implementation.

Coaching and clinical supervision

Coaching and clinical supervision are terms which are used synomonously and which help learners to see the need for change, and ways in which they may facilitate that learning. Smyth (1986b) talked of a spiral of clinical supervision as being indispensable in helping the coach and nurse plan collaboratively to identify needs, implement the plan into action, analyse the process, reflect on the analysis, and replan future strategies. It must be recognised that supervision is not directive as the word may suggest, rather supervision should be facilitatory and reciprocal. Within the empowerment that should occur through this process, critical analysis should be facilitated with practice experiences being analysed in a constructive manner that facilitates transformation and change (Carlson-Catalano 1992). This critical analysis needs to be applied to each empowering strategy discussed in this chapter.

Mentoring

In helping to integrate theory- practice it seems important to think carefully about how the mentor role would be chosen, who would be selected, and how they would be prepared. Mentoring is an interesting concept as there is some discrepancy in the literature as to the role and function of a mentor. A general agreement seems to follow that a mentor should be a guide and resource to individuals who are entering new professional worlds. Mentors should facilitate mentees to deal with their role development in the realities of the work setting and political scene (Hagerty 1986; Playko 1991; Cooper 1990). The process of mentoring should have an outcome of an autonomous person not a dependent person who is used to a guide (Armitage et al 1991).

Case management

Case management is not a new concept and has been used within community settings very successfully. However, it has been redefined more recently and has been hailed as a way of ensuring cost and quality control. Case management is now used to describe a variety of nursing care programmes both in hospital and community settings. Case management assists patients and families who need co-ordinated care across the health care continuum and is a way to decrease fragmentation of care and to promote praxis (Lyon 1993). Case management involves a health professional being totally responsible for all the client's care. With this total responsibility other health professionals for example a physiotherapist, dietitian, doctor, will be contracted for specified care required. In the confines of this thesis, case management will not be fully described, but,

suffice to say, that it has dual purposes - client centred and system centred.

Faculty practice

Faculty practice as described by Mauksch (1980) is seen as a vital component for nurse educators to develop as they can offer their expertise as teachers, consultants, clinicians, counsellors and researchers. Faculty practice can occur through clinical practice nurses participation in more formal teaching and educational practice nurses pursuing their own clinical practice with time release arrangements. Another way to promote faculty practice is to develop a faculty practice service that offers nursing care to clients. It is seen as a professional imperative by Mauksch that faculty practice will help increase the collaboration and credibility of nurse educators in the clinical practice setting and strengthen the nursing practice integration of the dynamic model (Figure 5). Faculty practice can also include **joint appointments** (Baker 1992). Joint appointments in both clinical and educational practice have the potential to be very effective. In reality, the appointments can readily become two positions and burnout of the employee is a possibility. With a clear contract which differentiates roles, joint appointment could be another effective strategy to help the developmental process of praxis to become a reality. In advancing the discipline of nursing through praxis, faculty practice can improve the outcome for clients and help consolidate nursing practice.

Reciprocal advisory groups

Reciprocal advisory groups are seen as a strategy which have already commenced in a small way in that educational practice has clinical practice representation on advisory groups and working parties to help develop, maintain and moderate programmes both at undergraduate and graduate level. Nurse educators and nurse clinicians have wide expertise to offer each other and they give a combined depth and richness to the discipline of nursing that can only benefit the health care delivery setting in which they practice. Nurse educators can help in a clinical advisory capacity in the same way and this is already happening informally. This reciprocity needs to be documented and the successes and learning in the process should be shared. The postscript of this thesis will begin that documentation.

Further Research

Speedy (1989[b]) saw ongoing research in the theory-practice debate as critical and imperative. She suggested that longtitudinal studies be instigated to discover

the relationship between theory and practice in a variety of practice settings.

This study suggests that research could be conducted to discover:

- The ways of learning which promote praxis,
- A theory or theories which facilitates praxis,
- The ways by which nurses think in a variety of settings,
- The complexities of praxis and the reflection and ideology critique which may be evident.

This research would need to be carried out in both educational practice and clinical practice and could be collaborative studies by nurse clinicians and nurse educators.

These suggestions are a sample of possibilities for researching theory - practice and its dialectical relationship in the nursing context. The present study illuminates the influences on the perception of theory-practice as expressed by the participants. Further research into the image of nursing, horizontal violence, power relationships, perceptions of leadership, and the culture of nursing would expand nursing practice knowledge in New Zealand as we approach the changing world of nursing into the 21st century.

Implications and Limitations of this Study

This study identified the beliefs and perceptions of nurse educators and nurse clinicians in relation to theory-practice. As discussed (in Chapter 4:43) in critical ethnography, there is no closure period and the emancipation or transformation within the participants is an ongoing process. Some of the participants still indicate that the changes which occurred in their thinking and their practice have been initiated through reflecting on their journey of discovery in this study. Again this point is evidenced by the postscript that concludes this study. Reflection in action, hopefully therefore, continues beyond the span of this study. The interviews in this study initiated the process, and the potential is there for those who participated in, or who read this thesis, to be encouraged to think further about their own relation to praxis.

In using critical social theory as a framework, a longer time period for the research would have facilitated the emancipatory nature for all participants but this was beginning to be achieved. It must also be recognised that this study was

undertaken in the midst of change to both the education and health sectors and with industrial negotiations. These conditions did not appear to detract from the discussion on theory-practice but may have impacted unknowingly on the discussions that occurred during the interviews.

Assessment of the Trustworthiness of this Study

Guba and Lincoln (1982) discuss four major areas of concern relating to trustworthiness. The establishment of confidence in the truth of the findings, how applicable are the findings to other contexts, are the findings solely of the respondents, and would the findings be consistently found if the study was repeated. These four areas are justified through credibility, transferability, confirmability and dependability (refer Chapter 4:41).

Each of these will be revisited for a discussion as to how effective they have been achieved within the study.

The credibility of the study has been addressed by the data being returned for comment to the participants as initial interview transcripts and as the initial data analysis script for comment (ie Chapters 5 and 6). This approach is supported by the tenets of critical ethnography in that the journey of discovery was a reciprocal journey between the researcher and participants and the ways in which the validation of the data occurred enhanced the credibility (Lather 1986[a]) and dependability of the research.

Transferability will occur at a later date following the dissemination of this thesis itself. Confirmability and dependability was achieved through triangulation of data, observation, peer debriefing, and member checks by participants and thesis supervisors.

Participants reported that being part of the study was stimulating, exciting and thought provoking. In reading the transcripts, apart from the accuracy of the statements, some participants found it enlightening to see how they had actually spoken. They made the commitment to become more clear in their comments. Some participants have made changes to their thinking and the way in which they have changed their approach to new staff and thought about theory-practice. The participants have actually made some changes in the ways in which they and other staff will function by using new agreed processes. For the participants to become aware of their beliefs and perceptions is, in itself, a beginning of

transforming the power and control conditions into a freeing of thinking and bringing about change that promotes professional autonomy.

Concluding Statement

This thesis was aimed at discovering a sample of nurse clinicians' and nurse educators' perceptions of and beliefs about the link between theory and practice. The study sought to identify the ways in which these beliefs and perceptions shape the practice of these participants. Through using the critical social theory approach, the socio political influences on theory-practice perceptions, both personally and professionally, were uncovered and subjected to reflection and reconsideration through reciprocal dialogue. The experience for the participants has appeared to highlight issues of interpretation, ways of thinking, and the power issues of language, culture, image, valuing and socio political forces that impinge upon nursing practice.

During the development of this thesis, the language used in relation to theory-practice was incongruent to the developmental process that emerged from the data. As stated previously (refer to Chapter 7:113) language is very effective at controlling what happens at a particular time and place. In deleting the word "gap" from nursing language, theory-practice becomes theory practice or praxis. This mirrors the integrated practice outlined in the dynamic model (refer Figure 5). The researcher, during the growth process experienced as a result of this thesis, has difficulty in writing theory-practice and concurs with the deletion of the word "gap". Moccia (1992:28) extends this by emphasising

> *within a dialectical understanding of the world, theory and practice share a co-determining interaction through which each grows, develops and changes.*

Nurses first need to examine the ways of thinking theory-practice (Figures 4 and 5) to understand the world of nursing and the processes involved in 'thinking nursing'.

The insights, ways of thinking and the dialogue experienced during this thesis have added a depth, breadth and richness in my learning personally and professionally. The many views, feelings and perceptions which participants shared with the researcher have provided new understandings and a bond that has promoted a sense of collaboration that is especially valued and respected. Chinn (1988) considers that, if nurses are ever going to be able to achieve unity

between their knowing and doing, then they must increase their conviction that this can be achieved and begin to take responsibility to heal the theory-practice split. Nurses need to tend and nurture this theory-practice relationship and they need to think praxis. The participants in this study have shown that this is beginning to happen and that the challenge must be taken up for the preservation and growth of nursing practice and for the shaping of nursing praxis in the future.

POSTSCRIPT - Transforming Practice

Integral to critical ethnography is the reciprocal dialogue between the researcher and the participants and the researcher's commitment to the credibility of the data. These tasks are achieved in part through returning transcripts of the interviews and initial analysis for the participants to check the validity of the data.

During the discussion with the participants on the final analysis of the data (Chapters 4 and 5), thoughts and feelings were shared of the research process and what they had gained by being participants in this study. As a result, one participant's thoughts are shared about the way in which her practice and thinking has been influenced through the journey of discovery which occurred during this research.

Following discussion of the analysis, Lou described the effects of participating in this research and stated that she had really enjoyed being involved, especially as it made her think and question her practice more. She acknowledges the change in her approach to practice. This change is consistent with an overall goal of critical ethnography being to free individuals to realise their optimal potential as professionals.

Lou explained the change in her approach to new nurses in her area. She acknowledged the difficulties which they may encounter on entering a new cultural domain.

> *It's changed my whole perspective on how to approach people. I know now that it is difficult to enter a new culture and by acknowledging that, you see the new person visibly relax and recognise that time will be given to adjust and feel accepted for what they personally have to offer.*

In observing the new nurses, Lou talked of the adaptations they appeared to make to be accepted and how these adaptations can be interpreted as a gap. On talking with the new staff and asking them if they had been taught or practiced this before the answer was - "oh yes, but they don't do that here so I follow the staff here." Lou recognises that support and feedback is required by new nurses to an area to gain the confidence to practice in a way that matches their own learning and standard but may different to how others in their area practice. If

they make the adaptations previously discussed, comments of theory-practice gap and ideal-reality arise as the new nurses try to fit into their new setting.

In recognising the expertise of both nurse clinicians and nurse educators Lou has initiated two innovations to help others to experience the thinking and challenge which she has experienced in relation to theory and practice.

- An advisory group on reviewing documentation has been established. This group consists of clinicians and educators and Lou comments, the sharing of expertise has been very valuable.

- A story sharing group has been facilitated for nurses. This group provides a forum in which stories can be shared, discussed and interpreted in a safe collegial environment.

Story telling offers an approach that assists in grounding the epistemological basis of the discipline of nursing through the telling, discussion and critical reflection that follows (Boykin et al 1991).

To provide opportunities for critical reflective dialogue to occur provides a basis for challenging thinking and can facilitate further transformation that may lead to praxis and professional autonomy. These opportunities generate power by providing dialogue among nurses for promoting learning, and for developing resources, networking, social cohesion and more specifically collegiality (Carlson-Catalano 1992). Lou shared the view that her participation in the study, represented a beginning and that she enjoyed the sharing, thinking and critique in which she had been involved.

Lou's views are not one way. In concert with the philosophy of critical ethnography as an expression of the growth experienced by the researcher, some final words seem appropriate:

> *Thank you Lou the dialogue with you has enriched my life and practice too.*

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Te Piuri Oranga O Tamaki Makau Rau

Auckland Area Health Board

Provider Division

YOUR REFERENCE

IN YOUR REPLY PLEASE QUOTE

Address reply to officer whose official title appears below signature.

15 May 1992

Ms Marion Jones
Principal Lecturer
AUCKLAND INSTITUTE OF TECHNOLOGY

Dear Ms Jones

THE CHASM BETWEEN NURSING THEORY AND PRACTICE - REALITY OR MYTH?

PLEASE QUOTE REFERENCE: 92/55

The above study was considered by Ethics Committee A of the Auckland Area Health Board at its meeting of 13 May 1992

The study is APPROVED until 20 May, 1993

The Committee thanks you for your cooperation.

Yours sincerely,

APPROVED by the
AUCKLAND AREA HEALTH BOARD
ETHICS COMMITTEE
until 20 May 1993
Secretary
Date 15/5/93

Beverley Carey
Secretary
Ethics Committees

cc B Glenie
General Manager, Auckland Hospital

Auckland Area Health Board
Purchaser Division Albert Plaza, 87-89 Albert St, PO Box 5546, Auckland 1, New Zealand. Telephone 09-377 4750, Fax 09-307 6725
Provider Division Eden House, 44 Khyber Pass Rd, PO Box 8593, Auckland 1, New Zealand. Telephone 09-377 6633, Fax 09-367 0334

Information sheet for participants in the Research exploring the

Theory Practice Gap in Nursing

I am seeking voluntary participation in a research study - The Theory/Practice Gap in Nursing. This study is part of my Masters in Educational Administration and consists of my thesis. I wish to have volunteers who are registered nurses, who have a minimum of five years post registration experience and are either nurse educators in a polytechnic or nurse clinicians working in clinical practice.

As a study participant I would like to interview you at a time and place convenient to both of us. The taped interviews will be conducted as reciprocal interactions (ie informal conversations) and could last 1 - 2 hours. The number of times I will interview will be 2 - 4 times and will always be negotiated, as will one observation with you in your practice setting. I will negotiate with you to keep a personal log of the process and you can share this as you wish. To respect your privacy your name will not be used in the research or in any documentation. Only you and I will know your true identity and I ask you to choose a code name.

The information you share with me will remain confidential and the only people who will have access to it will be my supervisors Dr Wayne Edwards and Dr Judith Clare, both of Massey University, Palmerston North.

There are no other risks to you by being part of this study other than privacy and confidentiality which I assure you. No other participant will know from me who the other participants are in this study. The benefits will be the opportunity to discuss and reflect on your practice, beliefs and values. You will be free to withdraw from the study at any time.

Information shared with me in this study will be used for my final report publication which is kept on file at Massey University. I would expect to publish the findings in a professional journal, and share information with you. Your identity and place of work will not be identified. When the study is complete I will send you a report of the research findings.

If you are willing to work with me in this study could you complete the attached consent form and return to me. If you have any further queries please do not hesitate to contact me at 489-7099 or at my home 534-6431.

Thank you for reading this information sheet.

Marion Jones RGON BA
M Ed Admin Thesis Student
Massey University

CONSENT FORM - for participation in the Research exploring the

Theory and Practice Gap in Nursing.

I volunteer to be a participant in the above study and to take part in two - four taped interviews and one observation, and to provide information on my beliefs and perceptions of the theory/practice gap in nursing and how these beliefs and perceptions shape my practice.

As a participant in this research I understanding I will not be identified in any written documentation and all audio tapes have been assured of confidentiality. My right to privacy will be respected in that I can divulge as much or as little information as I myself decide. I understand I am free to withdraw from the study at any time.

The interview will be conducted at a time and place that is mutually acceptable to myself and the researcher. I give my permission for information that I provide to be used in the final research report and will receive a written report of the findings once the research is completed.

I therefore give my informed consent to participate in this research.

Date: Date:

Signed: Signed:
(Participant) (Witness)

M. Do you think it has got something to do though with accountability and responsibility issues as well.

L. Oh yes, everything to do with it.

M. I mean that's been there for a long time but they didn't, a bigger push for it at the moment isn't there? The fact that you have to show how you make a difference.

L. Yes that's right, yeah. I remember the first lecture I went to on accountability and I'd never, sort of, heard the word before, its quite a long time ago when it started to come in. And I got a shock, I got real shock. I was a professional in my own right, there was nobody protecting me, the Board lawyer was there and he said "if you muck it up, you muck it up kid, you can go to court". It had never occurred to me before because there was always this hierarchy protecting me, I thought, who were actually perceived as being against me but also to protect me, if you know what I mean. And I kind of assumed that it would never really affect me, that my practice is just absorbed into this huge sponge and I was the cog in the wheel that didn't matter. I realised after that lecture that I was actually accountable for my actions and if anything happened to that patient or was not done to that patient in my care, for that particular 8 hours or whatever, then I was responsible for that, I was accountable for the effects of what happened.

M. So you went to a session, an inservice session?

L. Yes I went to an afternoon on it.

by saying that the new graduates are dumb, don't know anything, which is quite a standard thing to be said. By not helping people very well, sometimes if you have had a bad experience as a ~~bad~~ new graduate you'll give somebody else a bad experience as a new graduate because you have to pay it back. Which is so appalling, you would think it would go the other way but it doesn't. You would think that because you had such a terrible experience you would want to make it better but it doesn't seem to happen that way.

M. And when you are talking just before I observed with you the other day and I was working with you, and you were talking about two wards and as far as education is concerned that is one issue, but you also made it very clear that a role model was important and the charge nurse was the pivot. And it would be good if you just share a little bit more of your thoughts around that.

L. Ok. You want me to compare the two wards?

M. Well just how important the charge nurse role model was for letting people feel ok about themselves and to think nursing.

L. Right. We have, there is one other ward that I actually don't cover, the charge nurse took three years to institute primary nursing and her ward is known as a good ward because the nurses are good on that ward and that sometimes people say that with surprise in their voices.

M. What is good?

L. Because they're trying. Yes what is good? It depends on your perception doesn't it? Sometimes good means that you can do all the jobs properly ~~and they shut up~~, but on this ward these nurses think for themselves, they challenge doctors and they don't take any rubbish, they run the social round themselves,

B. I do. I think, I guess, yeah and I think we don't acknowledge valuing because it is really hard to acknowledge valuing. Again if you go back to the self, if you don't really value yourself, I mean it is part of that ever.....

M. It keeps coming back to the self doesn't it?

B. I think it comes back to the self. It is really hard to actually value beyond yourself unless you actually have some firm stable measure of your own value.

M. If you look at it like that it just seems an impossible task, when you have got so many nurses as one group of people who need to look at self image things, so to look at it as a whole just seems so overwhelming. But we need to be able to look at it in manageable chunks, don't we?

B. You can look at it manageable chunks if we are thinking on, not on valuing myself as an individual but I actually value myself as a nurse. I think to actually look at individual valuing of me as a person, or you as a person is too much, but if we just perhaps may be focus on the valuing of you as a nurse, because then there is a lot of commonalities that we can perhaps do, and perhaps reach more people with the same strategy.

M. We really need some charismatic leader at the moment, who is going to be a real motivator. Like any leader needs to have a support system too, because they won't survive terribly long.

B. So in a sense we need to yeah support and actually value that leadership and .....

M. And it is getting us to talk and think nursing, and thinking "I'm a nurse" and that is of value....

now I think that nurses often like this strategy - you lead I'll follow - or lets wait for someone to lead us - thus devaluing ourselves as needing to be led & waiting for the right man.

M. So that response that you are talking about of holding on to ideas and blocking creativity and change are all things that could indicate they could be threatened.

C. Yes.

M. When you talked about power, what do you mean when you talk about issues of power?

C. Well sort of mean the hierarchical system if you like of nursing, I think that some issues of power come through that. Hopefully they are disseminating out a little bit but there is still elements of it.

M. So we are talking about the history aren't we, of where nursing has been and the impact that has on what we are doing now

C. Yes.

M. And we can't ignore that can we, we have to consider history to look at how we can go ahead. So looking at the history and looking at the issues of how we feel about ourselves, do you think that, what are your impressions of the image of nursing and nurses at the moment?

C. I think outside, clients, might say nurses are quite special people in some instances, and the odd one might say not so, but I think as a whole the community quite values nursing. I don't know whether nurses always value nurses, and that is what bothers me. Its the professional valuing and of individuals and groups within nursing that I don't believe actually come together very well and assist in that process.

A. Well I did the science course at ATI, Science for Health Personnel I did that at night school.

A 7 A. Yes. And because I wanted to take up nursing again as a career so I was determined to learn about it and get on with it. I enjoyed it basically, and I wanted to get more knowledge. I did a surgical course as well, hospital board surgical course.

M. So what made you want to do these courses. I mean you have said more knowledge but was there something your saw as being important.

A. I suppose to be more recognised. To start with I worked four days a week and I found that the people that worked full time had more recognition I suppose with their seniority and everything,/ if you worked full time than if you worked part time. And having more knowledge also helped the recognition.

A 8 and I found I wanted to get more knowledge and get more out of life as well. Make a bit of an impact.

A 19 M. What about ongoing education? Do you see that as being important.

A. Certainly in the hospital there is lots of little lectures about all different subjects that you deal with, it is up to the nurses to get more education outside of nursing. I mean like with techs or with the diploma or university education that is up to the nurse. We certainly need people doing that even if everybody doesn't do it. And people also go off and do specialty courses, I think that is quite important to.

M. What does it do / to do those things, why is it important.

M. That is a really good way of looking at it, really isn't it - in saying well ok then this happens and it happens in many ways, it may happen with the new graduate, it may happen because you change areas and it may happen because the co-ordinator can't know the whole lot if they are doing a whole area, and how can you actually make it, that that is ok but lets do something about it.

A 2: 24 M. Right. Well that is really good. Where do you see yourself getting yourself, or wanting to see yourself as continuing to do, when you say you want to be in clinical do you see any education you want to go and do, apart from saying I'd like to learn more....

A. But one way I am restricted by finances actually, at the moment. I can't really go on to anything that I would have to pay a lot of money to because I am committed to pay my mortgage.

M. So that really makes it hard doesn't it, we need more scholarships around for people just like yourself so that the opportunities are there for people and certainly some of the ones that are around help but don't facilitate you taking a year off or something. I mean you can do a few papers at time and help and get help with those payments.

T 2:9 T. I think the more experience you get the less you get into tasks/ and the more you get into looking globally and like say, after you have been out for a few years, you can get to the stage where you can co-ordinate your workload better and do what's the most important and keep an eye around all your patients, know what is going on, whereas when you first there, you are just looking at one thing at a time, then you get to the stage where you can look at a few things at a time, and then you get to the stage where you can co-ordinate the ward and look at everything. So I think, I think it is a growing process really.

Ongoing Education

A 1:9 Important

A 2:34 no finances

K 1:3 Levelling system

K 2:20 expand skills

M 1:7 encouragement given practical skills courses integrity / accountability

M 2:1 ? over educated

L 1:5 Degrees needed.

K 2:17 (P 25/61 in 1) Education opens the mind

L 2:13 (P 31 in 1) - needs to be focused at senior nurses

B 2:6 (P 39 in 1) education brings people together legitmately.

A 1:7 (P 38 in 7) ongoing education.

L 2:0 teach experienced nurses (P 30 in 7)

L 2:30 older nurses have gap (P 73)

J 1:5 ongoing education and choice (P 135 in 7 P 136)

Automation comes with experience

M 2:12 (P 17 in 1) Automation but at patients risk

J 1:2 (P 133 in 7)

J 1:2:1 get into the habit of doing something (P 50 in 1)

K 2:1 (P 23 in 7) Thinking mostly tasks

A 2:0 - (P 42 in 7) automatic

A 2:2 gradual thing (P 44 in 7)

Thinker or Doer

T 2:29 (P 8/9 in 1) Communication and ask why

M 2:1 (P 14 in 1) Today have to be able to reason.

L 2:24 (P 29 in 1)

Link between theory + practice

L 1:9 - Gap between reality + expectation (check if already used in ideal / reality)

K 2:21 (P 25 in 7)

M 4 (P 29 in 7) Familiarization programme

M 1:9 (P 32 in 7) can't separate.

A 3 (P 37 in 7. Theory + practice meshed

A 5 Intuition v/s experience.

E 8 (P 59/51 in 7) make it work for them.

E 1:6 Frustration (P 53 in 7).

E 2:20 (P 61 in 7) Theory a blueprint for practice.

B 1:1 (P 78 in 7)

B 2:27 (P 87 in 7) Initially structure up.

J 2:15 Gap between clinical + education is a time lag (P 101 in 7)

R 3 work with clinicans (P 107 in 7)

R 5 ? educationalist - perceived idea. ? Gap (P 108 in 7)

R 2:4 Expert Nurse (P 112 in 7)

C 2:1 (P 126 in 7)

Ideal v/s Reality

What is theory?

K2 The ideal (P16 in 7)

K10 Theory guides practice (P20 in 7)

M1 Rationale behind practice (P25 in 7)

M21 Knowledge is anything learnt (P33 in 7)

A1 Theory knowledge gained (P35 in 7)

E2 Theory explains (P49 in 7)

E9 Framework guides practice (P51)

B1 Theory abstractions (P75 in)

C1 Theory is a framework (P118 in 7)

C8:6 Word theory interpreted differently (P130 in 7)

JU1 } Theory is knowledge
T10 } base (P133)

JU17 Theory out of practice (P144 in 7)

W1 different types of knowledge (P152 in 7)
interwoven with practice
use of knowledge (P154 in 7)
155

What is practice?

K3 (P16 of 7)

M8 Nsg. made up of technical skills technology (P30-31 in 7)

A2 Practice is the safe way of doing things. (P36 in 7)

A3 Education is part of practice (P37 in 7)

E6 Practice is all inclusive (P50 in 7)

B2 P76 in 7 R13 (P109 in 7)

L17 Act of nursing (P68 in 7)

B1 Practice is the doing

R1 Knowledge generated from practice (P105 in 7)

R2:6 Practice (P113 in 7)

C2 Practice is the doing (P119 in 7)

JU9 Practice is doing
Theory not always needed (P136)

JU15 (P139) JU2:13 JU2:15 (P147)

W14 Practice is all encompassing (P157)

Growing Process

T2:9 (P7 in 1)
Theory guiding practice is developmental process on a continuum.

L2 (P20 in 1)
Growth Process

J2:28 (P41 in 1)
Nursing is at a developmental stage.

R2:13 (P44 in 1)
Not a gap but a growth process.

C8:10 (P48 in 1)
Process of growth to consolidate practice.

JU2:3 (P51 in 1)
Developmental process link with Benner.

T2:7 Experience + then think it's normal is actually developmental

T2:9 (P12 in 7)

T2:24 (P140 of 7)
R1

A2:3 (P44 in 7)

Knowing what Knowing how.

L13 (P20 in 1)

W5 (P52 in 1)

E2:1 (P55 in 7)