The main problem is that social and political life in schools and elsewhere depends heavily on the upspoken agreement and the hidden cards. Studies which open the process in a particular (institution) *to scrutiny do not merely put personal relations at risk: they shift the balance of power.*

(Stenhouse 1982:28)

THEORY AND PRACTICE IN THE INDUCTION OF FIVE GRADUATE NURSES: A REFLEXIVE CRITIQUE

A thesis presented in partial fulfilment of the requirements for the degree of Master of Arts in Education at Massey University

Judith Perry

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ABSTRACT

This thesis investigates the induction of comprehensive nurses into a professional culture during their polytechnic nursing education and first year of hospital practice. It combines a critical theory approach with case study method. The ways in which social forces constrain individual and professional action are demonstrated through a critical reflexive analysis of the perceptions of five recently graduated comprehensive nurses. Each graduate was interviewed at regular intervals over a three month period.

It is argued that previous studies of professional socialisation of nurses conducted within both empirico-analytic and interpretive epistemologies, have tended to objectify the day-to-day actions that students and new graduates take. While providing descriptions of the socialisation process, previous studies have not explored the reflexivity of understanding and action as well as the structural constraints of nursing education and practice.

In this thesis critical social theory provides a framework in which to reveal, through empirical research, the constraining conditions of actions, and, through interpretive forms of enquiry, human perception and understanding. The reflections of the five participants in this study reveal that there are similar structural constraints in education as in hospital based nursing practice. There is, in effect, a continuity of structural constraints and this is contrasted with a disjunction between knowledge and beliefs gained through education and those apparently required in nursing practice. The graduates' perceptions are discussed and interpreted in terms of both the intended and the unintended learning states engendered by their actual experiences in the polytechnic and hospital settings. It is suggested that, at present, nursing education and practice are shaped by forms of technical control which arise from the dominant ideologies already embedded in the education and health care structures. In particular, nursing

curricula are dominated by the technical linear paradigm of curriculum design which contributes to a distorted separation of theory and practice and which obscures the process of reproduction of professional culture. It is argued that a more socially critical approach to the design of nursing curricula might begin to transform some of the structures which presently inhibit and constrain the professional choices and actions of student and graduate nurses.

PREFACE AND ACKNOWLEDGEMENTS

This thesis represents the culmination of many years of listening to student and graduate nurses as they attempted to explain their experiences in nursing education and practice. It also represents several years of my own growth as a person and as a nurse, while I struggled to find a theoretical perspective which, for me, best illuminated those experiences.

This thesis is presented in two parts. Part One comprises six chapters which explicate the context, theoretical framework, and analysis of the data in this study. Part Two contains the qualitative data base and provides a reconstruction of each graduate's perceptions as revealed in the interview protocols. I hope that people reading this thesis will read both parts as the theoretical perspective is grounded in the qualitative data.

I wish to thank many people who have assisted me in various ways in the preparation of this thesis. In particular I wish to thank Dr. John Codd for his encouragement and scholarly support, and Professor Nancy Kinross for her constructive advice and professional knowledge.

I wish to especially acknowledge the encouragement and support of my friend Helen. Grateful thanks are also due to Joan Thompson for her expert typing.

I owe a special debt of gratitude to the five graduates who so willingly shared their perceptions of their education and practice. I hope that the experience of sharing in this research has in some way enhanced their understanding of what it means to be a nurse.

Finally, I wish to thank my husband, John, for his constant encouragement and meticulous proof reading, and my children, Megan and Matthew, for their understanding. My family has shared in and lived through this experience with great fortitude.

PART ONE

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CHAPTER ONE

Preparation for nursing entails more than just acquiring a theoretical and experiential knowledge base for nursing practice. Students are also exposed to a socialisation process which inducts them into a professional culture and a set of institutional practices. This process of professional induction extends beyond the formal curriculum. The informal curriculum, in both the polytechnic and the clinical agencies where students gain their experience, constrains students to adopt attitudes and behaviours which conform with those already established by experienced nurses.

It has always been accepted by nurses that professional socialisation is an integral part of the declared aims of the curriculum for nursing education and practice. The emphasis on 'professional behaviour' in polytechnic courses, and the strong expectation that students and new graduates conform with existing practices and beliefs of the nursing team within the clinical agency, are manifestations of a concern by the nursing profession that nurses develop a strong commitment to professional ideals. During this process of induction, students and graduates are influenced and expected to develop 'professionally desirable' attitudes and values, to change previous patterns of behaviour and to accept and adopt professional ideals.

These attitudes and values are reflected in curriculum aims but they are often contradicted by institutional experience in both the educational and practical contexts. Thus, nurses may encounter discrepencies between the formal overt messages and the covert messages in both education and practice. For example, students may be explicitly taught that caring, empathy and trust are central values, but experience little of these values themselves. Or it may have been stressed that nursing values and beliefs reflect a concern for the person, yet as students they themselves may experience pressure to conform to the formal doctrine of the educational and health institutions. Similarly, a comprehensive

nurse, having been explicitly taught that nursing values and beliefs reflect a concern for the person rather than the person's disease, and that nursing is an important, independent health profession, begins her practice within the constraints of medical and technological ideologies and institutional regimen which may not recognise those values as being central to her practice. Comprehensive graduates are often led to believe, by educators and the profession, that their 'new' and different education will allow them to effect change in the ways in which nursing is practised. But the strong expectation of nurses in hospitals is that beginning comprehensive nurses will 'fit in' with existing beliefs and practices as quickly as possible and 'become like' their more experienced colleagues. There are already structured power relationships established within the hospital and the beginning graduate is expected to quickly find her place within them.

These double messages force a dichotomy between theory and practice - a contradiction between what is believed and what is experienced. It could be expected that many nurses, students and graduates alike, would be aware of the double messages they receive, aware of the theory/practice dichotomies, and aware of the confusion and inconsistencies that ensue in their every day practice. This awareness, however, instead of engendering a socially critical attitude, may tend to produce self doubt and insecurity at the psychological level.

There is, therefore, another often unacknowledged aspect of professional socialisation. Nursing students (and, later, graduates) may develop personal and professional dependency, a professional identity which allow them to become subordinate to other health professionals, interpersonal relationships based on traditional patronage, professional practice based on task-related curative functions; and nurses may experience lack of purpose, integrity and autonomy, and decreased self esteem. All of this could be said to constitute a dominant ideology, where ideology is taken to be a system of beliefs, values and practices which are socially constructed but which shape the self consciousness of individuals (refer Chapter Three). Thus contradictions between

beliefs and action may arise from the kind of educational and practice experience the student receives as well as the theoretical and practical orientations she is exposed to. These experiences can be expected to play a part in deciding which beliefs, attitudes and values become critical in forming the nurse's professional self (Perry, 1985). Consequently, the student's individual consciousness of herself as a professional may be socially constructed within an institutional context in which structured power relationships are already well established.

The contradictions between what is believed and what is experienced by students may arise from discrepencies between the formal and informal curriculum. While there has been attention paid to the formal curriculum in nursing education, less attention has been paid to the informal curriculum. More emphasis has been placed on the knowledge content of nursing courses and less emphasis has been placed on the selection, transmission and evaluation of that knowledge.

Bernstein (1975) suggests that the social principles which determine the selection, transmission and evaluation of knowledge in an educational context, allow a distinction to be drawn between the formal and informal curriculum. His model of educational transmission allows empirical study of educational knowledge codes. These codes are defined as:

> the underlying principles which shape curriculum, pedagogy and evaluation. Curriculum defines what counts as valid knowledge, pedagogy defines what counts as valid transmission of knowledge and evaluation defines what counts as valid realisation of this knowledge on the part of the taught.
>
> (Bernstein, 1975:85)

These "message systems" (curriculum, pedagogy and evaluation) which are both overt and covert, embody principles of power and control which enter into and shape the consciousness of those who experience them. The organisation of educational knowledge is patterned on two major codes - collection codes and integrated codes. These take their form from the social principles which regulate the classification and framing of knowledge in

educational contexts.

A collection code has both strong classification (for example, where subjects are highly separated from one another) and strong framing (for example, the timetables in nursing courses where designated hours are set aside for anatomy and physiology, psychology and sociology). This means that the tutor (or the institutional practices) controls the pedagogical relationship, the timetable, the order in which subjects are introduced, and the amount of time spent on each topic. The tutor may be constrained by the overt curriculum, but the student may be constrained by the message systems, or informal curriculum.

In a knowledge code with strong classification and strong framing, evaluation of the student's progress is likely to be by structured tests and examinations to decide whether the student has 'collected' the knowledge the teacher was trying to transmit. Such a knowledge code Bernstein calls a collection code.

Evaluation in an integrated code places less emphasis on specific knowledge acquisition. A greater range of the student's behaviour is visible so that evaluation may take into account the 'inner' attributes of the student - whether the student has developed the 'right' attitudes. More of the student is made visible in terms of thoughts, feelings and values and thus more of the student is available for control. Where an integrated code is developed in relation to professional education such as nursing, tutors (or institutional practices) exercise even greater control over students since what counts as professional knowledge, attitudes and values is even less able to be defined.

Strong classification and framing creates predictability - order is not problematic in collection codes. Evaluation of specific competencies and states of knowledge occurs according to previously established criteria, a procedure that could be said to be relatively objective in terms of the dominant ideology. Order created by integrated codes may be problematic since the openness of the message systems allows visibility of the underlying ideological structure.

The essential feature of an integrated code is that previously integrated subjects are subordinated to a rational idea; for example, health or holistic health care. In an integrated code, weak classification occurs where there is subject integration - the boundaries between subjects are blurred. Weak framing means that both teachers and students participate in decisions about the organisation and timing of educational transmission. The timetable is more flexible and the balance of power between teacher and taught allows student participation in all three message systems. The integrated code may foster co-operation and collectivism, rather than competition and hierarchy and may challenge the individualism, hierarchical assumptions and modes of assessment of the collection code. Whether or not this challenge occurs, however, depends upon the level of integration: whether the course is integrated at the surface level (a 'focussed' curriculum) or whether the integration is at a deeper level, integrating both intellectual and experiential dimensions of knowledge (a 'true' integrated code) (Bernstein, 1975).

Since the change in nursing education to tertiary educational institutions, nursing curricula have tended towards an integrated code at the superficial level, with the central relational concept being holistic health care. As well as weaker classification these courses have tended towards weaker framing, but have both explicit examination procedures and implicit evaluation criteria. That is, the student must meet examination criteria set by an external examining body, (The Nursing Council) for entry into practice, as well as exhibiting "professional behaviour" throughout the education period.

The move, in 1973, from service-based education within hospital schools of nursing to polytechnic nursing studies departments, was a move initiated and encouraged by nurses themselves for the advancement of nursing as an autonomous profession (Burgess, 1984; Kinross, 1984). An education based rather than service based system of nursing education would, it was thought, allow greater flexibility and integration of curriculum content; greater freedom and control over curriculum, pedagogy and

evaluation; and greater professional control over the induction of neophytes into the profession. As well, it was hoped that this move would decrease the socio-historical dominance of other disciplines over nursing as a profession, and over nursing education and practice. The focus of nursing could then be directed towards people and the maintenance of health rather than towards the traditional emphasis on hospitals, illness and curative practice.

Providing an integrated curriculum where subjects are subordinated to a relational idea such as holistic health care, would, it was thought, enable students to learn to provide health care from a nursing perspective, thus developing the appropriate professional knowledge, experience, attitudes and values. As well, it was hoped that nursing courses independent of hospital patronage and service needs would produce independent, autonomous, professional graduates capable of caring for patients in a variety of settings, from a nursing orientation.

Nursing, however, is now taught in the setting of two highly structured institutions - health and education - and all three message systems are constrained by the requirement of these institutions towards order, predictability and measurement. Nursing, in part at least, rests upon subjective professional judgements which cannot be objectified to meet these requirements (Mark, 1980). For example, a major difficulty arises over student evaluation - what is to be assessed and what form that assessment should take are highly problematic. Moreover, the institutionalised constraints, (such as the Nursing Council requirement of 1500 hours designated to each of theory and practice), ensure that strong boundaries are maintained between tutors and students and between subject areas. As well, strong framing ensures that tutors control what is overtly transmitted to students, and the nature of their relationship with students.

This control is reinforced by official registration procedures which ensure that the control of knowledge deemed appropriate for professional nursing practice rests with a credentialling authority - The Nursing Council of New Zealand.

Students who satisfactorily complete a three year comprehensive nursing course at any one of the twelve technical institutes, polytechnics or community colleges in New Zealand (herein referred to as polytechnic) receive a Diploma of Nursing. The name of the student together with evidence of the academic and professional competence (the Head of Department must sign a document attesting that the student is a 'fit and proper' person to be registered) is sent to the Nursing Council of New Zealand. The student is then permitted by the Nursing Council to sit the state examination for registration as a comprehensive nurse.

The majority of comprehensive nurses from polytechnic courses (approximately 90%) are employed by hospital boards throughout the country. The remainder are employed by the Health Department as public health nurses, and by other agencies. Of those employed by hospital boards, 98.2% begin their professional practice within general and obstetric, psychiatric, and psychopaedic hospitals while 1.8% begin as district nurses in the community (see Appendix 1.) The hospital, then, is the professional setting in which most comprehensive nurses from polytechnic courses begin their professional practice and it is therefore the setting in which most of their ideals are brought face to face with reality. The student or new graduate may experience contradictions between the formal and informal expectations of nurses in both education and practice. The structural constraints (such as the relations of power) in the education and hospital settings may produce personal and professional dilemmas for students and new graduates as they seek to develop a professional self. Thus comprehensive nursing education and hospital based nursing practice provide the context for the central research problems of this present study.

In the next chapter it will be shown that research already carried out in New Zealand has concentrated mainly on the process of socialisation of students in hospital schools of nursing, or graduates in a hospital, from a functionalist perspective which places the experiences of these nurses within a given role structure. Reliance upon questionnaires and surveys has tended to objectify the day-to-day actions (and consequences of those actions) that

students and beginning graduates take. Within this perspective such actions are seen as being passive in that they are defined as a reaction to a pre-determined set of role relationships within the already established social structure of the hospital. Neither these role relationships, nor the graduate's relationship to the established power structure in the hospital are seen as problematic. On these counts, then, previous studies are deficient in providing a comprehensive view of the student or graduate nurse's experience in a hospital, and in providing a theoretical perspective which is grounded in data closely tied to the lived experience of nurses. While providing descriptions of the socialisation process, previous studies have not explored the reflexivity of understanding and action as well as the structural constraints of day-to-day nursing education and practice.

In this present study, it is argued that the induction of new graduates into an existing professional culture and hospital structure can be understood within critical social theory. This requires a form of ideology-critique which entails an examination of the actions that students and new graduates take, and the subsequent consequences of those actions, as well as the social relationships they encounter and develop during their education and practice. Chapter Three provides a general outline of critical theory and discusses constructs such as ideology-critique and the application of a critical theory approach for the study of the professional socialisation of nurses.

Chapter Four provides a critical reflexive analysis of the case study material presented in Part Two of this thesis. In this way, the induction of five nurses can be seen to be, in part at least, a political process in which they come to terms with the organisational constraints which shape nursing education and practice.

In Chapter Five the educational implications of this present study are explored. Both the polytechnic experiences and graduate practice are viewed as phases in a process of induction into a professional culture. The graduates' perceptions of their nursing

education and practice are discussed and interpreted in terms of both the intended and unintended learning states engendered by their actual experiences.

The conclusions drawn from this study, implications for nursing education and practice, and suggestions for further research are presented in Chapter Six.

In Part Two, individual case studies of five staff nurses in their first year of hospital nursing practice are presented. This presentation is a synopsis, guided by the interpretive framework outlined in Chapter Three, of the data gathered during indepth interviews held with each graduate over a three month period.

This study is an attempt to go beyond description and explanatory analysis which many previous studies provide. It offers a critical reflexive analysis of the social relationships which influence the actions of five individuals, and of the consequences of those actions, within the context of the transition from nursing education to hospital based nursing practice.

CHAPTER TWO

In this chapter an overview of the theoretical and methodological positions of empirical-analytic and interpretive studies of professional socialisation of nurses is presented. Reference is made to the literature critical of these orientations, and the work of the critical theorist Jurgen Habermas is discussed in relation to the epistemological basis of the social sciences. It is argued that previous studies of professional socialisation conducted within both empirical-analytic and interpretive epistemologies have been unable to address the issues which are central to this study as set out in the previous chapter.

THE PROFESSIONAL SOCIALISATION OF NURSES

Most previous studies of student and graduate nurses in professional settings have been carried out by sociologists and psychologists seeking to illuminate the socialisation process that students and graduates must go through to become accepted members of the nursing profession. Some studies, (e.g. King, 1968; Birch, 1975; Chick, 1975; Miller, 1978; Bezuidenhaut, 1982) have been carried out within the empirical-analytic paradigm in social science and draw upon a body of knowledge characterised by a normative or structural functionalist approach to socialisation where there is a preoccupation with social integration based on shared values. That is, the analyses have been carried out in terms of the motivated actions of individuals - the student or graduate must be motivated to behave in ways appropriate to maintain the profession (or the institution) in a state of equilibrium.

Some studies (such as Olesen and Whittaker, 1968; Chick, 1975; Ramsay, 1978) make use of an interactionist methodology but the theoretical bases to their analyses are carried out within a functionalist framework. For example Olesen and Whittaker (1968) see socialisation as an over-arching process where an individual engages in role learning and becomes adjusted to the culture of a profession. Role theory in interaction does take account of social structures but only as abstract entities peripheral to the

individual's actions and experience. Olesen and Whittaker for example can say little about power, conflict and change, since they see social structures essentially as role structures with shared ideas, cultural values and norms at the centre of social organisation into which new members are socialised. This is similar to a functionalist view where the actions of individuals are governed by functional laws that operate beyond the individual's personal control.

Empirical Analytic Studies

Empirical-analytic social science, (following the tradition of Durkheim, Parsons and Merton) has as its central tenet a conceptualisation of social action which allows it to be analysed according to its observable characteristics - structure, function and adaptive change. Writers within this model assume that in everyday life individual behaviour is regulated by a set of rules which are internalised through socialisation. Therefore interaction is studied in terms of the relation between an individual's dispositions and role expectation, role conflict, conformity and deviance, and sanction processes. Understanding socialisation from a positivist model would allow the researcher to search for knowledge about order and control in the normative sense where the ability of the individual to 'fit' into the organisational structure is emphasised.

Wilson (1971) argues that since interaction is viewed as rule governed, theories within the positivist tradition "require an empirical assumption of substantive cognitive agreement among interacting individuals." This assumption of cognitive consensus - the implicit assumption that people within identifiable subgroups discriminate situations and actions in very nearly the same way - is an essential element in empirical-analytic social science.

A second essential element is that explanations of patterns of action should follow the deductive model characteristic of the natural sciences. The researcher explains empirically described 'facts' by demonstrating that they can be deduced logically from theoretical premises in conjunction with given empirical conditions. These conditions are then part of the social

phenomenon under study and are taken as established and not problematic for the research being undertaken.

From the mid-nineteenth century until relatively recently, empirico-analytical social science has been accepted as intellectually and academically respectable in determining criteria for legitimate knowledge.

This position has been challenged by many writers, mainly because it does not clarify value choices inherent in conceptualisations of human social life. The influential critical theorist who has most recently challenged the epistemological foundation of the social sciences is Jurgen Habermas (Fay, 1975; McCarthy, 1978; Held, 1980; Thompson and Held, 1980).

Habermas (1971) claims that science cannot be understood merely as a formal abstract system but as a product of concrete social activity in that it presupposes human interaction and language. He suggests that there are three knowledge-constitutive cognitive 'interests' each expressed in a distinct methodological approach to the generation of knowledge. The first cognitive interest is a 'technical interest' incorporated in the empirical analytical sciences; the second is a 'practical interest' grounded in human interaction and the intersubjective meanings of social activity; and the third cognitive interest is an 'emancipatory interest' grounded in the human capacity to act naturally and to reason self consciously.

As Habermas (1971) emphasises, natural scientific knowledge contains knowledge about reality from the perspective of a particular knowledge-constitutive interest: technical control. Therefore such knowledge cannot be 'value-free' since it takes the form it does from the value attached to mastery of the environment. A social theory modelled on empirical-analytic science, then, will be a 'technical' science and inherently manipulative but the 'objects' of manipulation will be people rather than non-human nature. Of course, it is possible to understand human activities that are causally produced, in an objectified manner. For example, nurses understand the relationship between altered physiology and illness behaviour (a person with an infection may indicate in

various ways that she has a raised temperature) but a positivistic view can only produce knowledge about mechanistic action, (infection results in raised temperature) rather than about human action - the intentions, desires and 'felt needs' of people (what meaning the infection and raised temperature has for the life of the individual).

Studies of the professional socialisation of nurses in the structural-functionalist tradition have had, necessarily, two major focal points - (1) the hospital or health care institution, and (2) the role development of the student or graduate nurse.

Commonly hospitals, for instance, are seen as bureaucratic organisations (Simpson, 1970; King, 1978; Miller, 1978) based on the principles of tasks which are segmented and routine, and external controls in the form of rules and supervision to ensure rationalisation of performance. From this perspective the researcher is able to separate descriptive 'facts' about the student from the student's own reasoning or understanding about her personal and professional world.

The socialisation of students and graduates has been seen in terms of role change - the individual must change to meet the demands of the bureaucratic organisation and in doing so experiences role conflict, role deprivation, and role ambiguity. For example, Miller (1978) emphasises role conception in her analysis of professionals in bureaucratic organisations:

> ... professionals can be expected to experience incongruities between their professional role conception and the bureaucratic demands of the organisation which lead to them experiencing role deprivation.
>
> (Miller, 1978:11)

This incremental notion of role is further emphasised by Olesen and Whittaker (1968) as they point out -

> In part, the variegated aspect of professional socialisation may be understood in the light of ever increasing role demands of the student.

and -

> ... in the multiple roles involved in the process and the variegated quality of the occupants' roles, we may infer that the student's progress in becoming a professional may be continually problematic ...
>
> (Olesen and Whittaker, 1968:12)

This structural-functional approach to the notion of role traces the way the sharing of norms and expectations creates networks of rights and obligations which individuals must internalize to become accepted by both the profession and the organisation. In this way the social world of the hospital is self regulating and the actions of nurses within the hospital can be seen as reflexes of this self regulating mechanism maintaining the order and cohesion necessary for efficient functioning.

Role, (first defined by Linton (1930) then described in the classical works of Parsons (1967) and Merton (1968)) has become an increasingly complex concept - from the fundamental notion that role is a set of social expectations of behaviour of people occupying certain positions, to the notion that an individual's social being depends upon the successful internalisation of the normative behavioural requirements attached to a position in a social group. Coulson (1972) suggests that at the most general level, role theory implies a sociological view which relates individuals to societies in terms of a process of adaptation - an individual is moulded to perform in ways which 'society' has determined. This reification of both 'role' and 'society' emphasises the notion of consensus about the content of roles, and obscures the evidence of dissensus, conflict and maladaptation while still maintaining the validity of the concept. Further, this reification allows the idea that existing patterns of behaviour within particular positions are inevitable. Miller (1978), for example, is able to say:

> it is not until they enter as graduate nurses that they are faced with the realities of the discrepencies between the idealised professional role they learned as students and their new role within the bureaucratic structure of health agencies ...
>
> (Miller, 1978:2)

Her assumption seems to be that the graduate must conform to a predetermined set of role expectations and furthermore, that there is a tacit understanding as to which set of values, beliefs and knowledge the new graduate must acquire (in order to move from student to graduate) to become a fully functioning member of the profession within the organisation.

The methodology used by researchers in these studies of professional socialisation has been, necessarily, hypothetical-deductive (as in the natural sciences) and, therefore, quantitative (the exception being Olesen and Whittaker's study) using questionnaires and surveys to measure attitudinal responses and changes. Olesen and Whittaker (1968) (and Chick (1975) to some extent) used qualitative methodology in an attempt to analyse the perceptions of their subjects. Their findings have been interpreted within a deterministic theoretical framework and demonstrate the conceptual gap between theory and practice which this framework exemplifies. (For example, the notion of 'role' is used in both of these studies to describe behaviours set apart from the student's understanding and control over her political situation. The process of socialisation is to 'encourage' the student to 'acquire' those sets of behaviours which will allow her to assist in the maintenance of existing organisational structures).

The Interpretive Tradition

While the empirical-analytic tradition has dominated studies of the professional socialisation of nurses, there has also been a strong tradition of interpretive studies. These studies have attempted to explore the intuitive, creative and experiential aspects of learning and practice, which the positivistic studies had tended to consider incapable of rational explanation.

Studies of the professional socialisation of nurses undertaken in the late 1970's and 1980's (for example,those reported by Davis, Kramer and Strauss, 1975; Buckenham and McGrath, 1983; Field, 1983) reflect the movement in social science towards the interpretive paradigm. 'Interpretive social science' is a generic term which includes a variety of positions.

In general, one of the main steps to the analysis of social phenomena is that of 'rendering intelligible' the subjective basis on which it rests. When social phenomena become involved with human subjective ends, they take on meaning and become elements within social action. For example, an artefact such as a monitor in a coronary care unit can be 'understood' only in terms of the meanings it has for the patient attached to it, the nurse who operates it, and the doctor who bases his treatment upon it. Thus, the basic assumptions about people, society and socialisation in this paradigm, shift emphasis away from a conforming individual in a rule governed culture, to an individual actively interpreting social action within her own awareness of the situation. The socialisation process has an essentially interpretive significance which evolves and changes over time, and although human behaviour is patterned, such patterns are understood by the individual in terms of previous experience and present meanings.

Fay (1975:73) suggests that one of the major tasks of an interpretive social science is to discover the intentions which actors have in doing whatever it is they do. The researcher is able to demonstrate reasons why a particular action was performed with reference to the aims, cognition and social setting of the actor. Qualitative research within the interpretive paradigm begins with the fact that a large part of the vocabulary of social science is composed of what Fay calls "action concepts" which are used to describe behaviour which is done with a purpose. Such concepts require more than just observation to be explained.

The explanation with the field notes from Davis Kramer and Strauss's research in a paediatric unit offer a good example of how a researcher may come to learn what meanings to attach to observed behaviour.

> These pediatric unit field notes tell us that the researcher observed two nurses in "deep conversation". The identity of one nurse is easily established by the tag on her uniform reading "Head Nurse". The researcher inferred the identity of the second nurse from a variety of cues; for example, about her appearance, "She looked very tired, harried, and harassed";

> the time of day, "It was 8:15 a.m." Since this observer already knew that the night nurse was supposed to be off duty at 7:30 a.m. she assumed (and checked out later) not only that this was the night nurse but that her late departure signalled that something was amiss.
>
> Further in the field notes we learn that during the night a child had died. The emergence of that piece of information begins to explain the observed tense interaction between the two nurses and the night nurse's late departure.
>
> Since the field work situation provides many more cues to what the observed action means, the opportunities for correction and refinement of observations are maximized. This method is in contrast to other research methods where meaning must be inferred from a single item of behaviour, such as the answer to a questionnaire item or the response to an interviewer's questions.
>
> (Davis, Kramer, Strauss, 1975)

Studies of the professional socialisation of nurses undertaken in the late 1970's and 1980's reflect this movement in social science towards the interpretive paradigm. Some of these studies (e.g. those reported by Davis, Kramer and Strauss, 1975; Thomson, Kinross, Chick, 1977; Field, 1983) have taken a phenomenological approach and deal with the individual perception of nurses in different practice areas. Other studies (e.g. Olesen and Whittaker, 1968; Buckenham and McGrath, 1983) have been based within a symbolic interactionist tradition. The well known generic study "Boys in White" (Becker, Geer, Hughes and Strauss, 1961) was based within this tradition. The principle origins of this theory can be found in the work of G.H. Mead (1934) but most contemporary sociologists have become acquainted with Mead's work through the teaching and writing of one of his students, Herbert Blumer.

Blumer (1967) identifies three premises basic to symbolic interactionism

- The human being has a self and acts towards

things on the basis of the meanings that the things have for that self.

- Human action is constructed by that self and is a product of social interaction in human society.
- Human action occurs within a social setting and is modified through an interpretive process.

Thus, symbolic interactionism sees meanings as social products which are formed in and through the activities of people as they act towards each other:

> ... when a person proposes meaningful behaviour he first of all points out to himself the meanings of the things towards which he is behaving. As a result of that self-communication, or interaction with himself, he is able to handle those meanings in the light of his current situation. Thus, the previously derived meanings are not merely applied to a new situation, but, through that self-interaction in the interpretive process, may be transformed or revised to guide the ultimate behaviour.
>
> (Buckenham and McGrath, 1983:29)

Because the person's behaviour is based on her own meanings and interpretations of the situation, it is imperative that the researcher attempts to view the world as the person views it, by adopting the person's perspective. If consideration of the covert aspects of human social behaviour is an integral part of understanding that behaviour, then the methodology chosen must provide opportunities for the investigator to delve into these covert aspects. (Bruyn, 1963).

The central aim of these studies has not been to establish causal explanations for the ability or failure of an individual to fit into the organisation as in the positivist studies, but rather to examine what the situation means to those involved, and by what frames of reference they make sense of their situation. The kind of knowledge gained from this perspective contributes to the understanding of professional socialisation by providing a context

of holism - an understanding of self, of action, and of the particular social setting of that action.

Some social theorists have defended the interpretive position. For example, Habermas (1971) argues that interpretive social sciences offers the second perspective from which social reality may be discovered. His second cognitive interest is a practical interest incorporated in the historical hermeneutic sciences and grounded in human interaction and intersubjective meanings of social activity. Habermas suggests that understanding social actions and social objects arises out of practical life. People are dependent upon being able to be understood by one another both linguistically and in terms of cumulative life experiences (Held, 1980:309). Knowledge claims from this perspective are made from a different methodological framework where the understanding of meaning determines the validity of the knowledge generated.

The interpretive social scientist, then, would seek to generate knowledge which promotes a self awareness and seeks to promote a self critical, but not socially critical, form of enquiry and open, non-distortive communication within a particular social setting. For example Buckenham and McGrath (1983) are able to say:

> As the student learns to adopt the professional attitudes expected of her, she reconstructs her social perceptions to accommodate this altered perspective ... that reconstruction was shown to occur from the very first week, as the student learns and accepts the 'we/them' phenomenon of the health team and patients respectively. From that initial concept of two teams in the hospital world, she begins to learn first her place in the team and then the place of the nursing division.
>
> (Buckenham and McGrath, 1983:102)

Several social theorists suggest that there are two main arguments against the interpretive model. The first has to do with the interpretive theory of social science and the second with how theory is related to practice. Firstly, then, interpretive social science does not provide a means of investigating the structural

factors which give rise to and support the meanings of particular actions. Furthermore, this model neglects an explanation of the pattern of unintended consequences of actions - a feature which, by definition, cannot be explained by referring to the intentions of the individuals concerned. It must include some reference to the social structures which constrain the alternative forms of action that are available. As well, and (for the purposes of this present study) most importantly, the interpretive model is inadequate in that it does not provide a way for the social scientist to understand structural conflict within a society, or the material conditions of a society, because it can only produce knowledge about a particular social setting based on the actors subjective interpretation of that setting. It neglects questions about the origins, causes and results of people adopting certain interpretations of their actions and social life and neglects the crucial problems of social conflict and social change. In accepting the participant's account the researcher may be in danger of neglecting the significance of the relation of power, and the political interests of people within the participant's social world. That is, what people do may not always be done for the reasons they give, but deeper, underlying socio-political forces in society (of which they may be unaware) may mediate what they think and do. (Fay, 1975; Bernstein, 1976; Reason and Rowan, 1981).

A second criticism of the interpretive model is that it inadequately relates theory to practice on two counts:

Firstly, an individual's identity as a person is tied to the particular world view of his group and the beliefs which are rooted in that world view. Therefore, competing interpretations of what that individual is doing may be seen by him as personally threatening or even ridiculous. A person's ideas about herself are never merely true or false but are ways of coping with the social and natural conditions of her life so that any theory which attempts to change the practice of individuals through the presentation of ideas is naive. Secondly, the interpretive model is profoundly conservative because it leads to

reconciling people to their social order. It systematically ignores the structural conflict inherent in social situations and, further, it implies that the source of conflict lies in the individual's interpretation of social situations rather than in the structures and constraints of the situation itself. The interpretive approach cannot help but neglect questions about the relationships between individuals' interpretations and actions, and external factors and circumstances. (Fay, 1975; Bernstein, 1976; Thompson and Held, 1982).

Interpretive researchers, then, are powerless within their own epistemology to change the participant's world because knowledge gained does not necessarily lead to a critique of the social situation but may lead to continuous new knowledge. The problem situation remains but knowledge is gained about subjective interpretations of the situation. Such knowledge cannot alert graduate nurses, for example, to the nature of the structural and political forces which constrain their day-to-day nursing practice in a hospital setting. It can only demonstrate to them that their nursing practice is constrained by forces apparently beyond their control.

Summary

This chapter has provided a brief, but critical overview of the theoretical and methodological orientations of some of the studies on the professional socialisation of nurses. Some of the major deficiencies of the structural-functionalist and interpretive perspectives were highlighted, including the inadequacies that these approaches have in examining the social relationships which influence the actions of beginning comprehensive nurses within a hospital setting.

Following this review, the next chapter provides a third perspective which allows the researcher to examine not only the meanings of particular forms of social action but also the structural factors that underpin such action.

CHAPTER THREE

This chapter begins with an explanation of the nature of critical social theory. Discussion then moves to the application of a critical theory approach for the study of the professional socialisation of nurses. Following this discussion, the principles entailed in the case study method that is employed in this research are outlined. A rationale for case study in the context of critical theory is presented and some points are made concerning the limitations of case study research.

CRITICAL THEORY - A GENERAL OUTLINE

The emergence of a critical theory tradition within the philosophy of social science has added another dimension to the study of professional socialisation. This tradition,which began in the 1920's and centred on the Frankfurt School, has been fully documented by Jay (1973). The influence of the Frankfurt School underwent a revival in the 1950's and the leading proponent of this 'second generation' of critical theorists is Jurgen Habermas (Bernstein, 1976; Fay, 1975; McCarthy, 1978; Held, 1980; Geuss, 1981).

Critical theory combines a form of action theory with a form of structuralist theory but it does not view each of these as dealing with an ontologically distinct area of social reality. Social structures have their origins in human action, not as systems of role structures but as systems built up out of the actions and interactions of individuals in a structural sense. But social structures may come to dominate those who produce them - they may fragment social relationships and oppress and alienate those who live and work within them. People, however, are capable of transforming their environment and themselves through individual and collective action - the creative ability of human action is able to shape the social world.

The intentions and desires of individuals may be socially constrained or redefined by external agencies so that the source of subjective meanings lies outside the actions of individuals. Social

structures,therefore, are as much involved in the production of individual action as they are in forming society. Moreover, since social life and social relationships are processes in that they develop and change, fixed relationships between different social phenomena are not possible. Such relationships are part of a long and difficult process which occurs over time.

By locating present society and views in their historical context, critical theory claims to show that people can create and recreate society. Critical theory, then, is not 'critical' in the sense of voicing disapproval of contemporary social arrangements. The critical character rests with its ability to focus attention on the irrational or oppressive elements within society, elements which take away or destroy people's abilities to make collective rational choices about their lives (Craig, 1984).

Essentially, critical theory is not a body of explanatory theory at all in the traditional sense, but a form of consciousness in which social agents come to realise the conditions for their autonomy, enlightenment, and fulfilment of their interests (Fay, 1975). It could therefore more correctly be called critical theorizing. It is founded on the conviction that human beings are agents and that their behaviour is properly described by action concepts - it does not presuppose an objectified theory of social structure.

As Geuss (1981:2) points out, critical theories have essentially three distinguishing features. They guide human action in that they enable people to determine what their true interests are (they are inherently emancipatory); critical theories have cognitive content (they are forms of knowledge); and "critical theories differ epistemologically in essential ways from theories in the natural sciences. Theories in the natural sciences are 'objectifying'; critical theories are 'reflective'." That is, critical theory presupposes interaction between theory and subject.

In these terms, then, a critical social theory "is a reflective theory which gives agents a kind of knowledge

inherently productive of enlightenment and emancipation" (Geuss, 1981:2). This form of social science would seek to illuminate social relationships which influence the actions of individuals, and the consequences of those actions, within a particular social context. Thus in the study of professional socialisation a critical theory would be as concerned with the conditions in which individuals exercise their choices as it would be with the effects of their actions on the established structures of the institution or the particular profession.

Fay (1975:94) explains that the critical model begins from the premise that social theory is inter-connected with social practice "such that what is to count as truth is partially determined by the specific ways in which scientific theory is supposed to relate to practical action." Truth or falsity of the critical theory will be partially determined by whether it is, in fact, translatable into practical action.

When it is construed in this way, a social science can acquire a critical dimension by being grounded in the experience of individuals and by seeking to provide a means by which they can conceptualise their situation. It can explain why the conditions they find themselves in may be frustrating to them, and it offers a programme of action which is intended to reveal a natural way of going about getting what they really want. The translation of theory into practice necessarily requires the participation and active involvement of social agents since the theory can only be validated in the self understandings of the agents themselves. A critical model of social science, then, "does not simply offer a picture of the way that a social order works; instead, a critical theory is itself a catalytic agent of change within the complex of social life which it analyses" (Fay, 1975:110).

Critical theorists in the Frankfurt School tradition accept both the interpretive categories of social science and the necessity of empirical validity since, in order to understand the subject matter at all, the theorist must attempt to understand the intentions, desires, and social conditions of the agents she is observing, from their point of view. The methodology accepted within this model, therefore, is necessarily qualitative (e.g. case study, participant observation, ethnography) since such methods have a sensitivity to

meanings and values of the participants, as well as an ability to represent and interpret practices, activity, creativity, and human agency, and allow these to come through in the analysis of the object of study (Willis, 1977). Quantitative analyses may be employed but they will always need to be complemented by an interpretive approach.

It is the combination of interpretive with empirical validity which gives critical theory its unique methodological strengths. Nevertheless, there are some limitations which have been pointed to within the literature. The most common general criticism is that critical theory is 'empty speculation' - that it has little foundation in the real world; that it cannot be confirmed or refuted by observable criteria; and that its generalisations are abstract and speculative. Some credence has been given to these criticisms within critical social science and, although it is not appropriate to fully discuss all of these criticisms here, there is an underlying issue which is important in the context of this study. As Bernstein points out:

> the very idea of practical discourse - of individuals engaged in argumentation directed towards rational will formation - can easily degenerate into a 'mere' ideal unless and until the material conditions required for such discourse are concretely realised and objectively realised. Habermas does not offer any real understanding of how this is to be accomplished ... in the final analysis the gap still exists ... between the idea of such a critical theory ... and its concrete practical realisation.
>
> (Bernstein, 1976:22)

Bernstein has identified a difficulty inherent in Habermas' work - the *use* of critical theory in real social action - the praxis of critical theory. The conception of human action, or praxis, remains very general and the critical theory approach does not always provide the conditions by which criticism can develop in a practical direction and produce emancipatory action. Nevertheless others (e.g. McCarthy, 1978; Geuss, 1981) have argued that critical theory does have the potential to produce political action within particular social and institutional contexts.

These issues involve complex philosophical arguments but critical social science does have a greater facility than other social science to absorb criticism of this kind because of its inherently reflexive nature. Criticism itself forms a basis for further theorizing and greater clarification of the fundamental premises. As Habermas (1982:219) himself indicates, the complexity of the growing volumes of criticism not only provides a penetrating analysis but also contributes to the continuing development of critical social science.

CRITICAL THEORY AND PROFESSIONAL SOCIALISATION

The central claim of this thesis is that the induction of new graduates into an existing professional culture and hospital structure can be understood within a critical theory perspective. This requires an examination of the actions of graduate nurses and the subsequent consequences of these actions, as well as the social relationships they encounter and develop within the hospital. Such an examination, within the context of a critical social theory, can be based on four separate but inter-related theoretical constructs: the relations of power, emancipatory knowledge, hegemony, and ideology critique.

Relations of Power

In both empirical-analytic and interpretive social science the concept of power has a behavioural focus and, incorporated into the analysis of power relations, are questions of control, authority and consensus. This view of power serves to reinforce theories of social integration based on shares values, and disassociates it from conflicts of interest, coercion and force. A number of studies reviewed in the previous chapter have construed power in these terms.

Lukes (1974) however focuses attention on the more subtle uses and less direct effects of power. He asks:

> ... is it not the supreme and most insidious exercise of power to prevent people, to whatever degree, from having grievances by shaping their perceptions, cognitions and preferences in such a way that they accept their role in the existing order of things, either because they can see or

> imagine no alternative to it, or because they value it as divinely ordained and beneficial?
>
> (Lukes, 1974:24)

This 'third dimension of power', Lukes suggests, arises from one group's ability to shape and determine people's wants and needs in order to both manipulate events and to influence the socialisation process itself. Rather than researching overt conflict and power-related issues, consideration should be given to potential or latent conflict "which consists in a contradiction between the interests of those exercising power and the *real interests* of those they exclude." This conflict is latent, Lukes explains, "in the sense that it is assumed that there would be a conflict of wants or preferences between those exercising power and those subject to it, were the latter to become aware of their interests" (p.25). Lukes' 'radical view' of power is based in part on the assumption that people are socialised into a system which works against their 'real interests' and that there is a need to ascertain what people would prefer were they given the choice.

For graduate nurses in a hospital practice setting, this means that specific knowledge and beliefs derived from their education may not become part of their hospital nursing practice. These principles and beliefs established during socialisation constitute the 'real interests' of graduate nurses (in that they would prefer to nurse in that way if given the choice). They may then become socialised into the routine practices and procedures of the hospital which may prevent them from using their education based principles and beliefs. In a hospital, organisational practices (such as hierarchical structures, and management of nursing personnel) and routines (such as doctors' ward rounds, and management of patient care) may be used by those who exercise power in the institution to suppress the 'real interests' of those who are subject to that power. Although those nurses who are subjected to power in this way initially may be aware of the contradictions between their education based principles and beliefs and their practice, their wants and needs are shaped and determined through the socialisation process they encounter in the hospital, so that their 'real interests' may be suppressed.

Geuss (1981) in his discussion of what might be meant by the claim that a group of agents is deceived or deluded about its real interests, suggests that agents may or may not have an 'interest' in the satisfaction of their wants or desires.

> If the agents are unaware of some of their needs they may have formed a set of interests which is incompatible with the satisfaction of those needs, or they may have formed a set of interests which is inconsistent or self-defeating, or I may have perfectly good 'empirical' grounds for thinking that the pursuit of their present set of interests will lead them not, as they suppose, to happiness, tranquility, and contentment, but to pain, misery and frustration. If agents are deceived or mistaken about their interests, we will say that they are pursuing 'merely apparent' interests, and not their 'real' or 'true' interests.
>
> (Geuss, 1981:48)

The translation of a critical social theory into practice, therefore, would necessarily require the active participation and involvement of the social agents themselves. People need the opportunity to discover their real or true interests for themselves through critical self reflection. Fay (1975:103) suggests that this is the 'educative role' of social theory in that the critical social scientist attempts to provide the means whereby the actors she is studying "can come to see themselves in ways radically different from their own self conceptions". Through the process of increasing self consciousness, the critical social scientist not only assists the social actors to define their self perceptions differently, but also facilitates an awareness as to which aspects of their social order are repressive and, therefore, provides them with sufficient knowledge and self understanding with which to increase their autonomy.

In the case studies presented in Part Two, five graduate nurses reflect on their education and the first few months of hospital practice. The interviewer, through open questioning and reflective responses, encouraged each graduate to describe her situation as she perceived it and to examine her nursing practice in the light of both her education and her understanding of the organisational constraints within the hospital. In this way, an attempt was made by the researcher (with the active participation of the graduates)

to increase the graduates' self understanding, and their understanding of the social context of nursing practice.

Carr and Kemmis (1983) point out that researchers:

> may seek to discover what it is that causes individuals to adopt certain modes of action by focussing on the way in which certain kinds of social structure constrain particular social groups in a way that limits the range of actions open to them.
>
> (Carr and Kemmis, 1983:95)

This form of explanation seeks to reveal both the constraining conditions of actions through empirical research, and human perception and understanding through interpretive forms of enquiry. In this sense critical theory goes beyond both positivist and interpretive traditions by seeking to unify elements of these approaches rather than setting them in opposition to each other.

Since critical theory is explicitly founded on an awareness of the ways in which certain conditions can generate certain beliefs, ideas and self understandings may be illusions which are necessary to sustain a particular form of living. McCarthy (1978:86) points out that institutionalised power relations bring about a reproduction of behaviour that is removed from criticism as it is based on shared social norms and enforced by unconscious affective mechanisms. The necessity to hold on to established beliefs and practices, even if they are shown to be irrational, may be an integral part of a person's understanding of self, and of her understanding of her social group, so that any attempt to challenge those beliefs and practices is met with resistance.

For example, graduate nurses in hospitals may organise patient care according to tasks to be achieved within a time frame. This kind of organisation may be supported by other hospital routines and practices and may become an unquestioned 'natural' way of providing nursing care. So much so that when questioned, nurses may find it difficult or impossible to conceive of any other way of "getting the jobs done". Nurses, through this socialisation process, may be prevented from perceiving that the issue of providing nursing care for the patient is subsumed by the issue of

tasks to be achieved and may resist any suggestion that this is so even though it can be demonstrated that this kind of organisation of nursing care is irrational.

The problem of resistance is overcome by a coming together of two inter-related factors - an account of the basic changes in a social order, and a theory which makes sense of these changes in terms of the real needs of those who are involved in them. Thus, the theory must offer an account which shows that the social structure will alter in ways which will undermine the appropriateness of the ideologies which people in the structure now hold (Fay, 1975:100). For structures to be transformed by individual agency in this way, the individuals involved must be able to reach the epistemic conditions necessary for emancipatory knowledge.

Emancipatory Knowledge

In the previous chapter Habermas's theory of knowledge-constitutive interests was introduced. It was argued that the technical interest gives rise to an empirical-analytic model of social science, whereas the practical interest gives rise to the interpretive model of social science.

Habermas's third knowledge-constitutive interest is an emancipatory interest. He contends that this third category of knowledge is incorporated in critical social science and is grounded in the human capacity to act rationally, to reason self-consciously, and to make decisions in the light of available knowledge, rules, and needs. (Bernstein (1976:193) suggests that this interest is grounded in power.) The form of knowledge most appropriate to develop the rational capabilities of human beings, Habermas contends, is self knowledge generated through self-reflection. Self reflection includes both rational reconstruction (the ability to suspend every day action and reflect upon it) and self criticism which is directly tied to practice, and is the ability to make unconscious elements conscious in a way which has practical consequences (Held, 1980).

Habermas's "emancipatory interest" is an interest in reason, an interest in controlling technical knowledge and in directing actions towards the realisation of personal and social goals. It is therefore

different from the other two interests. The act of knowing is not immediately connected to the utilisation of knowledge, but provides the impetus to achieve self understanding and autonomy.

Habermas (1971) contends that critical theory is "grounded in a normative standard that is not arbitary but inherent in the very structure of social action and language" (Held, 1980:256). All communication, Habermas argues, is oriented to the idea of a genuine consensus which is rarely realised. That is, there is an 'ideal speech situation' where a consensus is attained which is the ultimate criterion for the truth of a statement or the correctness of norms. As Giddens (1982) points out:

> ... the ideal speech situation is an analytical construct but .... any actual circumstance of communication anticipates it implicitly.
>
> (Giddens, 1982:88)

The conditions for a grounded or rational consensus, Habermas maintains, exist when:

- there is mutual understanding between participants
- there are equal chances to select and employ speech acts
- there is recognition of the legitimacy of each person to participate in the dialogue as an autonomous and equal partner
- and the resulting consensus is due simply to the force of the better argument.

(Held, 1980:343)

Where there is a disparity of social power existing in an interactive situation, conditions exist for a forced agreement based on distorted understanding (rather than a true consensus based on shared understanding.) These conditions may, to a greater or lesser extent, comprise:

- lack of mutual understanding between participants
- unequal chances to select and employ speech acts
- no recognition of the legitimacy of each to participate in the dialogue as an equal autonomous partner
- the resulting consensus is due to social coercion.

These conditions can be referred to as distorted communication which prevents the attainment of a rational consensus.

Habermas' theory of communicative competence has been challenged by many critics who, in general, argue that the only speech situation which would fully meet the 'ideal' would be one in which the participants were completely stripped of all their individual characteristics. As van den Berg (1983:1266) explains anything short of this could always be criticised as distorted since it would entail at least some inequality of discursive skills and hence power relations.

However, Habermas' contention is that people enter into communication, or a speech situation 'as if' optimum conditions for equality of discourse exist. It does not need to exist in 'reality' but rather is presupposed as a 'possibility' in every act of intersubjective communication.

That a rational consensus is rarely realised is not surprising as, in Habermas' view, systematically distorted communication is one way in which the dominance of dominant groups is maintained. As Held (1980:356) puts it:

> The process of emancipation, then, entails the transcendence of such systems of distorted communication. This process, in turn, requires engaging in critical reflection and criticism. It is only through reflection that domination in its many forms, can be unmasked.
>
> (Held, 1980:356)

Therefore, systematically distorted communication, which formulates ideology and assists in its maintenance, can be expected to occur whenever communicative consensus is established under conditions in which disparity of power exists between social agents. This kind of consensus establishes belief systems which maintain their legitimacy even though they cannot be validated when subjected to rational discourse. Systematically distorted communication may be used, deliberately or otherwise, within an institution to produce conformity amongst its members who act on the basis of principles established during early socialisation within the institution.

Instances of systematically distorted communication which ensure that new members conform with existing beliefs and practices within the institution, occur where a consensus is established under conditions of hegemony.

Hegemony

That dominant groups are able to define social situations for the individual may be understood through the Gramscian concept of hegemony which provides an understanding of the social and political nature of the relationships among groups of people. Hegemony refers to the ability of a dominant class or culture to exercise social and political control, and to legitimate that control, through influencing the consciousness of people to accept its particular world-view. Carl Boggs elaborates the concept in the following way:

> By hegemony Gramsci meant the permeation throughout civil society - including a whole range of structures and activities like trade unions, schools, the churches, and family - of an entire system of values, attitudes, beliefs, morality, etc. that is in one way or another supportive of the established order and the class interests that dominate it. Hegemony in this sense might be defined as an 'organizing principle' or world-view (or combination of such world-views), that is diffused by agencies of ideological control and socialization into every area of daily life. To the extent that this prevailing consciousness is internalized by the broad masses, it becomes part of 'common sense'; as all ruling elites seek to perpetuate their power, wealth, and status, they necessarily attempt to popularize their own philosophy, culture, morality, etc. and render them unchallengeable, part of the natural order of things.
>
> (Boggs, 1976:39)

Through socialization, 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. Through professional socialisation student and graduate nurses learn to think and act in ways which are defined for them by the traditionally dominant groups within the health system (such as medicos, administrators and policy makers) and which they

accept as natural, common sense views of social reality. The health institution itself is a hegemonic structure since the ideas, values and beliefs of the dominant groups in society are already embedded in the design of institutions and therefore in the consciousness of those who work in them (Apple, 1979:9). The hegemonic influences which define the nature, limits and status of nursing knowledge and practice act to reinforce the status quo. Hegemony is, therefore, a form of social control where active consent and participation of student and graduate nurses secures their subjection to the existing power relations. Thus, there is no need for coercion or overt mechanisms of control because individuals do not question the legitimation of that control as it has become part of their common sense view of their social world.

Hegemonic structures, however, are capable of transformation by individual and collective action, as Codd (1984) points out:

> Hegemonic structures constrain action, but they also allow transformations to occur because the limits of structure are always capable of penetration by the spontaneous actions of individual agents. Thus the contradictions between agency and structure become a powerful source of counter hegemonic struggle.
>
> (Codd, 1984:20)

One form of counter-hegemony is ideology-critique.

Ideology-Critique

The concepts of power, emancipatory knowledge, and hegemony are closely linked to the notion of ideology-critique, a key concept within critical social science.

Ideology is often taken to mean a system of ideas which legitimates and guides social action. Ideology in this liberal sense, is seen as a neutral description of sets of ideas and beliefs which allow those who hold them as true, to see the world in a particular way and to plan and execute courses of social action. However, commonly held views about the nature of humankind, the position of central values such as health in relation to people and to society, are relative to particular historical and social circumstances and, as such, present the world from a particular point of view and with particular interests at stake.

Ideology, therefore, may be seen as a set of theoretical stances which the individual holds and which involves attitudes, values and habitual responses which are embodied in definite social practices, and which serve to maintain the status quo. It is the means by which a society reproduces the social relations which characterise it. Ideology is created and sustained through definite practices of communication, decision making and productive work which creates meanings for people as they relate to one another in these practices. These meanings maintain their legitimacy even though they could not be validated if subjected to rational discourse.

As Geuss (1981:15) points out, a form of consciousness is an ideology in view of the function it has in supporting, stabilizing or legitimizing certain kinds of social institutions or practices. This "form of consciousness" is based upon a set of epistemic principles - a set of "second order beliefs about ... what kind of beliefs are acceptable or unacceptable and how these beliefs can be shown to be acceptable or unacceptable." (Geuss, 1981:60) A person's epistemic principles (which may be shared with her social group) allows her to develop a particular understanding of her social world and a way of legitimizing social practices within that world.

Through professional socialisation, a graduate nurse may be induced to take on a perspective of nursing knowledge and practice which is contrary to the epistemic principles she held as a student. The nurse cannot help but legitimate that perspective because the hegemonic nature of the institution prevents her from reflectively analysing or even discussing it - it is already defined for her as legitimate. The graduate would then, necessarily, adopt a different set of epistemic principles, which, if it were possible to engage in impartial and rational discussion and debate with nurses and others in the health system, would be shown to be reflectively unacceptable to her. Professional socialisation is hegemonic because it produces a particular world view and a relatively rigid set of behaviours based on that world view. Ideology-critique is a means of exposing the hegemonic nature of professional socialisation.

Ideology-critique is the demonstration of exactly in what ways the "ideologies of the social actors are illusions, with the idea that such a demonstration will strip these ideologies of their

power ..." (Fay, 1975:98). An 'illusion',Geuss (1981:39) explains, is a belief which may or may not be false but holding this belief satisfies some wish the agent has. The beliefs and attitudes that graduate nurses hold may be incoherent because they are internally contradictory, or their self understandings may be deficient because they fail to account for their everyday experience. Ideology-critique is one means by which these discrepencies and contradictions between a graduate's 'form of consciousness' and the conditions of her social world, are able to be made explicit. Ideology-critique may produce transformation of practices of decision making, communication and productive work through the promotion of mutual understanding, consensus and collaboration. In the case studies the interviews represent an exploratory attempt at ideology-critique.

In the case studies presented in Part Two, the dominant ideology will be revealed in relation to the ways in which graduate nurses cope with the contradictions in their daily practice. These contradictions, which are brought about through the pattern of power relations existing in hospitals as institutions, emerge as issues at the individual level because they prevent the graduate from perceiving the external constraints that limit options for practice. The graduate is forced into situations in which options for practice are contradictory.

Case Study Method

In critical social science, theory and method are closely inter-related. Since critical theory places present social action and relationships within an historical context and focusses on the individual's understandings and interpretive acts, it claims to investigate not just social institutions and practices but also the beliefs people have about their society - the social knowledge which is part of their social reality. While critical theorists accept the broad approaches of the interpretive tradition, they move beyond them in that they attempt to explicitly link theory and practice. Whereas the interpretive approaches accept the separation of persons as researcher and subject, critical social theorists see this separation as alienating. Researcher and subject should work together in order to develop theories that allow them to better

understand, and ultimately to transform, the conditions of their social world (cf Reason and Rowan, 1981).

Case study research involves "the study of an instance in action" (Adelman, Jenkins, Kemmis, 1982:7) and uses a variety of techniques held in common with the wider traditions of sociological and anthropological enquiry - types of observation, interview, field notes, and document recording. Sociological case studies of schooling (e.g. Sharp and Green, 1975; Willis, 1977) have used a combination of these techniques to relate micro-studies of school processes to the more traditional macro-concerns for the relationships between schooling and the broader structural features of society.

Case study, however, is not just concerned with micro-processes and single instances. When both rigour in terms of data collection, and a theoretical framework within which to make sense of the data is used, the understandings generated by case study are significant in their own right. Case studies are concerned with complex conduct (notions of intention, reflection and judgement) not covered by 'laws' in the natural science sense of the term. Case study allows the critical analysis of a series of human judgements as a way to knowledge which stands alongside the measurement of variables.

Rationale

Case study is one form of research, based upon particular theoretical, ideological and ethical commitments of the researcher, which may contribute to what Habermas (1974) refers to as "sciences of social action" guided by an emancipatory knowledge-constitutive interest. As Kemmis (1982) suggests:

> Case study research is both political and strategic in the sense that authentic insights reached through case study have the capacity to work reflexively to change the particular situation studied. The action-possibilities created by case study are grounded in the situation itself, not imposed from outside it. Case Study is thus emancipatory.
>
> (Kemmis, 1982:93)

Case study is dialectical, and therefore an educative process, in that it offers insights into the 'lived experience' of people

in particular situations and,through assimilation into current knowledge and perspectives, makes a reflexive contribution to social life. Kemmis suggests that case study is dialectical in the sense that:

> the dialectic is often intended to be quite explicit in the report of the study. That is, the case study worker will argue the nature of the case and the formation of his interpretation from his observations rather than ... the experimentalist who, in a particular study, may treat certain of his theoretical and observation-categories as <u>given</u>.
>
> (Kemmis, 1982:82)

The case study worker must make the dialectic explicit by constructing the case through describing each study. In the five individual case studies presented in Part Two, this is achieved through a careful selection of excerpts from the full interview transcripts. Each report creates the conditions under which the reader can recreate the case in imagination, bringing into play what Polanyi (1958) refers to as "subsidiary awareness of particulars" - the "tacit" knowledge that has been built up in the reader's awareness of social and professional life.

Case study is 'naturalistic' science, in that it is "as much a search for phenomena in the social world as it is an attempt to develop coherent theories about those phenomena within particular social contexts" (Kemmis, 1982). The case study worker studies the context or situation as a whole - she cannot create the situation she is to observe. Part of that observation is to treat the situation itself as problematic not 'given' - the observation process inevitably uses the personal, cultural and perceptual frameworks of the observer or interviewer. In this study these frameworks have been shaped by the critical theory perspective that is outlined in the previous pages.

Interpretive descriptive case study research is used here because this form of case study is most concerned with the relation of theory to practice (Stenhouse, 1982). The interpretive element in this research is used to provide a critical explanation of human action such that the social/professional situation of each individual subject

may be the focus of rational discourse. The validity of interpretation is achieved by informed judgement, not by proof. The descriptive element (discussed above) recreates for the reader the social reality of the participant's world and, when presented as an analytic narrative, allows the reader to speculate about causes and effects by providing a basis for alternative interpretations. At the same time, the author has provided a conceptual framework drawn from critical theory in which the concepts under study are anchored.

Stenhouse points out a dilemma facing case study workers. They somehow must decide which conception of reality the case study is going to reflect:

> The sort of issue involved can be illustrated by contrasting two typical viewpoints. In one of these reality can be seen as factual, or at least consensual .. From another viewpoint there are multiple realities, for the world in which reality is to be located is that of the perception of participants and the meanings they ascribe to them.
>
> (Stenhouse, 1982:30)

This present study employs a combination of these two viewpoints - the participants accounts are not 'real' in the sense that they are viewed as holding some 'false' beliefs, yet the accounts are 'real' in that the participants share a common understanding of the actions and events around them. This position is consistent with the theoretical groundwork on which the interpretive account is built. The social structures and power relationships are real and have real effects upon the participants, including their perceptions of these same structures and relationships.

Limitations of Case Study

Limitations of this research relate to both theory and method. Firstly, case study typically builds upon the study of single settings or occurrences and treats each case as empirically distinct. The purpose of case study is neither to verify covering laws nor to produce inductive generalisations. This type of research "does not presume therefore that different cases can automatically be thrown together to form a homogenous aggregate" (Hamilton, 1982). Because of this it is widely believed that case studies are not a suitable

basis for generalisation. In this view 'a case' is thought of as a single instance which cannot represent a whole population. However, as Stake (1983:59) points out, case studies provide both analogies and examples so that "as readers recognise essential similarities to cases of interest to them, they establish the basis for naturalistic generalisation."

Secondly, a critical theory approach should allow the researcher to become an "agent for change" and the participants to "see themselves and their actions differently " (refer p28). Because of the artificial boundaries of this study this claim was not fully tested. While it was possible for the participants to discuss and reflect upon their education and practice, a longer time period would be required for research into the kinds of personal and structural changes the participants made.

A further limitation of case study is the problem the researcher faces in maintaining 'critical detachment' or objectivity. It is difficult for the researcher not to become involved in the personal and professional lives of the participants.

Summary

Critical social theory and case study method offer the researcher an opportunity to move beyond the level of description and explanatory analysis in order to develop critical reflexive analysis of the political nature of professional socialisation. This provides a necessary corrective to the passivity of a social science limited to interpretive accounts of social action. Critical theory offers a means by which the researcher becomes a part of the social world of the people under study and therefore an agent for change.

Research into the actions which beginning nurse practitioners take as they seek to make sense of their personal and professional social worlds would attempt to address such questions as:

1. How are the 'real interests' of beginning graduates formed?
2. Are these 'real interests' in conflict with the established beliefs and practices of the hospital and health care institution?
3. Are there individual groups who exercise power, in the

insidious way Lukes suggests, to suppress or manipulate the 'real interests' of beginning graduates?

4. How does the beginning graduate reconcile her experience in the hospital with the epistemic principles she developed during her education?
5. To what extent does the institution use "systematically distorted communication" to produce conformity?
6. To what extent do beginning graduates "learn to tolerate, or conform, or let things go by default" (Ramsay, 1978) in order to survive personally and professionally in a hospital setting.

These are the questions which have provided the interpretive framework for the present study comprising five case studies of graduate comprehensive nurses during their first year of professional practice.

In contrast to the chronological order of the case studies presented in Part Two, the following two chapters provide a critical reflexive analysis of the graduates' perception of their experiences over the past four years. In this way, the continuity of social structures in the polytechnic and the hospital is demonstrated in contrast to the disjunction in knowledge and beliefs of five individuals as they reflect on their experiences in education and graduate practice.

CHAPTER FOUR

This chapter provides a theoretical analysis of the case study material presented in Part Two. It draws together the theoretical issues discussed in Chapter Three and the reflections of five nurses, then in their first year of professional practice, as they report on their perception of their education and hospital experiences which are outlined in Part Two.

The constructs of ideology, hegemony, relations of power, and distorted communication discussed in Chapter Three are critical elements in the descriptive and interpretive underpinnings of the analyses in this chapter. In this way the induction of these graduates can be seen to be, in part at least, a political process in which they come to terms with the organisational constraints which shape nursing education and practice.

THEORETICAL ANALYSIS

It is argued that the graduate nurses in this study became a part of an ideological consensus both during their education and within the hospital. They were 'persuaded' in various ways to take on the beliefs, attitudes and practices which were a taken-for-granted, natural or common sense part of nursing education and practice and which were legitimated by those with more power. This persuasion occurred, not as a result of individual agency, but because of the structures within which these graduates developed their professional practice. For example, routine practices and procedures often appeared to be inconsistent with the beliefs and knowledge these graduates had developed about themselves and about nursing practice during their education. These graduates also received many direct and indirect messages from tutors and senior staff about skills, efficiency, 'reality', the comprehensive course, and how they, and their work, were seen.

In each of these situations the disparity of power between the graduates and other agents, enabled the 'persuasion' toward ideological consensus to be effective. That is, through routine practices and procedures and taken-for-granted explanations, these

graduates were constrained to believe that what they understood and experienced in the hospital setting was *a priori* 'excellence' in professional nursing practice.

Although contradicting in many respects their educational ideals of 'excellence' they were constrained to believe that hospital practice was the approved and proper way. Because these beliefs prevented any serious challenging of the hierarchical social structures, this can be construed as a form of social control. As a result of this ideological consensus these graduates came to understand what actions they must take in order to be seen by themselves and by others to be competent members of the ward team. These actions were based on particular beliefs about the nature of their positions as students within the education system and as staff nurses within the hospital, and on particular beliefs about the nature of nursing itself.

As beginning staff nurses, these graduates entered the hospital with the knowledge that they were, in a sense starting in an institution all over again. They had become comfortable in their knowledge of 'the system' at polytech and, although they had experienced nursing practice in the hospital as a student, they were aware of their lack of knowledge of hospital practices and procedures.

Each graduate (except Karen) explained the misunderstandings between the tutors and themselves, the inequality of the communication act itself, and their perceived lack of autonomy as contributing to the realisation that they must conform, or at least acquiesce, in order to complete the course. The conditions of self blame, the feelings of personal inadequacy, mask any recognition of what could be changed within the organisation.

Karen participated unintentionally in her own domination both as a student and as a graduate. She readily accepted organisational structures (p167) and accepted the structured learning situation as a personal challenge - success was objectified in the form of a test mark (p168) and her professional self image was derived from comparison with others on test results. For Karen this sense of

measuring herself against others was so deep seated and pervasive that it prevented reflexivity in the interview situation. Even there she saw the interviews as a situation in which she was compared with others and judged (p204) It also influenced her ability to feel competent as a staff nurse in her ward. When there were no longer any measurement devices except those derived from her own and others'subjective judgements, she began to despair that she would ever feel, or be seen as, competent.

> *And you are expected to measure up - it's all very well to say they have had a different education - it sounds fine, but when you are out there in the whole cold reality of the ward that's what you are expected to perform to - to measure up to and be like them.*
>
> (Karen, p206)

As well, during their education four of these graduates reported that they had difficulty in seeing themselves as "nurses". They saw themselves as students. For example Mary (p147) explained:

> *(You feel committed?) I do. Yes. (But you didn't as a student?) No, you had nothing to be committed to really. You were out for yourself in a lot of ways whereas like now you're part of that ward - you are part of the people in it - like if I decided not to go one day I'd be letting them down - because of the fact that they might be short staffed - have to work harder - although they get someone in for the day or else a lot of the time with your patients - they say what duty are you working tomorrow - and you'd feel really awful - you'd feel as though you were letting the patients down.*
>
> (Mary, p147)

Although each graduate reported she was often more 'in control' as a staff nurse than she was as a student, instances of ideological consensus similar to those in her education were evident. The conditions for this consensus arose from two sources - the relative positions of these graduates in the nursing and hospital hierarchical organisational structure, and their educational background. Each of the graduates was well aware that she was a beginning practitioner entering into nursing practice which was well established within the hospital. Each graduate was also aware that she was 'new' - indeed Karen in particular felt 'new' for the first six months. This

experience of newness was both an excuse for the graduates - (they could not be expected to know) and a hindrance (they had no opportunity to be autonomous in their own practice).

The graduates in this study were often unaware of the contradictions inherent in their day-to-day experiences. Indeed, in many instances, the graduates became aware of contradictions and inconsistencies in their education and practice through critical self reflection during the course of these interviews. For example, Cathy (pp216-220) realised at the time of interview that much of the curriculum had no direct link with practical expectations:

> *It seems a very unreal kind of nursing that you are taught at tech which in practice can't be done because of how it is in hospital - short staff and time pressure ..."*
>
> (Cathy, p219)

Alice (p118) stated many times that she found the interviews uncomfortable because she was asked to reflect upon what, to her, was unsatisfactory nursing practice:

> *You know how you start working in the clinical area full time and you have - you have got to conform to sort of try and fit in with everybody else and get to learn how they do it and how they like to have things done, and you forget - you just push it to the back of your mind, what you've been taught at tech, the standards and the practices that you have been taught, while you are trying to adapt .... when I come here I remember all those standards and things, and I start thinking and try to apply them back at work.*
>
> (Alice, p118)

Mary (p159) realised that she had become 'task-oriented' in relation to the nursing care in her ward:

> *Last week I went away and I thought about what we had talked about and I think it has made me more aware ... of what I'm doing and what my actions are.*
>
> (Mary, p159)

These examples illustrate the way in which ideological hegemony masks contradictions between theory and practice. As students, the

dominant ideology of their education forced these graduates to think of theory and practice as distinct. For example, Cathy (p220) said that her education:

> *... does give you an idea of what the ideal kind of nursing should be. Like when you spent hours and hours doing nursing care plans and sometimes they used to end up about 8 pages long, and some of the little things like that you used to write in just to make it appear good - (To the tutor?) Yes, and to get that bit higher mark.*
>
> (Cathy, p220)

At the individual level, common sense defines the boundaries of practice by determining the possibilities for thought and action. But what is accepted and legitimated as 'common sense' meanings and practices is determined by those with the power to shape the consciousness of others. Therefore during their education and within the hospital neophytes would be disposed to accept as common sense, explanations given by tutors and senior nurses, and well established practices and procedures. In this way theory (comprising principles emphasised in their education) can be seen as 'idealistic' and practice (comprising what was expected of them in the ward) can be seen as 'reality', thus producing a distorted separation of theory from practice.

There were, however, three specific areas of concern to graduate nurses, highlighted by all the graduates who demonstrated varying degrees of awareness of the underlying contradictions in their practice. These areas related to professional conduct, giving medications, and task management. Underpinning each of these areas are three inter-related aspects of ideological hegemony, (1) the tension between structure and agency, (2) the unequal relations of power between social agents, and (3) systematically distorted communication. Each of these aspects of ideological hegemony is discussed below with reference to the theoretical position set out in Chapter Three, and as it relates to the concerns of the graduates in this study.

Professional Conduct

Each graduate reported instances of perplexity as she attempted to make sense of her personal and professional relationships with

tutors and colleagues. Although education and practice can be seen as separate stages of the graduate's experience, the kind of understanding of, and beliefs about, nursing and inter-personal relationships which produced conformity during the education phase, is analogous to the beliefs and principles developed during initial socialisation as graduates. That is, the kind of experiences these graduates had as students prepared them to accept more readily the structures and constraints they found on entry to hospital practice. Many times when the graduate attempted to use personal or professional judgements within a specific context, about which were appropriate attitudes, values and beliefs to hold, she complied with those which she perceived to be desirable by people who held the power to determine her future.

(1) Learned Expectations

The assessment of 'professional behaviour' constituted a large proportion of the student's educational preparation for practice, partly because it is a major criterion for registration. (see p7) The assessment of professional behaviour is difficult, however, since it generally relies upon subjective judgement and upon the contextual conditions in which it is assessed. All the graduates in this study had difficulty in defining what was 'professional behaviour' and all relied upon context for their explanations. For example, Mary explained that professional behaviour meant meeting acceptable standards:

> *I think we had two or three sets of standards - one was what Polytech wanted us to maintain ... and to the staff of the hospital ... and to the patients ... I think the hospital standards (had) more leeway ... you were there for eight hours ... they could look at things that happened in a context of a day or a week and they saw it differently (than) a tutor who came into the ward for half an hour and saw something happen and reacted to it.*
>
> (Mary, p142)

Each graduate reported many instances of receiving incongruent messages about herself as a person and about her professional development. In some instances these messages were explicit (e.g. Mary, p149, Cathy, p221, Alice, p99) and in others they were implicit within the context of the situation (e.g. Alice, p124 and Jane, p257). Although this communication occurred with, in many instances, only one tutor or senior nurse within a specific

context, the graduates perceived that communication as being supported by 'the system'. That is, they understood that they were not dealing with one individual but with the profession and/or the institution as a whole.

For example, Alice throughout her education received many messages that her classroom behaviour was unacceptable but she could not discover what was wrong and began to question her personal acceptability. She could not doubt her competence, so began to doubt her 'personality'.

> *... all my clinical reports were good. My class ones weren't so good ... I had a negative attitude... I think I felt they were judging me ... me as in my personality.*
>
> (Alice, p98)

Alice's experience exemplifies the way in which distorted communication produces conformity. She took responsibility herself for what were external constraints produced by the social relations within the education system. For example:

> *(Did you ever find out from anyone what the difficulty was?) No, not really. I just came to my own assumptions. (What were they?) Probably that I was talking out too much and that I wasn't looking interested enough and - I have got an emotional face apparently - everything that I think goes across my face so I tried to restrain that as much as I could but it was pretty hard after 19 years of doing it. (Was that a strain for you - did you like classroom work?) No it was a strain. Because I wasn't being myself. (You were conscious of that?) It was overwhelming - you thought about it all the time, whether you were - your self esteem just dropped.*
>
> (Alice, p101)

By the end of her third year Alice had acquiesced to the stage where, as she says:

> *I thought, well just stuff it - it's not worth it - I'll just sit back ...*
>
> (Alice, p100)

Mary (p137), Jane (p249) and Cathy, (pp218-220) had similar

experiences where they were constrained to adopt beliefs and behaviours which contradicted both their personal belief systems and explicit knowledge gained during their education.

(2) Exigencies of Practice

The educational background of these graduates contributed to the lack of mutual understanding and lack of equality they experienced in their respective wards and in the hospital itself. The knowledge these graduates brought with them to the practice setting was not valued to the same extent as was efficiency in practical skills, by ward and senior staff. The emphasis in the comprehensive course was on "knowing that" rather than "knowing how or what" (Polanyi, 1958:56) and these graduates entered the hospital with a highly developed subsidiary awareness of nursing. Each graduate discovered in various ways that this was insufficient, and, in some cases, detrimental to her nursing practice in her ward since a greater value was placed on skills and efficiency, - a focal awareness of nursing.

As Polanyi points out:

> Subsidiary awareness and focal awareness are mutually exclusive. If a pianist shifts his attention from the piece he is playing to the observation of what he is doing with his fingers while playing it, he gets confused and may have to stop. This happens generally if we switch our focal attention to particulars of which we had previously been aware only in their subsidiary role.
>
> (Polanyi, 1958:56)

For example Karen (p190) was aware of the power associated with practical knowledge and explained that professional knowledge was experiential, not theoretical.

> *I try to measure myself against women that I know that are achieving very well and that have been on the staff a long time ... someone who has been nursing for a lot of years in other hospitals, it's very good to see how they perceive these things.*
>
> (Karen, p190)

Mary (p156) and Cathy (p 220) explained that their theoretical knowledge was unacceptable and insufficient to provide adequate nursing care in their respective wards as this required practical judgements for which little preparation could be given in the educational context since:

> *You are never in a place long enough to feel confident in that area ...*
>
> (Cathy, p220)

As well, these graduates related many instances when they attempted to use personal judgement during their education, and in each case it was questioned (and sometimes ridiculed) by tutors or senior nurses. For example Mary (p143) explained a situation with a patient which she felt she had handled well. However, the tutor had not only questioned Mary's action but also had used it as an example of 'unprofessional behaviour'. Alice (p106) was particularly careful to monitor her judgements of her own professional behaviour - for example, when using self evaluation forms she said:

> *... I was never that confident. I would tick either side of the average column.*
>
> (Alice, p106)

These graduates, during their nursing education, had had their personal and professional judgements questioned and, in some cases overturned or even ridiculed. They were, therefore, ready to make personal and professional judgements in the hospital setting but they were ready to accept that these judgements were also likely to be judged by someone with more professional status.

Medications

The second issue, which all the graduates referred to as giving them cause for concern, is related to their views on giving patients their medications.

Each graduate was initially concerned about the expectations and procedures involved in giving medications. Each reported that throughout her education responsibility for safe practice was emphasised; knowledge of procedures, ethics, regulations and laws governing drugs, was an essential part of their education. Moreover

the graduates understood that the state registering examination had built into it a "Safety to Practice' component, failure of which automatically excluded the candidate from the rest of that part of the examination. This component is based largely on knowledge and procedures to do with medications. Therefore, during their education it was stressed that there were specific principles and practices which constituted safe nursing practice. For example Cathy, (p228) said:

> *And I forgot to check the name and I just handed her the previous patient's who had refused to take them - just handed them to her.*
>
> (Cathy, p228)

and she would prefer to:

> *...take the whole ring binder with you to your room so you can check the Bradma and check the number of drugs that you should be giving out. (Yes, so you would have the Doctor's order written out for each patient on each sheet, and your drugs right there, so you check the Doctor's order and the drug and the Bradma?) Yes, whereas now a lot of people - well since I have made my mistakes I have started taking the drug sheets with me to the bed. But a lot of people don't and so it will be a lot safer.*
>
> (Cathy, p229)

Checking the patient's name bracelet against the doctor's written orders and the label on the drug container was a procedure based on a strongly held belief about what was acceptable professional nursing conduct when giving patients their medications. The beliefs and principles which these graduates, as students, understood to constitute safe practice were challenged, and often contradicted, by established practices within the hospital when they attempted to carry out what they believed were responsible, professional procedures for staff nurses.

For example, Cathy, (p 227) Jane, (p 266) Alice, (p 122) and Mary, (p156) were very concerned about the procedure for giving medications. They considered that it -

> *'was often unsafe' 'that mistakes were easily made' 'there was inadequate time allocation for drug rounds' and 'the Doctor's orders were often illegible or not charted'.*

which contradicted the knowledge and beliefs they had gained from their education. All the graduates had strongly held beliefs concerning safety to practice and principles which were inconsistent with the accepted practices concerning medications in their respective wards. They considered that these practices were not only accepted in the ward, but were a part of normal hospital nursing practice.

These graduates appear to have resolved the underlying contradictions by accepting established practices as 'reality' and their beliefs as 'the ideal' and by using organisational rationales of time and staffing to justify to themselves the practices they initially saw as unprofessional and undesirable. This is a typical example of the ideological hegemony which nurses encounter - beliefs and practices are unchallenged and unchallengable as they are a part of the natural,common sense, taken-for-granted order within the hospital. For example,Mary (p although concerned about drug rounds, had little hesitation in replacing her education based principles with those she saw as appropriate in the hospital. For instance,she had no hesitation in giving drugs which had not been charted by a doctor as:

> *they are signed for the next day.*
>
> (Mary, p157)

Karen (p211) however, experienced a personal dilemma when she could not both hold to her education based beliefs and principles and also do what was expected of her. She resolved this dilemma by deciding to maintain her beliefs about acceptable professional practice and, if necessary, by refusing to comply with established nursing practice.

> *I have made up my mind - I was so worried that night about that - that I am not going to do that again ... Hopefully next time I'll have the courage ... to say I'm not going to take* (verbal orders) *... because there's no reason why he couldn't ring the house surgeon ... and tell him to come and chart it.*
>
> (Karen, p 211)

This example from Karen illustrates the exercise of individual agency to counter the hegemonic influences within the hospital, influences which

constrained her professional practice and prevented autonomous decision making. (refer to p33)

Some constraints caused frustration, but those which produced ethical contradictions (e.g. conditions pertaining to medication) were more likely to meet with resistance and with attempts at transformative action. For example, Cathy initially made strenuous efforts to produce what she considered was a safer procedure for drug rounds (Cathy, p229) and, although she accepted the structural constraints which prevented this, she was determined to try again when she considered conditions were more favourable for changes to take place.

These graduates faced varying degrees of challenge to their strongly held beliefs about this part of their professional practice but, in the main, the hospital explanations and practices were inculcated into their understanding of nursing practice. These graduates 'understood' what was legally and professionally required of them as staff nurses, just as they 'understood' that these 'requirements' were often ignored, changed or reversed as a routine part of daily nursing practice. They were also quite clear that they would be held to be personally and professionally responsible for any mistakes which might occur as a result of their compliance with those routine practices. For example, Alice (p124) said she would:

> *go to the chart and find out what has happened before. Then at least you know that somebody else has done it so you don't get it in the neck.*

and Karen (p211) thought that it would *take a lot of courage* to refuse to take verbal orders for drugs, and if she did refuse she would:

> *hear about it ... probably from the charge nurse or supervisor because there would be very loud complaints made.*

These 'understandings' may be referred to as the communicative consensus which underpins ideological hegemony. Constraints produced by power relationships are accepted as natural and unchangeable. In both the educational and the practice contexts the individual is

seen as 'responsible', the system merely 'exists'. This illustrates again the tension between structure and agency and the insidious use of power within the hierarchy of the institution to produce conformity. This 'insidious use of power' is not necessarily a conscious act - those who exercise power in this way are also constrained by the institutional ideology which they knowingly or otherwise seek to perpetuate.

Task Management

The third issue, which was identified by the five graduates as a cause for concern, was the management of tasks related to patient care.

Each graduate in this study expressed her dissatisfaction with the time available to her to provide what she considered to be adequate nursing care for her patients. Each was aware of the apparent 'double standard' commonly held by both tutors and hospital staff. For example, Mary in attempting to provide what she considered to be holistic nursing care found that:

> *the tutor as well as staff there were really down on me about it, and I was really angry ...* (The tutor explained) - *you are still part of a team in the ward and you've still got this, that and the other to do. I worked really hard all day - I felt there was pressure on me and I felt really guilty about it.*
>
> (Mary, p141)

Alice, for instance, found that there was insufficient time for discussion with her colleagues or for planning nursing care for her patients. It was also frustrating to her to be constantly interrupted and unable to think about the nursing care she was giving.

> *I think it's just the pressure with time you know - just everything - everybody is always demanding from you - I found that very hard when I first started. You've got no time just for yourself. You have to wait till you finish work then you can sit down and think. (There's no time on the ward to actually sit and find out about conditions or talk about nursing care?) No, we try and have a ward meeting once a week but then if you've got days off you miss out on*

those. You just forget about them.

(Alice, p108)

Each graduate appeared to be aware of these contradictions and all appeared to resolve the ensuing dilemmas in favour of the explanations and practices already established within the hospitals. Hospital nursing practice was seen as legitimate and all that was possible under the existing conditions - conditions which could not be changed.

Nursing care plans, which were such an important aspect of their education, and which were recognised by each graduate, as important for professional nursing practice, were often not used in the practice setting. Alice recalled that:

> *Everyone has a nursing care plan but they're not kept up to date but we try. It's just lack of time you don't have time to spend on them.*
>
> (Alice, p108)

and Cathy said:

> *like when you spent hours and hours doing nursing care plans ... all that sort of stuff appears so irrelevant now ... You want to know whether they can all walk, eat, dress themselves, are they continent or incontinent ... in practice you just haven't got time ...*
>
> (Cathy, p220)

These graduates appeared to willingly accept and participate in this traditional organisation of nursing care. The attitude that it was a 'waste of time' to document nursing care appeared to be common to each clinical area and was defined as common sense by all the supporting structures (i.e. staffing levels, management styles, hierarchical relationships, physical layout of wards, services provided and so on). For these graduates, 'time' became a valuable commodity not to be squandered on 'unnecessary' documentation. Documentation, however, shifts the balance of power. It enables nurses to 'argue the case' on rational rather than intuitive grounds. It is, therefore, in the interests of the dominant groups in the health structures to maintain and perpetuate nursing's oral tradition.

This is an aspect of ideological hegemony.

There were two major structural components related to task management which helped to maintain ideological hegemony throughout the hospital: ward organisation and hospital staffing.

(1) Ward organisation

All the graduates referred to the 'task' orientation of their respective wards where nursing care was given as a series of tasks to be completed within a time frame. Although all five graduates were practising in wards which had patient allocation, rather than task allocation (and one ward was described as primary nursing) as their organisational model, these graduates 'understood' that their nursing practice was based on tasks to be accomplished. For example, Cathy (p225) suggested that she could not provide holistic nursing care because:

> *I feel very limited by all the routine things round the ward which interrupts nursing care - you kind of forget that patients are humans and need talking and listening to.*

She also considered that the ward staff endorsed this kind of organisation as acceptable, legitimate nursing practice, and although she herself was still able to question this, she appeared to prefer to take on the existing practices as quickly as possible since she understood that a good nurse is one who:

> *is very efficient and gets things done around the ward.*
>
> (Cathy, p226)

Mary's experience as a student established for her the task related nature of nursing in a ward. During this study, she became aware of her commitment to this definition of 'good' nursing practice and made some attempts to change (pp159-160) Karen (p207) also experienced contradictions between her experience as

a staff nurse and the principles derived from her education as is illustrated by her comment:

> *the whole ward is geared for (achieving tasks by the end of the duty) - if you can't fit in you fall by the wayside.*
>
> (Karen, p207)

Each of the graduates experienced some confusion in determining what was expected of her. As comprehensive students they had developed a perspective of nursing which appeared to be at odds with the way in which nursing was perceived and organised within their respective wards, and which appeared to be legitimised by other hospital routines and practices. It was communicated to them in various ways what a 'good' nurse was - someone who could 'fit in' and 'get the job done' but they also understood that they were to provide holistic nursing care.

(2) Hospital Staffing

It was well known that, at the time of this study, the hospital (in common with other New Zealand hospitals) was experiencing a staffing shortage. However, all the graduates were unprepared for the workloads they had to carry, the additional responsibility that short staffing created, and the added stress of being moved to unfamiliar wards at short notice.

All five graduates perceived the staffing situation in the hospital as being personally and professionally unacceptable and distressing to them. They understood that they were to provide good quality nursing care and, at the same time, accept additional work and responsibilities. They described the reaction of senior staff to this situation as being unhelpful, disbelieving and destructive (of good working relationships). For example, Alice (p111) explained that when students were available -

> *we just try to catch up on what we haven't been able to do when we've had the bare minimum of staff.*

but Alice considered that senior staff implied that the presence of students allowed the ward staff to 'take it easy'.

While Alice (and the other graduates in this study) resented this implication and the implication that because they were 'unorganised' they could not cope with their workloads, they accepted that these and similar explanations had some legitimacy since they were made by senior staff. Because of a number of similar instances, these graduates began to act in accordance with what they perceived was expected of them. In this way, established hospital nursing culture became an integral part of the graduates' understanding of their social environment. The ideas, beliefs and self understandings derived from this cultural orientation became so much a part of their daily routine, that these graduates had difficulty perceiving any other way of organising their practice.

All five graduates in this study reported many instances of feeling frustrated and angry about staffing levels in their respective wards and in the hospital. This aspect of their work influenced their perception of themselves, of nursing, and of their patients. For example, Alice, who had described herself as being competent and confident as a staff nurse, thought that she was 'lucky' that her patient was able to teach her how to nurse her - she seemed to readily accept that she was expected to personally 'cope' with a new and 'worrying' situation:

> *We had two students - three staff nurses and an enrolled nurse. And I had a lady with kidney failure having peritoneal dialysis which was new for me - but I was lucky because she'd been on it for quite some time doing that all at home and had been taught down in Wellington how to do it all and her daughter as well had been taught, so they were able to teach me what to do and it was really quite basic but because it was new I felt a bit worried about it - that I wouldn't be able to cope.*
>
> (Alice, p110)

All the graduates reported that the level of satisfaction they derived from their jobs was influenced by the quality of nursing care they could give to their patients. For example, Alice explained:

> *... we only did what we had to do - just pans and washes and there was only a lot of top and tail washes not through the showers because we*

> *didn't have the time ... it was a horrible day ... just because we felt so pressured for time I think. And you know that you didn't have time to spend with your patients. Even if they were upset or anything you had to say - well, you know I can't spend any more time, I've got to do the next task.*
>
> (Alice,pp108-109)

All the graduates experienced feelings of incompetency. They reported that often they 'were made to feel' personally or professionally incompetent when, for example, they could not complete their work on time. Jane (p270) for instance, explained that staff nurses were considered to be unorganised by senior staff if they could not get off duty on time and, although there was a procedure for claiming overtime, it was 'understood' that overtime should not be claimed. In the same way the graduates said that asking for additional staff was perceived by senior staff as an admission that the staff nurse 'could not cope'. Cathy, (p223) Jane, (p270) Alice, (p115).

This 'personalising' of what were essentially structural deficiencies within the hospital emphasised the commonly held belief that providing nursing care was a personal responsibility. Coping under pressure, accepting the inevitability of the institutional structures, became a 'criterion' for professional competence. The graduates came to see themselves as the cause of delivering what they saw as a poor standard of patient care - they had had inadequate educational preparation, they were unorganised, they were lacking in both skills and knowledge for their respective wards, and 'the system' was inviolate to the extent that they believed that nothing could be done about the situations in which they found themselves. The institutional structures were masked by an ideology of individualism.

All of these graduates felt 'let down' by the education system they had been through because they saw their educational preparation as the reason for their feelings of inadequacy. For Alice and Mary in particular, their education was not 'real' in the sense that they were not given the knowledge or experiences that would allow them to be professionally autonomous in a hospital. Alice explained:

But its all hypothetical isn't it. You're not doing the real thing. And you know that you are missing out on all those other experiences on the ward. Dealing with patients - and the demands they make on you. Communicating with them. And the practical things like, medication and drips and that sort of thing because that was really where I dipped out. I had never seen a Naso Gastric put down, I had hardly anything to do with drips, I was absolutely terrified of them. I had to put a Naso Gastric down yesterday and today.

(Alice, p106)

Well I think it's pretty hard especially when you first get there and you've been taught all these ideals at tech and you come to the reality of it all and you've got to come to grips with it. Try and adapt yourself to what you've learned and how you are going to meet these needs of the hospital and just try and fit in.

(Alice, p119)

The graduates readily accepted the prevailing norms of the hospital as an explanation for their apparent incompetence. For instance, during their first week of hospital practice they accepted without protest what they later described as a totally inadequate orientation to the hospital. The root cause of their 'incompetence' lay within them and had little to do with hospital structures.

All of the graduates experienced discrepencies between their education-based principles and the established practices within the hospital. These experiences were at best uncomfortable and at worst distressing to them, but the inherent contradictions in the situations they describe were masked by an ideology of consent.

This led to a change in their belief systems - either to accept the ideology of the hospital as quickly as possible, or to strengthen their own beliefs and risk censure, ridicule, and self doubt. Jane, however, (and to some extent Karen) quickly resolved the discrepencies she was aware of. She was able to accept her powerlessness as a natural, common sense result of her position as a student or as a staff nurse. For example, Jane (p262) saw the hierarchical structure as natural and accepted uncritically the

the power that went with being a charge nurse - the charge nurse was, by definition, more capable and more responsible. Jane saw the charge nurse's actions as legitimate by virtue of her position.

> *But we don't even do doctor's rounds really - the charge nurse always does those. But I often tag along on the end - I like to hear what's going on. She does always tell us what's going on but sometimes things get missed. (So the charge nurse really controls the knowledge about people and about treatments and so on?) Yes. (Would you be able to ask to do the doctor's round on your own?) Oh yes, she's really keen to let you. But she likes to tag along too - cause she's going to miss out on something. Fair enough too.*
>
> (Jane, p262)

Jane's account of this experience exemplifies the way in which professional socialisation provides a legitimation of the exercise of power through organisational structures that are taken to be natural - not capable of transformation by individual agency.

Cathy (p221) appeared to accept the hierarchical structure of the hospital as being natural and perceived constraints to be intrinsic to the system. Her experiences of acquiescence and conformity to rules during her education had prepared her for an acceptance of these structural constraints.

> *... the main qualities they wanted us to come out with - assertive and confident. But I don't really think they gave us much chance to be assertive and confident.*
>
> (Cathy, p221)

Resistance to the gratuitous use of power was diverted through rationalization:

> *I thought partly it was me - in that I had come from University and I picked things up fairly quickly ...*
>
> (Cathy, p217)

Although Cathy realised that attempts to produce change in her educational experience were not able to succeed because of the structural constraints in the system, she readily gave a personalised rationale for inability to produce change:

> *We would probably call a class meeting and get a general consensus about what people feel, then bring it to the tutors. (Did you do this?) No ... it was boring ... most people felt like that ... (What prevented you from doing something about it?) Apathy I guess.*
>
> (Cathy, p218)

This comment indicates that she locates the problem within the individual rather than with the education system.

Each graduate in this study explained in a number of ways that she thought she would be able to validate her professional judgements now that she was a staff nurse. Each of them found, however, that legitimation of their judgements came to be more important than their validation. The hierarchical structure within the education system and within the hospital diminished the graduates' sense of personal agency and prevented autonomous practice. Each graduate brought to the communicative setting in the hospital, a disproportionate degree of social equity which ensured her domination by those who were able to define and legitimate their own perspective of professional practice.

CHAPTER FIVE

This chapter explores the educational implications of the present study. Both the polytechnic experience and the first six months' graduate practice are viewed as phases in a process of induction into a professional culture. The graduates' perceptions of their nursing education and practice are discussed and interpreted in terms of both the intended and unintended learning states engendered by their actual experiences. It is argued that nursing curricula are currently dominated by a technical objectives model and that a socially critical approach to the design of such curricula might begin to transform some of the structures which presently inhibit and constrain the emergence of professional autonomy in the education of nurses.

Nursing ideals embody principles of professional autonomy and accountability which may not be compatible with the instrumental function of the educational and health institutions which provide the conditions in which nursing is taught and practised. Both the educational and health institutions have hierarchical structures and organisational practices which reflect a concern for cost-effectiveness and quantifiable goals. (Wilkes and Shirley, 1984; Ramsay, 1983; Davis, 1982; Easton, 1976). This produces inherently contradictory conditions for both nursing education and practice because forms of technical control embedded in these institutions limit the professional's ability to be autonomous and responsible in her own practice.

These conditions have been described by many writers as authoritarian and paternalistic where control of nursing education and practice is exercised by both medical and organisational practices. (Muff, 1984; Cohen, 1980; Flanagan, 1982). Such practices reflect a concern for instrumental approaches "which emphasise the management of a system, the measurement of input and output, the specification of objectives, the maximisation of gains and the minimisation of costs". (Codd, 1982). In the educational context, nursing is not only bound by the rules and regulations of the

polytechnic and the health system, but also by the control exercised by the Nursing Council of New Zealand in its registering and disciplinary functions (Nurses Act, 1977 and regulations). What tutors teach and how they teach it is, to a large extent, prescribed either by regulation, or by specific kinds of organisation (for example, timetables, availability of clinical experience, hours designated to subject areas and so on.) Although tutors may have some choice as to specific content in subject areas, they are constrained by the requirements and formal expectations of both the education and the health systems in the exercise of that choice. This "formal component" in the hegemonic control of nursing education and practice provides the coercive conditions which prevent successful challenge to the dominant ideology (cf Ramsay, 1983).

INDUCTION INTO A PROFESSIONAL CULTURE

Nursing education is concerned with the induction of neophytes into a professional culture and existing health care structures to prepare individuals to meet certain health care needs in a community. This professional culture comprises many elements - theories of knowledge and knowing, symbolic forms of knowledge (such as non verbal conduct, rituals and rules governing the actions of individuals) as well as patterns of personal beliefs, values, and commitment to nursing. In this present study these elements of professional culture were perceived by the graduates in terms of (1) what counted as valid knowledge and ways of knowing, and (2) the symbolic forms of knowledge which structured the individual's every day experience. For example, Karen in explaining what a 'good' nurse was, said -

> *I want to improve my skills ... seeing how some of these other women that have been there for years can move from ward to ward and be slotted in .... it would be really good to be that sort of nurse - to be able to have those skills and that knowledge."*
>
> (Karen, pp188-189)

Mary recalled an incident which, for her, highlighted the contradictions between 'classroom' knowledge and 'practice' knowledge. This incident, which occurred during her first year as a student,

gave Mary an understanding of what she perceived to be valid knowledge for professional practice.

> *I was down in a ward once and there was an old man down there who - I'm sure he would have just shrivelled up and died - he probably has by now - but he was a grumpy old man, his wife had died and he couldn't really cope, and he wouldn't get out of bed in the morning, you virtually had to get two nurses and lift him up and I'm sure in his mind he had nothing to live for, nothing to get up for and no-one bothered with him. I went in one morning and I took him in his breakfast, and I was chatting to him and I asked him what he liked to do and he told me - he grinned at me and said - I hold a good hand at euchre - and I thought I don't know how to play that - and I said to him, I'm looking after you today, how about you get up and have a shower and get dressed and I'll sit down and you can show me how to play. I said I bet I can beat you, and he grinned at me and he was up by himself that morning. I helped him in the shower, he got dressed and I had to follow my end and - you know before that you had to sponge him in bed and dress him and everything and so I sat down and I played cards for about 15 minutes and I said to him - look I'm going to have to do some work but this has been good, I'll come back later and I did - but it comes back to the task orientation - all the beds were all ready for making and other patients being bathed and the tutor as well as staff there were really down on me about it, and I was really angry - I could understand why but you know it was the first spark of life I had ever seen in this man and all his reports every day was - difficult, grumpy, and he hasn't been - he had been -* (He was responding really well to you?) *Yes. I felt that that was really important - I thought stuff the beds, I don't care.* (Did you talk about it to anyone? To the tutor?) *I did a little bit and it was understood but you're still part of a team in the ward and you've still got this that and the other to do. But if it happened again I'd do the same thing.* (Were you able to talk to the ward staff about it as well as the tutor?) *I tried to with a couple. Because I worked really hard all day - I felt, there was pressure on me and I felt guilty about it. But no - everyone else just considered this guy a waste of time - just a grumpy old man.*
>
> (Mary, p139-141)

The following excerpt from an interview with Alice suggests

she believed there were certain characteristics that she should display to meet the requirements of the polytechnic course that had little to do with her own learning or with what she considered to be appropriate professional conduct.

> *Actually the report said that I was rude and impolite. And this behaviour will not be tolerated. (Can you remember any instance which might have resulted in a comment like that?) No, I took it out and showed it to the other girls and they just couldn't believe it. So they went and saw the course supervisor too. All she could say was that she felt that there were reasons for it - that I had been doing something - (But she didn't know what it was?) No, she couldn't put her finger on anything again.*
>
> (Alice, pp 99-100)

> *So after that I felt a bit paranoid about - who was it, was it this one, or I'd better be careful. That sort of thing. (What about your classroom behaviour. Did you stop talking so much?) Yes. (Did you ask questions?) No - I just - I thought well just stuff it - it's not worth it, I'll just sit back ....*
>
> (Alice, p100)

> *Mainly in the clinical area you have got to be a bit more contained - you can't just let out whatever you think at any old time because you have to think of the other people - patients and the other staff and that sort of thing. But in the classroom when you are learning, I think it is important that you do behave how you want and talk about things that you think should be discussed and that sort of thing.*
>
> (Alice, p103)

It would appear that the individual's consciousness of herself as a professional nurse is produced both by her perception of the relationships she develops with her colleagues and the conditions (structures) which enhance or constrain her professional practice. This consciousness of self should be understood as something produced rather than as the source of ideas about self (i.e as constituted not constitutive) to adequately explain the actions which beginning graduates take. In this way the politics of change (from personal to professional; from student to graduate) can be seen for what it is - the development (production) within the individual of a

commitment to an already existing professional culture and hospital structure.

The experience and reflections of the graduates in this study indicate that they were as much engaged in learning those elements of a professional culture which impose a preconception of a professional self, as they were in reproducing them. Those health professionals with whom they came in contact provided the conditions in which cultural production and reproduction could occur. That is, once the individual had accepted into her consciousness of self these elements of professional culture, the conditions were such that little change or reflection could occur. Indeed, such elements often reappeared in a stronger form in these graduates (for example, ideology of individualism - they knew they were to blame for poor patient care).

The graduates in this study recalled many instances which illustrated for them their inability to influence, or even feel a part of, the educational process. For example, Mary felt that she was 'trapped' by what was, to her, distorted communication between the tutor, the charge nurse and herself during her third year clinical placement.

> *I was really upset about it. And it came out in my report that I'd played senior staff off against each other which I thought was really, really unfair. And the tutor never discussed it with me ... she had agreed - approved - then the charge nurse was saying to me - well your tutor's very angry about it, you shouldn't have done it ...*
>
> (Mary, p149)

In Chapter Four it was suggested that this kind of incident demonstrates the way in which distorted communication can produce conformity (refer to p48). It illustrates the unequal relations of power in an educational context which produces a continuity of structures in both the education and the health care contexts. That is, as Mary pointed out (p150) the hierarchical nature of both education and clinical practice, and the nature of the relationship between the polytechnic and the clinical agency allowing access for student experience, meant that there was little opportunity for a rational

discourse with tutors or with the charge nurse.

These distortions arise because of the domination of the technical models and instrumental approaches in both the polytechnic and the hospital. For example, as students, these graduates were subordinate to both tutors and nurses in clinical practice. This subordination, which, on the one hand can be instrumentally justified with reference to safe practice, can also be seen as a means of technical control which limits individual choices for autonomy and responsibility in the educational and practice setting. Thus, social values such as passivity in the face of authority, and conformity with existing practices, are internalised during the educational experience and thereby reproduced later within the professional conduct of graduates.

All five graduates in this study reported hierarchical relationships with tutors and nurses in clinical practice and all seemed to be aware of the structural constraints that this placed on their education and practice.

For example, Alice reported that throughout her education she was aware of many social constraints at polytech. For example, roll call 'annoyed' her.

> *I did mind it because I thought that especially after 7th form at school and then the year at Varsity - a year away from home and now out flatting that I should have had a bit more responsibility and I had chosen to do this.*

Alice also explained that 'the hierarchy' at the hospital are:

> *...set up there by all the other staff as well as themselves and it's just the system, that they think that they have got the power and they really have because they control what happens to every staff member - where they are going to go, how long they are going to stay there for and how many staff are going to be on that ward and just everything. So they really have got the power and people - like when you go you want to have a ward change or something - they can say it's just not on, you can't leave yet and that's that. (Is that kind of control reasonable?) No not at all. Because you are people. You've got every right to have control over where you*

> *want to go as long as it's reasonable. And what you want to do with your life.*
>
> (Alice, p 115)

Although Cathy generally felt 'confident' as a student in a clinical area she reported that:

> *I don't really think they do much to build you up there, at tech. I think partly because it's this structural bit for your clinical and theory, you are never in a place long enough to feel confident in that area, you have tutors popping in to see you - specially in your third year and you kind of see that as a threat which immediately puts you on the defensive so you are not feeling so confident anyway.*
>
> (Cathy, p 220)

In this way hierarchical relationships diminished each graduate's sense of personal agency and reinforced their understanding of the tacit approval given to the instrumental functions of education or clinical structures. Freire (1973:46) refers to a hierarchical relationship as "anti dialogue" and suggests anti-dialogic teaching is a relationship of authority which presupposes "manipulation" on the part of the teacher. Thus, this kind of relationship prevents transformative action through shaping the individual's choices and actions. Further, anti dialogue results in a "banking" concept of education - the teacher makes "deposits" of knowledge and all that is left to the student is to "receive, file, and store the deposits." However, a horizontal relationship between teacher and taught is a "relation of empathy between two poles who are engaged in a joint search". This dialogic relationship is more likely to be an "active, critical and criticism stimulating" method than a hierarchical relationship.

A dialogic relationship between teacher and taught, may result in "conscientization" where students may "come to feel like masters of their thinking" (Freire 1973:118). Teacher and student engage together in a socially critical approach to 'reality' in which the ideological positions of particular interest groups are exposed. Thus students would gain an awareness of their place as 'subjects' rather than 'objects' in their social worlds.

As Van Manen points out:

> Conscientization, in Freire's sense, is the paradigm for critical practice. It refers to the process in which people, as knowing subjects rather than recipients, achieve a deepening awareness of the sociocultural reality that shapes their lives and of their capacity to transform that reality - thus the practical as emancipatory action (in the sense of praxis) has a quality that transforms the life of the person who adopts this highly reflective frame.
>
> (Van Manen, 1977:222)

In this present study, the graduates (except Karen) reported in various ways that they felt alienated during their education. In particular, the distress over term reports recalled by Cathy (pp220-221) Alice (p101) and Mary (p138) clearly demonstrates the powerlessness that these graduates felt as students. For example, Cathy recalled:

> *... at the end of the first term they said - doesn't seem to be motivated this term, or something like that. Obviously I was like that (after six years of study and just got married) but I didn't take any days off and I was getting consistently high marks. I didn't feel it was a fair comment.... All of us complained about .... our reports .... they had more negative than positive comments. I guess I could have gone further with it.*
>
> (Cathy, p221)

Moreover these graduates were well aware that structures (such as the pattern of relations of power, organisational practices, and the accepted discrepancies between education and practice) militated against any action to produce change.

Alice, in the incidents already discussed (refer to Chapter 4, p48) appeared to be aware that the difficulties she was having were not necessarily linked to her own learning, knowledge, or theory and practice, but rather to the implicit theories of education held by tutors. She describes this as 'moulding' and as contradictory and confusing. In her own words:

> *I think that they have got set ideas on what a nurse should be.*
>
> (Alice, p104)

It would appear that these graduates (except Karen) had developed a reflexive understanding of their social conditions during their education. For Karen, however, reflexive understanding did not appear to occur until she had been in the graduate setting for some time. Personal knowledge, for these graduates in both education and practice, was often discredited since it seemed they had to be "initiated" into what was deemed "worthwhile" knowledge for practice. In this way these graduates not only learned not to trust their own judgments - they also learned to internalize the conditions which prevented them from clarifying their actual educational, professional, and social situations. This kind of distorted self-perception, which has social and political consequences, has often been referred to as arising from a hidden curriculum or unintended learning states produced by the conditions under which intended learning occurs.

THE HIDDEN CURRICULUM OF NURSING EDUCATION

Tutors act on the basis of educational theories whether explicit or implicit, and upon their intuitive and experiential knowledge and understanding of nursing. As well, behind every philosophy or statement of policy, is a set of assumptions about educational priorities - an implicit theory of education. These aspects of educational transmission normally taken-for-granted by tutors and therefore 'hidden' from students, transmit beliefs about nursing knowledge, education and practice, nursing's place in the health system, the relative worth of individuals, teaching, learning, professional conduct, and so on. This 'hidden' curriculum constitutes one aspect of the relations of power between tutor and student. The tutor is able to define and legitimise one way of knowing over another, one kind of knowledge over another, as well as what counts as professional conduct.

Thus, the hidden curriculum is intimately linked with learning, and with the beliefs students come to hold within the contexts of nursing education and practice. Martin (1976) has pointed out that:

> The learning states of a hidden curriculum can be states which we think of as character traits - for example docility or conformity. They can also be cognitive states such as believing or knowing, states of readiness or of skill, emotional states or some combination of those and other sorts of states.
>
> (Martin 1976:137)

What students and graduates do learn is as culturally formative as what it was intended that they learn. For example, it appears that it was intended (i.e. part of the formal curriculum) that students learn to practice differently, but they also learnt to conform quickly to the requirements of the clinical agency. Thus conformity (unintended consequence) took precedence over different practice (intended learning state) and became the basis on which the student's professional self was built. Therefore, a discrepency arises between what it is openly intended that students learn and what they do, in fact, learn. These learning states are not necessarily tied to one particular educational setting - rather what is learned may cut across settings so that a particular learning state (e.g. conformity) may be dominant for the student as a result of practices, procedures, relationships and structures in a number of different settings (Martin, 1976).

Hidden curricula, or unintended learning states, are not just associated with formal educational transmission but operate wherever learning takes place. Therefore the structures of nursing education and practice (including professional and social elements) provide the conditions in which nurses learn to think and act in ways that educators (and others) may, or may not, have intended. Thus, there is a certain paradox between the apparent educational aims of tutors and practice aims of senior nurses, and the relationship between intentions and outcomes. At the abstract level, tutors and senior nurses appeared to expect students to develop emotions, purpose, integrity, and autonomy consistent with the professional attributes that are assumed to enhance teaching-learning-professional relationships and which are a part of the formal doctrine of the nursing profession. For example, Cathy thought that:

> *Obviously the ideal that they were trying to get through was a very assertive confident - I think*

they were the main qualities they wanted us to come out with - assertive and confident. But I don't really think they gave us much chance to be assertive and confident.

(Cathy, p221)

Karen (p198) recalled that polytech had taught her to be 'self critical' and to use 'self analysis' to improve her practice and Alice (p105) reported that tutors expected students to meet certain objectives related to clinical practice as set down in self evaluation forms. These aspects of their education and practice focussed attention on the self. Thus, self criticism, rather than self reflection, became a criterion for professionhood that was also part of an ideology of individualism. Attempts to be self reflective or socially critical were actively discouraged. For example, it appeared that social values of obedience, passivity and conformity were perceived by these graduates as desirable by those to whom they had to demonstrate their professionhood. This incapacity for critical self reflection allowed the graduates to perceive forms of social domination as personal inadequacies in their own professional competence. Mary, for instance, considered that students had to meet 'acceptable standards of professional behaviour' but she had difficulty in reconciling her personal beliefs and knowledge with how she perceived the tutor wanted her to act:

And I thought well O.K. from her point of view maybe it did look really bad but in the context of the relationship I had with this lady how well I knew her, the whole - the way she related to me - the way she talked - everything else - I didn't think it was unprofessional - I didn't think it was a big deal. (When the tutor gave the example were you able to explain that to her?) Well I tried but she just kept saying to me - I think that's unacceptable to talk to someone like that. I thought well yes, I could see her point. And I tried to explain that - but I think she would have had to have been there for a few days or talked to the lady for a while - got to know the patient to have understood the situation. (But that wasn't acknowledged by the tutor?) No.

(Mary, p 143)

Jane recalled that her term reports indicated that she was

'quiet' 'confident' and 'participated well' but that was not how she saw herself:

> *Yes, sometimes being a bit naughty probably. (What do you mean by a bit naughty?) Not concentrating. That sort of thing - just being there as a body. Not really though. (Did you participate in class?) Oh not bad. Not always volunteering though. One tutor always used to ask me for things. There was me and someone else - she always used to ask - we couldn't decide if it was because she could remember our names easiest. But at least I always gave an answer. So that was something. I've never been one for participating in class right back to primary school - it doesn't really say you don't think though. (Was it noticed by the tutors that you weren't participating?) Oh they put on my reports that I participated quite well. I don't think I did though. Because I knew I didn't. I think in our class we had quite a few really domineering people that always did the answering and sometimes they used to complain that they did it but they could just sit there and be quiet but they had to open their mouths and say whatever they had to say. So that was their choice. (So it didn't bother you particularly that you were quiet?) No not really. As long as I thought I had a few ideas of what was being said it didn't worry me but if I was really away with the fairies - but that didn't happen very often.*
>
> (Jane, p250)

At the practical level, and in the ethos of both the polytech and the hospital, the aim appeared to be towards co-operation, conformity and acceptance of existing practices, beliefs, attitudes and values. Thus, the continuity of structures ensured the effectiveness of the hidden curriculum.

For these graduates, their experiences as students in the clinical setting established for them the co-operative nature of nursing practice and the nature of the control exercised by more senior nurses. Of one experience Mary said:

> *...but you are still part of a team in the ward and you've still got this and that and the other to do ... I really worked hard all day ... there was pressure on me and I felt guilty.*
>
> (Mary, p141)

Induction into a professional nursing culture is an integral part of the lived experience of students and graduates in nursing education and practice. In the present study this induction was focussed on the apparently unintended outcomes of education and practice. This mostly unwitting transmission of knowledge, beliefs, attributes and values prepared the neophyte to more readily accept established professional and hospital culture. Thus the induction process is intimately linked with the structural factors which support teaching/learning processes. As students, these graduates not only achieved the formal curriculum aims (in that they became registered comprehensive nurses) but they also learned how to effectively function in a polytech or hospital context. There are inherent contradictions between the 'formal curriculum aims' and 'what the students learn'. This gap is widened by the technical-linear paradigm in which nursing education occurs because of its inability to recognise the processes of cultural reproduction.

FORMAL NURSING CURRICULA

Curriculum, in its broadest sense, is often taken as a neutral term embodying the content of an educational enterprise. Curriculum, therefore, may be defined as "all the learning which is planned and guided by the school whether it is carried on in groups or individually inside or outside the school" (Kerr, 1968:16). This broad view places emphasis on the total effect of an educational enterprise and focusses attention on both the overt content and the manifest context of learning. Curriculum developers in nursing education are instructed to use an objectives or systems model (Nursing Council of New Zealand, 1977) which exemplifies this view.

Nursing curricula are, therefore, based on a model where concern for input, process and outcome is expressed in terms of objectives, content and evaluation. This kind of curriculum model (based on Tyler (1949) and outlined by Torres and Stanton (1982)) allows the curriculum developer to use a four stage process to formulate a philosophy, define the elements of the curriculum, select and organise the content and learning experiences, and evaluate learning outcomes in terms of the overall objectives. Among the basic premises of the

objectives model are a set of principles and technical-practical recommendations which seem appropriate for the practical task of achieving certain objectives of curriculum development. This practical task is guided by the "technical application of educational knowledge and of basic curriculum principles for the purpose of attaining a given end" (Van Manen, 1977:226). It would appear that to follow this procedure would be to act rationally and to plan rationally - means cannot be chosen before ends have been identified. However, the separation of means from ends prevents any critical examination of the justification for objectives (Wise, 1976; Sockett, 1976).

In this study there were instances where the graduates questioned the validity of the objectives which they encountered. For example, from the first day Alice understood there were ways of saying the 'right' things:

> *We were in small groups with a tutor and we had to say why we wanted to be a nurse and various other things like that. I found that quite hard because you had to say it in front of other people and you had to try and think of the right reason. (You can't remember what it was?) No, but I do remember thinking, I'm going to put my foot in it now.*
>
> (Alice, pp96-97)

Mary explained that:

> *As long as it was passable you got an A written on the top - I remember thinking I was doing really well getting an A for the first couple and not realising that in a way - I think after a couple of months everyone realised that a B was virtually a fail. (So you more or less made your own scaling system?) Yes we did.*
>
> (Mary, p136)

> *I think some of the assignments were a waste of time. (In what way?) Just that it was all a lot of up-in-the-air stuff that half the time I didn't understand what I was writing - like I wrote - I remember spending hours writing this big assignment on food obsessions and it's totally irrelevant - the only good thing about it was I got an A and that went on my record. It was the only thing I got out of it. Some of them*

> *I didn't really understand the relevance. (Are they relevant looking back on them?) (I've forgotten about them. Not really. Some were - I couldn't cite an example but I know I did some assignments where I felt like I really got into reading and I read more than I had to and I really researched it and was interested. But others I did a minimum amount of work and got the minimum number of words and got to hand it in on the last day.*
>
> (Mary, p137)

To meet clinical objectives as set out in her self evaluation form Alice said:

> *I was never that confident. I would tick either side of the average column. It wasn't very often that I'd tick in the upper one - I'd try to vary it a bit.*
>
> (Alice, p106)

Alice explained that there seemed to be inconsistencies between the formal objectives of the course as she understood them, and the course as she experienced it.

> *We couldn't understand it. Because it just seemed to go against what we were being taught about - caring - you know all the psych and everything. And how to treat the patient. Whereas it seemed that the nurse - don't give a stuff about her. (You mean what you were being taught was not the same as how you were being treated?) Well it wasn't really at all because like with the rolls and having to be at class and that sort of thing and having to fill in forms. I found a lot of those things at tech just didn't tie up - they were sort of - hypocrisy, with things that tutors said and then things that they expected of us.*
>
> (Alice, p102)

All five graduates in this study explained in various ways that they understood that, as students, they could legitimately be moulded according to the intentions of tutors. This view of education is incompatible with the view that regards students as active and dynamic people who can, and should be, autonomous and self-directed in their learning. This'moulding' process may be seen as an outcome of a technical approach to curriculum design.

The technical approach to curriculum would provide a framework

for action based on the philosophical beliefs and values set out in the first stage of its development (Stenhouse, 1975:125). The curriculum developers would see the curriculum offering solutions to problems through the process of determining objectives, content, and evaluation procedures. Such solutions can then be judged as 'right' or 'appropriate' in terms of the stated philosophy and objectives.

This model, Stenhouse (1975:125) argues, is tautological in nature since the intended learning outcome, or behavioural objective, becomes the basis on which the curriculum is designed and education becomes a means to an end expressed in terms of student attainment. In this way, the ideological functions of the curriculum (transmission of norms, values and knowledge 'necessary' to function as a graduate) are maintained and recreated not only by curriculum developers but also by the 'common sense' practices of selection of students and teaching and evaluation procedures. For example, the only formal requirement for entry into a school of nursing is a recognised educational qualification (such as University Entrance) yet it is also well known that nursing is a 'caring' profession - a humanistic discipline where other qualities as well as academic achievement are essential. This entry qualification may deny Maori and Polynesian students, for example, access to nursing education when they may well have highly developed 'caring' attributes.

Teaching and evaluation procedures may place emphasis on those components of nursing practice able to be objectified - a curious procedure when nursing claims to be based on human-to-human relationship (Travelbee, 1976; Leininger, 1980) involving subjective responses. Stenhouse (1975:97) argues that this is a function of the objectives model - "the objectives model appears more suitable in curricula areas which emphasise information and skill". He suggests that a process model, which emphasises the epistemological basis of the curriculum is "more appropriate than the objectives model in the areas of the curriculum which centre on knowledge and understanding" (Stenhouse, 1975:97). The objectives model is most concerned with control - the curriculum is seen not only as a means of maintaining an organised health system, but also as a means of preserving the

'desirable' characteristics of graduate nurses as determined by dominant groups in the health system and in society (cf Apple, 1979:49). Curriculum content is selected as a means to achieve goals and allows knowledge to be regarded as of utilitarian value. Learning becomes tied to achievable goals where understanding and knowledge may be artificially separated (Downey and Kelly, 1979:205). The nature of the knowledge which forms the epistemological basis to the curriculum may be left unquestioned.

The objectives model epitimizes the technical approach to nursing education which masks the contradictions that exist in the dialectic between learning relations and the general social relations of education and practice. The appropriate response to this is not to focus on the formal content of nursing curricula but on the covert message systems, or codes,which are intimately involved in educational transmission and which constitute the hidden curriculum.

For the graduates in this study, their perception of what counted as valid knowledge,and understanding of what counted as professional practice,appeared to be shaped by the social and cultural contexts in which such knowledge was acquired. Such knowledge and understandings constitute the organising principles by which students learn what it is to be a student or graduate nurse.

In Chapter One it was pointed out that Bernstein (1975:85) defines curriculum as "what counts as valid knowledge" in an educational transmission. This definition places emphasis on the epistemological basis of curriculum and separates it from pedagogy and evaluation of educational knowledge. Moreover, this view of curriculum focusses on validity of knowledge - who decides, and on what basis, which forms of knowledge are valid. Bernstein's distinction between curriculum, pedagogy, and evaluation provides a useful framework of analysis of nursing education for it highlights the tensions and contradictions between education and practice, between the underlying theories of education and pedagogy, and between the formal curriculum and the student's experience of the curriculum. For example, in a collection code it is possible for students to study nursing as an intellectual endeavour transmitted and assessed as any other discipline yet

divorced from the realities of practice. The process of learning, the intended and unintended learning states of the collection code, and the world view of the dominant ideology within the institutions of health and education, may all remain unchallenged.

It would appear that the graduates in this study did experience their education in a collection code (refer p4) with clearly defined subject boundaries and hierarchical structures. Moreover, these graduates experienced compartmentalised timetabling with hours designated to subject areas and evaluation procedures such as regular formal (objective) tests and examinations during their education. Some elements of an integrated code did appear to be present however. For example, self-care and holistic health were themes which ran throughout the three year course, and tutors did tend to teach across subject boundaries as well as in both classroom and clinical areas.

Courses based in a 'true' integrated code can challenge the ideology and structures of an education system both theoretically (in the overt curriculum) and experientially (through structuring the hidden curriculum to be congruent with, for example, the philosophical base of the overt curriculum). Traditional tutor-student hierarchical relationships, including criteria and methods of assessment, may be challenged by students who are encouraged to reflect upon their own existential world. That is, the subjective dimensions of knowledge become a part of the curriculum (Bernstein, 1975). Knowledge is seen as arising through praxis, and student praxis becomes a legitimate part of the curriculum which acts to minimise the theory-practice and ideal-real dichotomies.

Both the objectives model and the collection code place emphasis on the student as an individual to be changed. That is, the student, in an objectives model must meet specific (behavioural) objectives, and in a collection code must collect 'parcels' of knowledge. Thus attention is focussed on the characteristics of the student which can be changed, rather than on the knowledge and understanding that the student may have gained. The ethical and ideological nature of control in the educational setting does not have to be addressed.

The judgments made by tutors (based on the assumptions inherent in the objectives model and in the collection code) become the legitimate measure of normalcy, professionhood and competency. Therefore there is a strong tendency to perceive any difficulty as a problem with the individual, as something the individual rather than the institution lacks. Thus, combined with the assumption that the official definition is the only right definition, almost all action is focussed on changing the individual rather than the defining structures of the larger institutional contexts (cf Apple, 1979:145).

Knowledge may be separated from practice, fragmented and objectified, alienated from the subjective learning of students and thus exists as an independent entity. Nursing education then comes to be adaptive training - a socialisation of the individual for professional life. In this sense, objectifying knowledge is a denial of culture - a denial of the lived experiences and understanding of students in both the educational and hospital contexts.

In this study nursing education and practice were characterised by a lack of opportunities for the individual to critically examine the epistemological basis of educational transmissions, and the elements of culture central to nursing as a profession. As Bottorff and D'Cruz point out:

> The two primary functions of education are, firstly, the relational transmission of important aspects of culture, and, secondly, the development of a capacity to distance oneself from that which one has been initiated into, in order to make judgements on it. Even though it is vital for people to be initiated into a particular culture, if the element of distancing were omitted the result would be mere socialization. The educated person is one who can form judgements not only on particular issues within the context of a cultural tradition, but one who can also critically reflect on the cultural tradition itself. Such a person should be able to decide on a reasoned examination of the evidence and to accept, reject or modify any particular aspect of the cultural traditions into which he/she has been initiated.
>
> (Bottorff and D'Cruz, 1985:3)

Rather than denying these experiential components of education and practice, the nursing curriculum should focus on these cultural

traditions, on the qualitative, lived experiences of students and graduates. In other words, the 'hidden curriculum' should be 'surfaced', made explicit.

In this way the structures and constraints which shape education and practice could be critically examined. Martin (1976:146) suggests that rather than concentrating on the hidden curriculum of a given setting "what matters is the hidden curriculum for a given individual or group". Her premise is that settings can combine to produce learning states and "to do away with the complex network of practices and structures which in a given setting produce highly undesirable learning outcomes ... may leave the learning states for someone unchanged" (Martin, 1976:147).

The possibility for the development of this kind of critical consciousness ("conscientization") is directly related to the practical possibilities of reflective understanding. These 'practical possibilities' are dependent on the critical participation of students in their attempts to understand the norms, values and social knowledge they have accepted as part of their social lives. As Freire points out, a critical consciousness allows:

> ...(people to) develop their power to perceive critically the way they exist in the world with which they find themselves; they come to see the world not as a static reality but as a reality in process, in transformation"
>
> (Freire, 1970:70)

This critical perception results in emancipatory knowledge (Habermas, 1971; refer Chapter 3) which would provide the individual with a means to socially critique the ideological character of education and practice. Where the thoughts, values and feelings of individuals are brought under the effective control of the curriculum, or where the instrumental consciousness of those in nursing education and practice control the lives of others through the use of objective information, emancipatory knowledge would lead to transformative action. This is the point in making a hidden curriculum explicit for an individual or group.

As Martin says:

> The point of raising a hidden curriculum to consciousness is not to foster but to prevent acquisition of the (unintended) learning states belonging to it.
>
> (Martin, 1976:148)

The hidden curriculum would then not only become the object of cognitive states but also of skill states - "knowing how to avoid the learning states that one does not want to acquire" (Martin, 1976:149). If the social and political structures which shape nursing education and practice are 'surfaced' in this way, action may then be focussed on critical practice as a whole (rather than on manipulating parts of that practice - the individual, education, or clinical agency). Nurses in education and practice could become socially critical and engage in a rational discourse which may lead to increased dialogue and debate about the nature of nursing education and practice.

At present the nature of nursing education and practice is shaped by forms of technical control which arise from the dominant ideologies already imbedded in the education and health care structures. Nurses themselves elaborate these dominant ideologies - they "spread and make legitimate dominant ideological meanings and practices attempting to win people over and create unity ..." (Mouffe, 1979:187). Curricula in nursing education play a vital part in maintaining ideological hegemony. The overt and hidden curricula sustain the social, cultural, and political conditions which enables nursing education and practice to generate the dominant values and practices that constrain the professional choices of nurses.

CHAPTER SIX

The aim of this study has been to investigate the process of induction of five nurses into a professional culture within the contexts of polytechnic nursing education and hospital based nursing practice. This chapter provides a brief summary of conclusions drawn from the information obtained, identifies the main limitations of the study and presents some recommendations for future research.

Major Themes

The central issues set out in this research have not been addressed in previous studies conducted within both empirical-analytic and interpretive epistemologies. In this study, the combination of a critical theory perspective and case study method has provided a means to demonstrate the ways in which social forces constrained the individual and professional actions of five nurses.

The critical theory approach used in this study is grounded in the reconstruction of each graduate's perceptions of her experience as a student and as a graduate nurse, as revealed in the interview protocols presented in Part Two. The theoretical analysis of this qualitative data, leads to a number of conclusions about the nature of the educational experience and graduate practice of the five participants. When interpreted from a theoretical point of view two major themes emerge from the interview data.

The first theme relates to the tensions between social structure and individual agency. The continuity of social structures between education and practice were manifest in the descriptions the five graduates gave of their experiences. They described such structures as, for example, hierarchical social relationships; staffing levels; instrumental organisational practices; and procedures and practices which were routine and

taken-for-granted by tutors and senior nurses. These social structures, which supported and maintained the dominant ideologies in the polytechnic and the hospital, constrained the personal and professional choices and actions of the five participants in this study in various ways.

In the theoretical analyses it was pointed out that an ideology of individualism, predominant in both education and practice, masked the social conditions which produced feelings of personal inadequacy, as well as masking the social conditions producing self-blame. Therefore, each participant in this study often took responsibility herself for what were external constraints produced by the social relations within the polytechnic and the hospital. The kinds of experiences these graduates had during their education prepared them to accept more readily the structures and constraints they found on entry to hospital practice.

In both the polytechnic and the hospital, an ideology of consent masked the social structures which produced contradictions between the graduates' education based ideals and beliefs, and the exigencies arising from clinical experience and hospital practice. In this way each graduate was inclined to give a self-effacing rationale for her apparent inability to validate her personal and professional judgements in the practice setting. The graduates reported many instances in which they had attempted to use personal or professional judgements but had complied with those practices, principles and beliefs which they had perceived to be desirable by people who held the power to determine their future. They learned to act in accordance with what they perceived was expected of them. In this way established professional nursing culture became an integral part of these graduates' understanding of what it means to be a student or a graduate nurse.

The second major theme which emerged from this study relates to the production and reproduction of professional culture.

The graduate's individual consciousness of herself as a professional appeared to be socially constructed within the

institutional contexts in which structured power relationships were already well established. This consciousness of self was produced both by the graduate's perception of the relationships she developed with her colleagues, and by the structures which enhanced or constrained her professional practice.

The reported experience and reflections of the graduates in this study indicate that they were as much engaged in internalising those elements of a professional culture which impose a preconception of a professional self, as they were in reproducing them. The health professionals with whom they came in contact, as well as the social structures which shaped and constrained their choices and actions as students and graduates, provided the conditions in which cultural production and reproduction could occur. These graduates were actively encouraged to be self critical, but attempts to be self reflective or socially critical were discouraged. It appeared, therefore, that they had little opportunity to formally distance themselves from aspects of professional culture and to formally reflect upon its effects on their personal and professional lives.

This incapacity for formal critical self reflection allowed these graduates to perceive forms of social domination as personal inadequacies in their own professional competence. It also prevented them from understanding the contradictions between beliefs and action and produced a distorted separation of theory and practice.

These contradictions between beliefs and action emerged as personal issues at the individual level because they masked any recognition of what could be changed at the social level. Each graduate, to some extent, was aware of some of the contradictions in her everyday experiences in the polytechnic and the hospital. This awareness, however, instead of engendering a socially critical attitude, tended to produce self doubt and insecurity. Therefore, although these graduates realised, to some extent, that social structures constrained their actions, they did not recognise their ability to challenge or change those same structures. The

epistemic conditions necessary for emancipatory knowledge which would enable the graduates to transform these structures were not present either during their education or in graduate practice.

These distortions between theory and practice arose because of the domination of the technical models and instrumental approaches to nursing education and practice. These models and approaches are derived from the dominant ideologies already embedded in the polytechnic and hospital structures. In particular, nursing curricula are presently dominated by a technical linear paradigm which masks inherent contradictions between 'formal curriculum aims' and 'what the students learn'. Moreover, because the processes of cultural reproduction are not recognised within this paradigm, the epistemic conditions necessary for emancipatory knowledge are not available to the student. Thus, existing professional nursing culture is reproduced in graduate practice and ideological hegemony is maintained. A more socially critical approach to the design of nursing curricula might provide the conditions in which individuals can critically examine the hegemonic character of nursing education and practice.

Some Limitations of the Study

Although it has been successful in unmasking some of the social processes or forces which constrain personal and professional choices for action, this study has some limitations. First, the boundaries of time imposed an artificial end point for the study, but it is expected that the process of reflexive critique encouraged (and demonstrated by four of the graduates) during the interviews, would continue beyond the study itself. Although these four graduates were able to critically reflect on their education and practice, they demonstrated little awareness of their ability to analyse and change those social conditions which produced contradictions between belief and action, and which limited their choices for action. The brevity and limited focus of self-reflection engendered by the interviews prevented full examination of the reflexive effects of this study on the participant's actions.

A longer time period would be required for research into the kinds of personal and structural changes the participants may have been able to make.

Another limitation of this study relates to its generalisability. Five interpretive-descriptive case studies are presented in Part Two and, although each is presented as an analytic narrative which provides a basis for alternative interpretations, the number of cases and the single institutional context cannot provide a general account of the induction process for all nurses in all kinds of institutions. It is argued, however, that such generalisability is not appropriate in an interpretive study. Moreover, the opportunity for the reader to arrive at a tacit knowledge of the professional experiences of these graduates has been provided.

The number and depth of interviews (also limited by the imposed boundaries of the study) make problematic the contextual or interpretive validity of the study. The analyses of the data from the interview protocols, however, take account of each piece of evidence being interpreted in the context of the total situation as reported by each participant. In this way, a measure of contextual validity was achieved where the whole model comprising theory, method and explanations was especially suited to the phenomena being studied.

A further limitation of this study relates to its evidential base. Because a single research method (the in-depth interview) was employed, the empirical data could not be confirmed by triangulation - a form of cross validation of evidence used in participant observation research. However, because the focus of this study is on the reflexive understanding of graduate nurses during their induction period, the interview data is considered sufficient as a basis for interpretive analysis. Any attempt to broaden this focus to include analysis of the institutional contexts would have required additional data sources.

Some Implications for Further Research

Nursing education may be narrowly conceived as occurring within a polytechnic but, as this study has demonstrated, nursing education is not bound by institutional contexts. It may be seen more broadly as a process of induction into a professional culture which occurs across a number of contexts. This study has focussed on one aspect of nursing but it has implications for other areas of professional nursing practice. Because knowledge is not separable from practice, research utilizing a critical social theory approach may facilitate many people - health professionals and their clients - to challenge those social processes which constrain their choices for self directed action.

A study of the experiences and actions of nurse educators in both the polytechnic and the hospital may reveal similar social and political processes which constrain professional autonomy and maintain ideological hegemony. Indeed, manifest in the descriptions given by the graduates in this study, there were social constraints which limited the tutors' choices for professional action.

This study has focussed on comprehensive graduates beginning their professional practice in a hospital. The ideologies embedded in the hospital as an institution produced the social conditions in which personal and professional actions were constrained. An interesting comparative study could be carried out with comprehensive nurses beginning their professional practice in the community. Such a study may or may not demonstrate similar structural constraints.

Clients or patients in the health structures may be subject to similar constraints. Studies of the experiences of patients in a hospital setting, especially those with long term illness or disability, may also be carried out within a critical theory framework.

Concluding Statement

This study has demonstrated that critical social theory holds promise for research in nursing. The central goal of critical social theory - which is to unmask, or make apparent, those social forces which limit or constrain self directedness and personal and professional responsibility - fits well with the central aims of both nursing and nursing education. Nursing often aims to assist clients to exercise choices for self-care in relation to their level of wellness. Nursing education claims as its central concern, the education of professionals to exercise autonomy and responsibility in their working lives. This study has shown that developing autonomy is only part of the educational enterprise. Nurses should also recognise that both education and practice are political processes which induct individuals into a professional culture. Explicit recognition may enable nurses to transform some of those social and political structures which presently limit and constrain individual action and professional autonomy.

PART TWO

METHODOLOGY

In Part Two the qualitative data for this study is presented. First, the methodological and ethical procedures adopted for this research are outlined; then individual case studies of five staff nurses in their first year of hospital practice are presented. This presentation is a synopsis, guided by the interpretive framework outlined in Chapter Three, of the data gathered during six to eight in-depth interviews held with each graduate in this study. At the conclusion of each case study an interpretive profile of the graduate concerned is presented.

Procedures

Six names were randomly selected from a list of eighteen comprehensive staff nurses beginning professional practice at the same hospital. These six people agreed to an individual meeting with the researcher to discuss their participation in the study. All six preliminary interviews were conducted in an informal setting at the researcher's house. Five of these graduates were enthusiastic about the study and their participation in it; the sixth was willing to participate (she subsequently withdrew after the second formal interview). These five remaining graduates became the participants in this study.

All five participants who completed the case study interviews were in their third month of professional nursing practice when the interviews began. They had recently graduated from a polytechnic course as comprehensive nurses (refer p 7) and were employed as staff nurses in different wards of a large base hospital. They were among thirty three newly qualified comprehensive nurses employed by the Hospital Board. In their particular hospital they were among eighteen new graduates and twenty four other registered nurses to be employed during the same period.

An interview time was set each week with each graduate to fit in with her duty and other commitments. These six to eight interviews,which were conducted in the researcher's home and lasted between 45 minutes and 90 minutes each, were held over a period of three months. Each participant could stop the tape recorder and

could request that recorded material be deleted at any time. Each participant also spent several hours in informal (unrecorded) conversation with the researcher over this three month period.

The interviews were generally unstructured but they focussed upon recent experience of nursing practice and recollections of educational influences. Each interview, after the initial ones, began with the question:

Would you like to tell me about your week?

After the second interview each participant was asked to write a list of events she would like to discuss at the following interview. This was an attempt to link the participant's reflections during the interviews with their experience of daily nursing practice.

The number of six to eight weekly interviews over a three month period was decided upon because of the limits of the study and because it was thought that this time period would allow each participant to feel comfortable in the interview situation and to critically reflect upon her practice as a staff nurse. Although there were artificial boundaries on the study, it was expected that the self-reflective process would continue beyond the termination of the research itself.

Tape recorded in-depth interviews are used as the research tool in this study for two reasons: Firstly a tape recorded interview not only protects the participant against misinterpretation, it also captures the immediacy of the situation and the vividness of speech. Since all taped interviews could be transcribed and given to the participants to read and alter if necessary, some of the ethical problems of case study research (discussed below) could be resolved.

Secondly, in depth interviews are used (rather than types of observation) because they are more consistent with a critical theory approach. The people interviewed are participants in that they are observers of themselves and of others, and an interview can provide them with the conditions which help them to talk reflectively about their observations and experience. Since the author is attempting to disclose the meanings that actions and events have for the participants, the interview is used to explore and test the conceptual framework already established in the theory base to this

research. Information thus gained is used as evidence to support an interpretation which is tenable in that it carries meaning and rings true without violating the larger store of information from which this selection is drawn.

Ethical Concerns in Case Study Research

An explicitly ethical stance is taken in this present study, based on the conviction that research with human subjects should not be conducted without their informed consent and comprehension. This position is consistent with the theoretical framework used in this study. Critical theory is interventionist in that it provides the conditions in which the participants in the study are able to see their actions and situation differently and act upon that knowledge. Therefore, not only were all participants required to give their informed consent (the mechanism through which the individual's right to self-determination is protected) but they were expected as far as possible to comprehend the nature of the study being undertaken.

The extent to which comprehension actually presents a serious problem in social research has not yet been subjected to systematic investigation (Bower and Gasparis (1978:39)) but is an issue which must be dealt with if research using a critical theory approach is to be carried out. When a proposed study is too complex for easy comprehension by the participants, informed consent is difficult to obtain. To ensure the protection of the individual, an ethically valid consent in research should contain, among other components, both adequate disclosure and sufficient comprehension (of the purpose, procedure, risks and benefits).

To this end a research protocol was discussed with the Massey University Sub-Committee on Ethics in Research Involving Humans (see Appendix 2); a contract was signed by the researcher and each participant (Appendix 3); each participant was interviewed twice before formal interviews began so that the nature and likely consequences of the study could be fully discussed; each participant was informed that she could withdraw from the study at any time; and all transcribed material was given to each participant to read at the conclusion of the study.

As a result of the informal discussions, one participant withdrew from the study following the second formal interview. This participant was reluctant to discuss her practice in a particular ward in the hospital for two reasons. She stated that she felt very uncomfortable because she could not practice in the way she was taught and the interviews were highlighting this; and she was experiencing difficulties with the charge nurse such that she did not want it to become known that she was participating in this study. The participant's right to self determination was respected and she withdrew from the study - all tapes and transcripts were destroyed.

In the case studies presented here, the five graduates reflect upon their education and upon their daily practice as registered comprehensive staff nurses in a hospital. The notation following an excerpt from the transcript refers to:

interviewee pseudonym/interview number/transcript page number

e.g. (Alice/5/43).

CASE STUDY ONE : ALICE

EDUCATIONAL EXPERIENCE

Alice began her nursing education at the age of nineteen after a year at University. In the seventh form she had decided to apply for physiotherapy school but this application was unsuccessful.

> *I went right to seventh form at school and then I really didn't know what I wanted to do so I thought I might as well go to University, and I didn't enjoy that - I didn't want to be a teacher, and I couldn't do it anyway because they had to have studentships so I thought well its not much point doing three years and then not being able to put it into practice and I'd been doing nurse aiding in the holidays at a private hospital and I'd really enjoyed it and so I thought I'd like to give nursing a go.*
>
> Alice/3/29

Alice applied to the Polytechnic close to her home and was accepted for the Comprehensive Nursing Course.

> *I didn't want to do the general course - my mother's a nurse and she thought that comprehensive was the better course and my cousin was already doing it as well, so I just applied for comprehensive, and I got in.*
>
> Alice/3/29

Alice remembers that she wanted to make a good impression right from the start.

> *(Do you remember what your first day was like?)*
> *Yes. Why do you want to become a nurse? That terrible cliche question. We all got asked and all those other questions that I suppose you should have asked yourself - but that I never really had - and we were meant to tell everybody in our little group - we had to say why we wanted to be a nurse. I found that quite hard because you had to say it in front of other people and you had to try and think of the*

right reason. (You can't remember what it was?) No, but I do remember thinking, I'm going to put my foot in it now.

Alice/3/30

She remembers also how hard it was to get to know the other students when she was in a flat and they were in hostels.

It was quite hard because I think like when I was at Varsity I lived in a hostel and you always had people that you were living with going to your lectures with you and the girls that were living in the hostel this time - they were all quite clicky - they had got to know each other so that made it a bit hard because they had an established group.

Alice/3/30

Alice had difficulty in reconciling her experience at university, where she had felt quite independent, with the requirements of the Polytechnic Course.

... and also taking rolls and it was quite like going back to school. (In what way?) Well, just that at Varsity you don't - you just turn up if you feel like it - and it's your problem if you don't get your education that you are there for. Nobody takes a roll - nobody is on your back if you're ... (Were those rolls taken at the beginning of every class?) Yes. (What happened if you missed a class?) We had to fill in a form saying where we were or why we weren't there. You got into trouble if you didn't fill that in - if you had been away and you didn't put the right reason - I put one time - I was late for class - so I put that reason - I was late for class and you couldn't go in if you were too late - and so I arrived for the next class and I had to say why I hadn't been to the previous one and I said I was late for class. One of the tutors came up to me and said why were you late for class - so I had to be specific and say that my alarm clock hadn't gone off.

Alice/3/31

Roll call throughout her education was a continuing source of annoyance and frustration for Alice who saw it as contributing to a loss of her independence and privacy.

> *(Did you mind roll call very much?) Yes. Yes, I did mind it because I thought that especially after seventh form at school and then the year at Varsity - a year away from home and now out flatting that I should have had a bit more responsibility and I had chosen to do this. (Were you told why those rolls had to be called? Why you had to do a certain number of hours?) I can't remember if we were told right in the beginning - I know we were told later on - second and third year, well second year anyway, that it was for Nursing Council - that we had to account for so many hours. (Looking back now can you see that that was necessary?) Yes, I guess so, but it still made it hard to take having to say - Yes M'am, I'm here.*
>
> Alice/3/32

Alice found that she could meet the formal expectations of the nursing course with little effort:

> *(Do you remember what the course work was like?) Well I never really worried about it - some other people did. I didn't usually put too much work into it - but the tests were a good way of keeping up with your work - reading over it - revising.*
>
> Alice/3/33

However, she became confused and upset by the differing and apparently inconsistent interpretations of her behaviour. For example, her clinical reports indicated that she had considerable ability in nursing and communication skills but her class end-of-term reports stated that she had a 'negative attitude'.

> *All my clinical reports were good. My class ones weren't so good. (What did your class ones say that weren't so good?) I had a negative attitude. (To what? What did that mean?) I think I felt*

that they were judging me I think. Me as in my personality. (Can you tell me a bit about it?) I was absolutely astounded because I couldn't work out how they had got that idea in the first place. Because I was really enjoying it. And I didn't know just how they reached that conclusion. And also that my clinical reports had been so good. (So you had felt pretty good about yourself?) Yes.

Alice/3/34-35

This confusion was not resolved although Alice made several attempts to clarify the comments made on her reports during the first year.

(Did you go to the tutor and talk to her about it, or the course supervisor?) Yes, I talked to the course supervisor about it. (What did she say - do you remember?) She said that it had come from more than one tutor. She said it was certain things that I had done, but she couldn't pinpoint what I'd done to upset them. (So you didn't know?) No. (Did you try and check it out any further?) No, I don't think so - I think I was too angry.

Alice/3/35

In her second year Alice received a class report which 'devastated' her but again she could not discover what these comments related to, or which behaviours were unacceptable, or who had written the comments.

Actually the report said that I was rude and impolite. And this behaviour will not be tolerated. (Can you remember any instance which might have resulted in a comment like that?) No, I took it out and showed it to the other girls and they just couldn't believe it. So they went and saw the course supervisor too. All she could say was that she felt that there were reasons for

it - that I had been doing something - (But she didn't know what it was?) No, she couldn't put her finger on anything again. (It wasn't very helpful for you?) No, it wasn't. And I was wondering who it was because she said that so many tutors had - it was more than one tutor that had said this because they used to have their meetings or something - KGB meetings. (Was that how you thought of them?) Yes its how we all thought of them. And our files - KGB files. So after that I felt a bit paranoid about - who was it, was it this one, or I'd better be careful. That sort of thing. (What about your classroom behaviour. Did you stop talking so much?) Yes. (Did you ask questions?) No - I just - I thought well just stuff it - its not worth it, I'll just sit back ...

Alice/3/38

Alice decided that her 'personality' was not acceptable and made some effort to change her classroom behaviour.

(How did that affect you after you had got that report, in your class work?) I felt like I had to grease - (And did you?) To a certain degree I think. Well I just tried to be nicer. You know not myself. (If you tried to be nicer what were you doing before that might have resulted in that kind of report?) I think I was speaking out in class more. Our lot weren't exactly vibrant or very vocal. I wasn't the most vocal thats for sure. (Can you just give me an idea of the climate in the classroom when you were most vocal - was the tutor asking for participation or ...?) Yes, she was. You know, what I'm saying is - this is overall not just one particular tutor - just in every class I was like that. I wasn't overly assertive or anything - or aggressive.

I was just involved in the class - I think that was all really.

Alice/3/36[1]

(Did they improve in the 3rd year then?) They weren't too bad. (You were being very careful?) Yes, thats right - I just got - I was working steadily or something like that. No comment, just the one sentence. They couldn't say anything else because I wasn't doing anything. (Were you actually working though? Because it sounds to me as if you weren't doing terribly much?) I was doing all my work that we had to do.

Alice/3/42

Alice used the 'complaints procedure' of the Nursing Department many times but was only successful in changing the comments on one 'classroom' report.

(Did you ever find out from anyone what the difficulty was?) No not really. I just came to my own assumptions. (What were they?) Probably that I was talking out too much and that I wasn't looking interested enough and - I have got an emotional face apparently - everything that I think goes across my face so I tried to restrain that as much as I could but it was pretty hard after 19 years of doing it. (Was that a strain for you - did you like classroom work?) No it was a strain. Because I wasn't being myself. (You were conscious of that?) It was overwhelming - you thought about it all the time, whether you were - your self esteem just dropped.

Alice/3/39

(1) During this part of the interview Alice expressed her anger and perplexity about these reports - much of this was not taped at her request.

(Did you get a chance to change that behaviour and have it commented on? Or was it just in the report for ever?) No, you could go and get it changed or you could go and talk about it - I know I went and talked about one of mine and they said something about how my theory - the test that I had been doing I had satisfactory results - getting 70s to 80s every time, and I felt that that wasn't a fair comment. (What do you think it should have been?) Well, I think it should have been - good results. Something like that - so I got it changed to - very satisfactory. (Make you feel better?) It made me feel better in letting them know how I felt about it.

Alice/5/58

Alice's experience in receiving negative comments about her classroom behaviour appears to have been a common experience in her class. Her classmates seem to have been equally perplexed and concerned about the inconsistency between what they were being taught, and their experience of the course.

Generally our reports were - you know nothing positive in them. (This was in your second year?) Yes, and first year. (So they were fairly negative reports for everybody?) Particularly in our - both years really. There was never anything positive put in them - for our group that I was in. (Why was that?) I don't know. We couldn't understand it. Because it just seemed to go against what we were being taught about - caring - you know all the psych and everything. And how to treat the patient. Whereas it seemed that the nurse - don't give a stuff about her. (You mean what you were being taught was not the same as how you were being treated?) Well it wasn't really at all because

like with the rolls and having to be at class and that sort of thing and having to fill in forms. I found a lot of those things at tech just didn't tie up - they were sort of - hypocrisy, with things that tutors said and then things that they expected of us.

Alice/3/40

I remember talking to students after we had got our reports and everybody saying - all they seem to put is something - some sort of criticism - there's never anything about what you did good, and its also - they single out one specific thing that you did wrong, and they home in on that, and that's the only thing that you did for the whole of the term and that's all that they comment on. That came out in a lot of people's reports.

Alice/5/58

Alice identified two distinct areas of behaviour - professional behaviour in the clinical area and classroom behaviour. She thought the classroom should be a place for sharing ideas and 'being yourself' as a student.

Mainly in the clinical area you have got to be a bit more contained - you can't just let out whatever you think at any old time because you have to think of the other people - patients and the other staff and that sort of thing. But in the classroom when you are learning, I think its important that you do behave how you want and talk about things that you think should be discussed and that sort of thing. (So its your professional responsibility to ask questions and to disagree if needed?) Yes, and also probably I don't see anything wrong with not having full attention all of the time because its pretty impossible for 8 hours a day - especially if you

are finding what is happening is not as interesting as something else.

Alice/5/60

Alice still felt angry and resentful about what, for her, was the 'moulding' process she went through during her three years of nursing education.

... I understood about professional role and that sort of thing, but my clinical reports were all fine - I was always professional in the clinical area and I felt that in the classroom you could be more yourself. Well I was myself in the clinical area, but you should be able to say things in the classroom anyway. (Looking back now do you think the kinds of things you said in the classroom were things that indicated that you want to learn or things that were just a jolly nuisance?) I always thought they were trying to mould us and that you weren't being your sincere person. (Did you think they had good reason to try and mould you?) No, not at all.

Alice/3/36

I think that they've got set ideas on what a nurse should be - and that's how every nurse should be. I remember one of the tutors saying how nurses are a very conservative group - how they always dress conservatively and they don't have outrageous ideas and that sort of thing, but its no wonder. We were put down if we did anything different. That's how I feel anyway.

Alice/5/59

The tutors were looking too much at the negative side of that person and pulling their personality to pieces. Not boosting up their self confidence - and their self esteem. (We have talked about this before I know but when I was reading through the

transcripts - one of the questions I really wanted to ask you about was - Why do you think those things happened? What were the reasons for writing negative reports - for attacking the student's personal characteristics?) I think probably power, manipulation. Trying to fit you into a mould of the perfect nurse - I don't know. (You sound a bit cynical?) I sort of think it was though. Trying to decrease the individuality of each nurse. (Did it succeed?) I think to a certain degree.

Alice/6/79

Alice accepted the tutor's evaluation of her behaviour during clinical placements. She thought this evaluation was fair and liked being able to discuss her performance with the tutor. She was careful in her evaluation of herself, however.

When you got a clinical report were you more prepared to accept what the tutors said about you in clinical? Than you were about what they said about you in the classroom? Yes, I think so because generally you went over it individually with the tutor and you ticked what you thought and then they ticked what they thought. (These were self evaluation forms?) Yes, and she would talk about it with you, why she had put that and why not that one, and that sort of thing, so you knew why you were getting it and it was one to one, you knew it was her evaluation of you. It wasn't just six others of you. And the good thing was that you would discuss it. (So you felt much more a part of it?) Yes, and also because ... especially in a person's 2nd year, they had been working with you closely so they did know. (And you were prepared to accept their estimation of how you were getting on?) Yes, because it was reasonably good. I was happy with it because I could discuss the good and bad points with the tutor.

(Were there times when you marked yourself well up and the tutor marked you down?) No I was never that confident. I would tick either side of the average column. It wasn't very often that I'd tick in the upper one - I'd try to vary it a bit.

Alice/5/63

Alice felt more comfortable during her third year. She had 'relaxed' in the classroom and enjoyed clinical practice.

All my third year reports were good. (Had you continued to be fairly careful in the classroom or had you stopped doing that by third year?) Yes I think I had - I was still reasonably careful. (But you were questioning and commenting?) I think I had relaxed a bit more.

Alice/3/46

Well in the third year basically it was all really good - most of it. So its hard to remember what the other two years were like and why we got so hacked off with it all. Probably because it was just so much of it - not enough getting out and into the clinical area. (And yet you were learning about nursing and about patients?) But it's all hypothetical isn't it. You are not doing the real thing. And you know that you are missing out on all those other experiences on the ward. Dealing with patients - and the demands they make on you. Communicating with them. And the practical things like, medications and drips and that sort of thing because that was really where I dipped out. I had never seen a Naso Gastric put down, I had hardly had anything to do with drips, I was absolutely terrified of them. I had to put a Naso Gastric down yesterday and today.

Alice/5/66

NURSING AS A GRADUATE

Alice obtained a position as staff nurse in a large hospital immediately after she graduated as a comprehensive nurse. She began her career with a one day orientation to the hospital and her ward. The following day she had five patients to care for as well as her routine staff nurse responsibilities.

Adjusting to social constraints

Alice found that providing nursing care in this ward demanded heavy physical work. The patients were mainly elderly and often immobile and the ward "seemed to be always under-staffed". She describes her nursing practice as "coping with a heavy workload" and providing mainly "physical care" for her patients.

> *It's a heavy ward. Sometimes we have got hardly any heavy patients and other times the ward is just full of them and you've just got the same amount of staff on all the time. You just find it so hard to cope. (Can you get more staff if you need them?) Often we are sent them - if we ring up. Other times we are not. We just have to cope. (If you do ring up you can get registered staff?) No, usually only students - general students, they're sent along.*
>
> Alice/1/1

> *You've got to do two hourly turns and that sort of thing. You've just got to look for the short cuts all the time. (You wouldn't be sitting down by the bed?) No that's right - the patients miss out with just having a bit of time spent with them. (Are you conscious of that?) I am, I think more than the others are. Because we used to do it a lot when we were training.*
>
> Alice/1/2

A typical duty for Alice included concern about 'coping' where such factors as lack of staff were very important.

(Do you want to describe today to me? Was today typical?) Yes, it was - horrible. There were two staff nurses on, an enrolled nurse and the charge nurse. (Was that including you?) Yes. And two students and an older student who is just about to sit states and a new prelim. enrolled student in her first couple of days of taking a list - and she had five patients and the rest of us had five or six, and our other enrolled student got sent away and we had two - a staff nurse and enrolled nurse coming on from 11 to 8 shift. On our ward we have a staff nurse who is a runner who does the drugs, answers the phone and helps with lifts and that sort of thing. (And doesn't have any patients of her own?) No, but she had to take patients today and then there were three other patients left and the charge nurse just wanted them left for the 11 to 8 girls just to give them pans and you know, face and hands washed, until they got there.

Alice/1/4

Another such concern was the pressure "to get things done" in the time available.

I think it's just the pressure with time - you know just everything, everybody is always demanding from you - I found that very hard when I first started. You've got no time just for yourself. You have to wait till you finish work - then you can sit down and think. (There's no time on the ward to actually sit and find out about conditions or talk about nursing care?) No, we have a - we try and have a ward meeting once a week but then if you've got days off you miss out on those. You just forget about them.

Alice/1/12

(Do you write care plans for your patients?) Everyone has a nursing care plan on the front

sheet but often they're behind, they're not kept up to date but we try. It's just lack of time you don't have the time to spend over them. (Are they always physical problems or do you include emotional problems?) Usually they are only physical.

Alice/1/6

Alice was not prepared for the hard physical labour of nursing practice and the lack of time to "think" about the nursing care she was giving.

One day we were all registered - we didn't have any students - that was quite different, I've never struck that before but we have only had about one student this week because of the states and what have you. (So you have had a charge nurse and you?) and 2 staff nurses and one enrolled nurse. We seem to have had about 5 or 6 patients every duty which is one or two more than what we usually have. And they really only have the basic needs done and that's about all that we have been able to ... (Do you mean their physical needs?) Yes. Well we did really because we only did what we had to do - just pans and washes and there was only a lot of tops and tail washes not through the showers because we didn't have the time and that was different. (So you were pretty busy?) Yes, it was a horrible day. (What, because of the jobs to do?) Yes. Just because we felt so pressured for time I think. And you know that you didn't have time to spend with your patients. Even if they were upset or anything you had to say, well, you know I can't spend any more time, I've got to do the next task.

Alice/2/13

She was unprepared for the need to learn procedures and practices that were unfamiliar to her:

Well, when we got to work it looked like a good lot of staff but then we found out that we had two off sick. So that reduced us down to 6 which still wasn't too bad. (And you had students on that day?) Yes, two students - three staff nurses and an enrolled nurse. And I had a lady with kidney failure having peritoneal dialysis which was new for me - but I was lucky because she'd been on it for quite some time doing that all at home and had been taught down in Wellington how to do it all, and her daughter as well had been taught, so they were able to teach me what to do and it was really quite basic but because it was new I felt a bit worried about it - that I wouldn't be able to cope.

Alice/2/15

Alice found that she worked hard each day:

And we just had yesterday - we had the charge nurse, myself and an enrolled nurse and a pre-lim enrolled nurse student and an enrolled nurse on from 11 till 8 and we had three people off sick, so again it looked like we were going to have a good day with staff, but then we ring up the duty officer and find that we have got a few off. (So there was really only two registered nurses there?) Yes. (How many patients did you end up with?) End up having seven, because we started off with 20 out of 24 beds filled and we were on acutes - acute admitting - so we soon got those filled up from admitting room - no not from admitting room - we had one from admitting room and the other two from A & E. So they had to be fully admitted and that was a bit of time. One came at a quarter to 12, and one came at 2 o'clock - so they were both really bad times - we were trying to get things done and trying to settle them in and spend a bit of time with them - well we got

there. One of them came in as an actue admission and we tried to get her to get into the bed but she just didn't know what to do - she was going to move down the end of the bed instead of just going across so we had a bit of trouble - just trying to get through to her what we wanted, and the doctor ended up thinking maybe it was depression because she was responding to some things but wouldn't talk to you about other things.

Alice/2/17

She began to rely on students as extra "hands".

(Time's a big thing isn't it?) It sure is. It's really good when you've got the polytecs on. Because we just don't have enough staff of our own. We had two staff nurses and two enrolled nurses and a charge nurse on on Monday, because we didn't have polytecs, and we were just frantic, we just got basics done and then the polytecs came on Tuesday, and a big sigh of relief, because they were able to take patients and we were able to do more things.

Alice/5/68

She recalls how much she resented the implication that students made it easier for the ward staff.

The Principal Nurse came round this morning and ... (Does she often come?) No she hasn't been round for ages, but she usually comes every couple of weeks. She was saying to the charge nurse - you've got polytecs on today, and how many other staff have you got, and what do you do when you haven't got the polytecs on, and the charge nurse said we work a lot harder. "And when you have the polytecs on, do you take it easy then, she said - but it doesn't work like that. We just try and catch up on what we haven't been able to do when we have had the bare minimum of staff.

Alice/5/68

The physically demanding nature of the nursing practice in the ward was exacerbated by the difficulties Alice and the ward staff experienced with obtaining a duty roster which was satisfactory to them.

> *It's just that we are having a bit of trouble with ours at the moment because we complained about our roster that we had had and so our charge nurse asked us to make up one so we made up one and we sent it in to get it approved and I think it hasn't got approval, and so our supervisor is now organising something and it's just because it's so up in the air - we don't know where we are.* (Who normally makes it up?) *Usually they've got a set one that has been approved and the charge nurse is just meant to use that but I think because we were getting new staff nurses and she wasn't using it and so she was just making it up and wasn't following anything so we are really higgledy piggledy.* (And you would like regular weekends off?) *Yes, that's what we tried to put into our roster but it didn't quite work out.* (Do you know why?) *The one that we did - it was because we had split days. Apparently there is certain days off that you can have and certain days off that you can't have - like apparently Sunday and Monday, you aren't meant to have off - I don't know. That made it hard to make it up.* (Are you able to talk to anyone about that?) *Yes our charge nurse is quite open about it, she knows the problems that we have to put up with and she was really willing for us to see if we could do any better and because she hates doing it - making up the roster herself - especially when it is not for her.* (And what about the supervisor? Can you talk to her about it?) *No not so much I don't think. I think if she was more worried about it we might have got there a bit quicker.* (So you haven't actually had an official answer?) *We could have done but I might not have*

heard about it.

Alice/2/20

Alice thought that "the hierarchy" was not interested in catering for the needs of the ward staff because those at supervisor level and above were "too far removed from bedside nursing and were unable to understand the nature of the job." Alice was concerned about this as she thought the standard of nursing care dropped when staff were dissatisfied.

> *(In general do people working in the hospital care about other people?) Yes, in general, but there also comes in a bit of blaséness about the whole place. Oh another day at work - another hard slog and there's never enough nurses - too many patients, too many bedpans - I think that comes back to the hierarchy a lot - like if the staff aren't happy the level or standard of care - the standard of nursing care will drop, because you are a person first and a nurse second, I think. (Can you tell me a bit more about the beliefs that the hierarchy have about people and about the job that you're doing?) Well, I think that they're too far removed from the job itself - what the nurses at this level are doing, how much work they are having to put in and how much of themselves that they have to give for that job and they can't understand and therefore they can't cater for the needs of their staff and they are losing out because the standard of nursing care drops. (Is there a general feeling of powerlessness amongst nurses at your level?) Yes I think there is. Everybody shivers in their shoes when the Principal Nurse comes around and everything - you have to try and put on a good front when she's there and then you just lapse back again when she's gone. You know the morning that she's coming. She comes early in the morning so everything is chaos anyway. I think it's*

the best way for her to see it. Whenever she's been around I've been busy doing something - I've never had to come up to her and say anything to her. So I just carry on with what I'm doing. Some of the comments that she says to the charge nurse sound like you have to be standing up with your feet together. She came last week and the first room she went into there was a lady sitting there - she had just had blood taken off, and there was blood all over the sheets and her porridge had gone cold because they had been in to take blood off - she didn't think that that was on - but it was hardly our fault that that had happened and there were 23 other patients wanting their breakfast as well. Lots of little things seem to go wrong as they went round the ward.

Alice/6/74-75

Alice was concerned about the "impersonal nature" of decision making at this level and wanted to retain some individuality and control over her own future.

Well I think that because they're set up there by all the other staff as well as themselves and it's just the system, that they think that they have got the power and they really have because they control what happens to every staff member - where they are going to go, how long they are going to stay there for and how many staff are going to be on that ward and just everything. So they really have got the power and people - like when you go you want to have a ward change or something - they can say it's just not on, you can't leave yet and that's that. They can just lay down the law and you can't move. It's hard to put your case to them for what you want to do with your life - with your career. Once you are in there you're stuck. They are not flexible. (You feel as if you are being pushed and pulled around?) Well, I haven't tried

to move yet but if you wanted to you would find it quite frustrating. (Is that kind of control reasonable?) No not at all. Because you are people. You've got every right to have control over where you want to go as long as its reasonable. And what you want to do with your life.

Alice/6/77

Problems of professional identity

Alice experienced some difficulty in feeling accepted as part of the ward team because of her educational background. She felt she was being "protected" because she was a comprehensive graduate.

I think that has something to do with me being comprehensive as well, they find it harder to trust me - whether they don't know if I've got the knowledge - I know it does take longer for us to adapt and that sort of thing, but sometimes they will protect you more than what they really need to, don't extend you.

Alice/6/74

This feeling of inadequacy made it difficult for her to rely on her own professional judgement.

I do feel that I'm sort of prejudiced against. That they think that I'm not quite as capable as them. Some of the other nurses - and even the charge nurse ... (Do you think that you are being compared all the time?) The charge nurse - I think she's quite aware because she had two comprehensive nurses starting out last year - she was telling me that she became aware of it when they started out last year and she said since then she has tried not to compare general and comprehensive nurses and tried to keep them separate because they take different times to adjust and get used to the ward and that sort of thing. (Do you think that is so?) To a certain extent it is. Especially when you are

first there. It is like being thrown in deep water You don't know where you are. There is so much to learn and you are bound to take time to get used to it and fit in. (But you are feeling pretty comfortable at the moment?) Well, yes, fairly comfortable. I'm still asking heaps of questions. And if there's somebody else there when I have to make a decision or something generally I will ask anyway, even if I have got a fair idea of what I would do if I was there by myself.

Alice/2/28

These experiences made her more aware of the opportunities she did have to be relatively independent.

(Have you been on when there hasn't been any other registered staff on?) Yes, I have ever only done that once. (How did that feel?) Quite good. It meant that I could - that I was going to be making the decisions, that nobody else was going to be saying well, I've done such and such when I could have been doing it. I think that I felt as though I've been sort of pampered. Or not given - been extended. The other girls - because they are general trained, they know the hospital routine, they've been given more responsibility than I have. So that when I get it I like to be able to do everything. Get a bit of practice in.

Alice/1/10

Alice felt unable to approach the charge nurse for advice or with any difficulty, because of what she called her "abrupt manner", and because Alice felt "put down" by her responses.

Yes, she is reasonably approachable but I would rather not. But that's just me, but I find that her manner - I don't know - it's sort of a bit - puts you down a bit or something. The way you'll say that you've done something and she'll go - but why? Makes you feel about this big. It seems quite hard

to go and tell her when you know what she is going to do. (Who would you go to?) One of the other staff nurses. Just to find out what I should do sort of thing. (Have you thought of doing anything to change that?) I just keep out of her way. Ask somebody else. (Well that's an avoidance response isn't it? What about using reflective responses. Do you know what I mean?) No. (Saying things like - I really feel uncomfortable when you speak to me like that - or restating what she said in a different way so that she realises what she has said and what effect it's had on you. Can you do that with her?) I don't think I'd have enough confidence to do it. (What would stop you?) What she might say back to me. I think also that you often haven't got enough time to sort out problems like that.

Alice/5/68

Alice found that getting accurate feedback about her performance was difficult. She relied on patients for positive comments about her work, and on other staff nurses.

(How do you find out how you are getting on?) It's really a matter of talking to the other staff and maybe even your patients. They often tell you - that they've enjoyed you looking after them. (You get some feedback from them?) Yes. (The other staff nurses - do you actually ask for feedback or do they give it?) Well, you sort of edge around it a little bit - and say, I didn't think that I did very well with that - and they say - oh yes, you did. Something like that. (Is it important, getting that sort of feedback?) Yes, I think so, especially when you are still not feeling sure of yourself. You think that you are making

heaps of mistakes - and they say that you're doing all right. (What about the charge nurse?) Well she has done an evaluation but I don't tend to ask her.

Alice/5/69

SELF REFLECTION AND PROFESSIONAL ACTION

During these interviews Alice discussed many aspects of her pratice which she would like to change.

You know how you start working in the clinical area full time and you have - you have got to conform to sort of try and fit in with everybody else and get to learn how they do it and how they like to have things done, and you forget what - you don't forget, you just push it to the back of your mind, what you've been taught at tech, the standards and the practices that you have been taught, while you are trying to adapt and when I come here remember all those standards and things, and I start thinking and try to apply them back at work. (So you think if you weren't talking to me those sorts of things would get pushed further back?) Yes really it might be just me - maybe other nurses wouldn't do that.

Alice/5/70

She thought that having to discuss her education with the interviewer was uncomfortable because she felt she was not nursing as she was taught to.

(What sort of things stop you from nursing in the way that you would want to nurse?) I think time. Not enough staff. Also because I'm still new - fitting in - still learning about the ward and that sort of thing. Less self care. I think that's one of the main things due to the pressure of time you have to do more things for the patient, not letting them do them for themselves, because you're running out of time and you feel as if

you've got to have these things done by the end of the duty. (How does that make you feel?) Well I think it's pretty hard especially when you first get there and you've been taught all these ideals at tech and you come to the reality of it all and you've got to come to grips with it. Try and adapt yourself what you've learned and how you are going to meet these new needs of the hospital and just try and fit in. (Have you consciously said well we've been taught this but this is what I have to do?) Yes, I have thought about it as I'm doing things - I think oh - I should really be letting Mrs. so and so do this for herself - but you know if we don't get things done we'll never get done sort of thing. (So you are aware of what you should do?) Yes. (Do you get down about that? Do you feel that you ....?)Probably I think that's what one of the depressing things about the place. That you can't do as much of your ideal nursing care as what you would like to do - that you've been taught to do.

Alice/6/72

Further practical experience enabled her to have the confidence to suggest and implement changes in her ward.

It gave me more confidence - I was able to increase my confidence on the ward - I felt more sure of my decisions about patient care - students coming to ask me things - I felt that the training I had was O.K. - I had the right answers. (What about the satisfaction you have had working in the ward?) I don't think that's changed much - maybe with the other staff - it could be - I have more confidence to - not to stand up to them - be assertive maybe. (You think talking to me might have increased your assertiveness?) Yes, I think so - I have to think more along the lines of how we were taught at tech - thinking more of the

patient holistically - not just taking it for granted that just because its always been done that way it has to stay that way - improvements can be made.

Tape 7, 120-170

Alice was aware that she was providing a different kind of nursing care when she was able to:

(Is there any emphasis at all on the other things - communication or meeting other kinds of needs. Or is that fitted in after the physical ...?) Yes, I think so - it comes second. (Is that opposite to what you had at tech?) Well it's opposite to what we were led to believe. That their philosophy ... I think it's different because once you are at the hospital it's reality and you've got to get those things done. (Why do you have to get them done?) Well, the patients have to be washed, they have to be kept clean. It's probably just being ingrained into them and that. That's how it's always been and that's the way it's going to carry on. (Since you've been there - you've been pretty concerned about learning how to do your job properly, fitting in with the others; have you thought about doing things differently?) Well I do when I have got a patient list, I'll do things for my individual patients a bit differently from what other people will do, like if somebody hasn't been up - they have just been having bed sponges for a while and they can get up for a shower, then I'll tend to get them up more than other people will do.

Alice/4/56

Communication Gaps.

Alice identified several areas that she would like to change so that her own nursing practice, and the nursing care in the ward, could be improved. "Communication gaps" she saw as the most important area of concern.

I think they are everywhere. You know between every person - like between charge nurse, staff

nurse, between doctors and nurses, social work department just everywhere. Nurse and patient. Relatives. (What is causing the breakdown?) Just not talking I think. (Why?) I don't know if people aren't aware that there is a need. Maybe it could even be a lack of communication skills - not being able to talk about things. (Do you think you are more sensitive to the communication gaps than perhaps some other staff nurses would be?) Yes, I think so. (Why?) I think it's mainly because of our communication lectures at tech.

Alice/2/21

Alice thought that there were specific areas where "lack of communication" affected nursing practice

- planning nursing care
- giving medications
- gaining access to information

Planning nursing care

We have our nursing care plans but often they are not kept up to date enough - you know lots of things like they are still on bed rest when they have been out of bed - well you know - usually that is not right, but ... (So you can't use them as a reliable source of information at the beginning of each duty?) Not always. (Would you like to change that?) I think it would be too much if you changed them a great deal - because really you just don't have the time to have lots of information in there - to be able to have the time to put it in and to spend time making them up. As long as you have the basic things in there - things that have to be done - then I think the care would improve. (So you would want at least a daily up-date?) Yes. (Who would do that?) Well I think that for the patients you are allocated - that you could do that when you write up their reports. (Is that done at the moment?) Well I try to do it

but not many of the other people do. (Again is that a hangover from your education?) Probably, I feel guilty if I don't do anything with nursing care plans. But everybody uses them - you know whenever we read out reports we are always referring to them. That's why I think it's important that they're kept up. Because you can always put somebody wrong about something - dressings, they've been done like that. (Is the charge nurse aware that the care plans are not up to date?) Yes she must be because she reads them out too. (Does she make any comment about keeping them up to date?) Not really. I think it's come mainly from the other comprehensive staff nurse and me. We have passed comments to the other staff nurses about nursing care plans getting behind.

Alice/2/23

Giving medications

(Is that the sheet that you take with the drug trolley?) Yes, both of them. (Both of them, right. Do you check both lists?) For the new ones I do. But for the other ones that we have got long term I don't. Because you know who they are. But even then I suppose you could still make mistakes. If you are not thinking about what you are doing. Quite often in those wards with big drug rounds like that it is really hard to get people to take their medication - lots of people can't cope on their own - the patients need help to swallow their pills - that takes a lot of time, it really does. They say, no I don't want to take them - you know our little confused ladies and others have to have them crushed and you're running backwards and forwards to try and get it done. (How do you feel about that?) Usually if you have only got one or two that have to have them crushed I'll

say I'll come back and get on and get the rest done and then you can fiddle about with those others later. Often you feel impatient with them because you know you're pushed for time and they are mucking about but you have just got to try and keep calm otherwise they would just get more het up as well they'll adamantly refuse. (Are you aware of any mistakes that have been made with drugs on the drug round?) Yes. (Have you made any yourself?) Yes, it's really easy. It's too easy. (What sort of things go wrong?) I haven't done any for a while thank goodness. But when I first started I did. They were just silly things that if I had thought about it longer I would never have done it. I don't know why I did it. The charting has a lot to do with it. Often you can't read the doctor's charting and just the fact that how it's set out - it's not really safe. You don't have to sign for it - you just have to put a time - that's easy enough to forget to put a time in that little slot there. I was talking to a staff nurse who trained at another hospital and their system sounds so much more safe and a lot easier to follow. I don't know why this hospital is so behind - they're meant to be an up-to-date hospital.

Alice/1/9

Giving individual medication where a professional judgement had to be made was also affected by lack of communication.

(If patients wanted some pain relief in between times what would you do?) It would all depend on what sort of pain relief they were on. And what sort of pain they were having. And what they had been doing, maybe something had caused it. And find out if something else could help them - change position or hot water bottle or something like that - and then if that's not

going to help then you know often they will give it in between. Well, what I think - when I'm at home and you've got a headache or something you just go and dish it out for yourself, how you think you need it, so you have to trust your patients. (So you take their decision as to whether they need pain relief. Is that a common thing that happens in the ward? Would the other staff nurses give pain relief on the patient's request?) Generally speaking, they do. It is just on some occasions, there has been - well she's not really in pain. Look at her sort of thing. Well you think, she says she is. (Is that a professional judgement that you have to make?) Yes, I would say it would be. (What basis do you think it ought to be made - that kind of judgement?) How do you mean? (When you are looking at someone who has requested pain relief, how would you make your decision as to whether to give them extra digesic or ring the house surgeon for extra morphine?) We just usually have to look at them and see physically what they are doing - how they position their body and their face - facial expression, and just asking them. Where it is, how long they have had it. (Would you talk to other staff nurses?) Yes, probably, or even the nurse that's looking after that patient. Find out what's brought it on. (What about looking up the records and the nursing notes to see whether or not she'd had extra pain relief before?) Yes, go to the chart and find out what has happened before. Then at least you know that somebody else has done it so you don't get it in the neck.

Alice/2/18

Gaining access to information available in the ward:

I think we have just got a lack, a lacking of information coming into the ward. We had one of

the pharmacy ladies come in to see us about different creams and things that we have got in the ward that I didn't know anything about - what to use them for - or when they were best used and she said - "Oh, I could come down and give you a talk" and that's really what got me thinking about it. There's lots of people in hospital that have got oodles of information that we could do with. (Right - so you would probably want to organise a regular education time?) Yes, not too regular. Otherwise people, I think, would find it a bit sort of threatening.

Alice/2/24

Alice thought that one way of overcoming these communication gaps was through the regular weekly staff meetings.

(So in order to get over these communication problems you'd like things like weekly staff meetings - when would you have those?) We have them now - we have them every Wednesday - you know between changeover of morning and afternoon but I don't think people are that keen on them - they don't mind them but they don't get ready for them - we don't discuss, or sometimes we do discuss things that have to be brought up in it, but often we forget. (Tell me how is the meeting run - do you have an agenda?) No nothing like that. There's really not enough time. I don't think. Because all the registered staff are in the office and the students are out there.

Alice/2/21

She describes these meetings as follows:

The door is closed. We are sitting in there. There is a lot of laughing and carrying on and we are all asked if there is anything we want brought up and if we do start discussing something,

everybody is asked - the charge nurse asks everybody what their opinion is. Once we have finished that she will ask somebody if there is anything they want brought up - anything different. (Do you think it is effective?) Sort of, but I think it could have a lot more benefits. It could really do a lot. It is very informal. There is a bit of professionalism there. (Is there any way in which you as a fairly new staff nurse could make any difference to that meeting?) I think by talking to the others about it - are you going to be bringing anything up at this meeting and talking about it before we get there and talking with other people about things - about the ward, you can sort of discover new things that you'd like to get changed or things that need to be discussed and that way you could probably work out an agenda between a small group of you, before the meeting. (Would they accept that coming from you?) I think so. I have done it a couple of times but not to any great extent.

Alice/2/23

Dignity, Privacy and Respect

The second major area Alice would have liked to change related to the amount of dignity, respect and privacy patients in the ward received:

It is really hard when you've got a ward of old ladies who are deaf for one thing and you've got to yell at them for them to be able to hear what you are saying, so everybody else down the ward hears it as well, but I find I go round after everybody else pulling the curtains behind them - I feel as though I'm quite conscious of it. Everywhere you go - you walk down the ward and see people sitting on pans and that

sort of thing - it doesn't do any good for the mobile patients who are walking along seeing that sort of thing, it doesn't do any good for the person sitting on the pan. (Is there any way you can change that? The amount of dignity and ....?) The amount of dignity you can but the amount of privacy is a bit difficult because - just the facilities.... (The physical layout of the ward?) Yes, its so cram packed together and the curtains are too short - that sort of thing but if the way you treat your patient - the way you talk to them, you try to do everything possible to keep their dignity - well then that is one way around that.

Alice/6/71

Time available

She would want to increase the amount of time she was able to spend with each patient both in giving nursing care and discussing nursing care with her colleages.

(The lady who is diabetic - did you have to do her insulins at all?) Well I just had to supervise - she draws it up and everything and gives it. (That is still time isn't it?) Yes that's right. At 7.30 and 11.30 you have to be free for her. If you are in the middle of a sponge or something - (Is she fairly competent?) Yes. She wasn't doing SNA's at home. We started her on that - she wouldn't do them unless you gave her a push. (So she needs encouragement and support?) Yes, she's only young, 22 - and just separated from her husband. So she's having a hard time I think. (Do you feel as though you can give her enough time?) Because it is only those two times - usually that she really needs the time spent with her - not not really because those times are always busy. Half past 7 in the morning, you've got to get all the patients sitting up for breakfast - breakfast arrives - you've got your heparin and all this sort of thing - half past 11 -

it's nearly lunch time and you've got to get them ready for lunch. (So as well as her you had about five other people?) Yes, I had a couple of asthmas and a DVT - it sounds like I'm talking about just conditions. (Do you see them like that - conditions?) No, we never talk about them like that either. And I had a lady with - 2 diabetic ladies. So that was a bit of time involved there. And nebulizers being given out. I also noticed - we had a staff nurse acting as runner, - when you do the handover at the end of a.m. duty, you take the other staff nurse - the staff nurse coming on for the afternoon, take them round and just give them a verbal report on each patient. Then that afternoon one staff nurse came on at about, I think, it was about 20 past 2 and so they started the hand-over before the other staff nurse came on and I thought that was a bit rude. (Why?) I think that you do the handover as a communication and that the other staff nurse would have been missing out.

Alice/2/6

(Were you busy the next day?) It wasn't too bad because a lot of my patients were sort of able to help themselves a lot more - you know they were all fairly young as well which meant that they were able to be - that even though they were sick - they were more healthy than what the older people are. So you know you could give them a bowl and they could wash themselves and you would just have to wash their back and pull up the bed and things like that, and that was alright. So it was better than the day before. But then I had that diabetic lady again and she - I think she was even going downhill with her insulin and so we talked about it - I talked about it with one of the other staff nurses - we were wondering if we should go back and start again to try and get over her confusion - but I talked about it with the charge nurse the next day and she felt that we should probably still carry on and so we wrote her out a

very short simple list of what - of each step, and that seems to have helped her quite a bit. So she's on her way up again.

Alice/2/17

Alice appeared to be both optimistic and realistic about the extent of the change she could make as a beginning graduate.

(How able are you personally to suggest or to make these changes?) I think I should do it. In our ward meeting. But I haven't been to one for a while because usually I seem to have a lot of Wednesday/ Thursdays off. You tend to forget about them. And you don't go. (You really do feel able to mention these sort of things that you are a bit unhappy about, or it would be good if you could change. What sort of reception would you get?) Oh not too bad I don't think. Most of the staff are fairly forward thinking. I think it would go down quite well. (How would the charge nurse feel about it?) I don't know - I think she'd agree especially with that education one, but I think there the trouble is time and getting time to organise them and things like that.

Alice/2/25

INTERPRETIVE PROFILE : ALICE

During the first two years of her education Alice made several attempts to resist some of the strong socialisation pressures she encountered. She discovered that she was thought to be competent in the clinical area, and she considered herself to be a "good" nurse based on her own judgement and on her clinical reports. Alice, however, because of the tutor's comments about her classroom behaviour, began to doubt her "personal acceptability". She reported:

> *They were trying to mould us and that you weren't being your sincere person ... I think that they've got set ideas on what a nurse should be and that's how every nurse should be. I remember one of the tutors saying how nurses are a very conservative group - how they always dress conservatively and they don't have outrageous ideas and that sort of thing, but it's no wonder. We were put down if we did anything different. That's how I feel anyway ... The tutors were looking too much at the negative side of that person and pulling their personality to pieces. Not boosting up their self confidence - and their self esteem. Trying to decrease the individuality of each nurse.*
>
> (Alice, pp 104-105)

Alice was also aware that the tutors were constrained by the same structures in the education system as she was, and that this resulted in inconsistency of action and "double standards".

> *We couldn't understand it. Because it just seemed to go against what we were being taught about caring - you know all the psych and everything. And how to treat the patient. Whereas it seemed that the nurse - don't give a stuff about her. (You mean what you were being taught was not the same as how you were being treated?) Well it wasn't really at all because like with the rolls and having to be at class and that sort of thing and having to fill in forms. I found a lot of those things at tech just didn't tie up - they were sort of - hypocrisy, with things that tutors said and then things that they expected of us.*
>
> (Alice, p102-103)

By the third year Alice had decided to passively resist pressure to conform although she remained aware that transformative action (refer to p34) was possible. At the time of this study Alice was still angry and upset with what she considered to be an intrusion into her privacy.

In the polytechnic Alice could identify specific institutional requirements (roll call, hours, reports), but in the hospital the power relations within the hierarchy were personalised.

we just have to cope

and the constraints were "explained" in impersonal terms - lack of time and physical demands.

For Alice, the feeling of powerlessness as a staff nurse is accentuated by the perceived "reality" of the system - the possibility of social change is not recognised and Alice accepted her subordinate position with a certain amount of resignation:

> *I don't think I'd have enough confidence to do it. (What would stop you?) What she might say back to me. I think also that you often haven't got enough time to sort out problems like that.*
>
> (Alice, p117)

There are, however, indications that Alice was aware of the importance of communicative competence (refer to p31) in producing change:

> *I think by talking to the others about it - are you going to be bringing anything up at this meeting and talking about it before we get there and talking with other people about things - about the ward, you can sort of discover new things that you'd like to get changed or things that need to be discussed and that way you could probably work out an agenda between a small group of you before the meeting.*
>
> (Alice, p126)

CASE STUDY TWO : MARY

EDUCATIONAL EXPERIENCE

Mary applied for a comprehensive nursing course when she was midway through her sixth form year. She had passes in three School Certificate subjects and intended to work hard to pass the University Entrance Examinations since:

> *My aim was to get U.E. because I wanted to go nursing.*
>
> Mary/3/35

Mary is the second child of a professional family. Her parents have supported her both emotionally and financially throughout her education, and indeed supported her desire to become a nurse. The decision to apply for a comprehensive nursing course rather than a hospital programme was, in part, influenced by her father's interest in formal education.

> *I always wanted to be a nurse all my life, and it was just a matter of where - I think it was basically my father, because he was right into education and I saw it through his eyes - he basically saw polytech as being an academic occupation or whatever, and in his eyes it was like me going to Varsity or Teachers' College or something like that which I think he was happy about. I think the other way would be more like being a nurse aid, an apprentice, that type of thing. My parents never put pressure on me at all but Dad got me all the information about polytech and talked about his days at Teachers College and I was directed that way. I was convinced - by the time I had decided, I was convinced that polytech was the way it would all be done in future, and the hospital wrote back to me - I did write to the hospital to get information - and they*

strongly suggested I apply to polytechand polytech didn't strongly suggest I applied to the hospital - I thought well there you've got it.

Mary/3/33

Mary had her first application declined. She immediately wrote back to the polytechnic restating her intention to pass the University Entrance examinations. Her name was placed on the waiting list for the course. When Mary had University Entrance accredited she notified the polytechnic and, ten days before the course began, she was accepted. This rather uncertain start both delighted and concerned her:

I was delighted. I had sort of resigned myself to going back to 7th form and that's not what I wanted. I wanted to get on with this. I knew what I wanted - I wanted to do it but then I felt - I remember the first few tests and things, feeling like I had to pass to prove myself.

Mary/3/35

At the age of seventeen, Mary left home and entered a polytechnic comprehensive nursing course with fortyseven other students. She found a position in a flat with both nursing and teachers' college students as flatmates.

The memory that Mary has of her first week of the course is mainly one of surprise: Surprise that it all seemed so "basic" -

It was all so new - I found it really basic the first week - I think they were just - it was a fairly casual way - we didn't really do anything that made any great impression. The first week was more social so we could get to know each other and everything that was suggested to us was really basic, and I remember hoping that it wasn't always going to be like that.

Mary/3/35

She felt surprise that it was "so much like school" and so different to the first week's experience of her teachers' college flatmates.

> *What bugged me was roll call at the beginning of every class. It drove us all round the bend because I think like for me I was in a flat with Teachers' College kids, and their thing was so different. I felt that I had just moved to another school, for a while there, it was that sort of set up. (What do you think should have happened?) I don't know how they could have got around that one - I wonder if they could have been a bit more subtle especially in our first year, by our third year no-one cared - you just sat there and said yes ... But really it made you feel - it wasn't like University, it's up to you if you go. They explained to us and we all understood why it had to happen but especially with small classes they could have taken a head count and after two weeks at tech they would have known if I wasn't there anyway. (So that really annoyed you?) Yes. (Did that happen for the whole of your first year?) Yes it happened for three years. The roll call bit - but I just didn't care after a while. It was just so like school.*
>
> Mary/3/34

Mary recalls her surprise at discovering new ideas and ways of thinking, as well as having to justify her decision to enter the nursing course.

> *As I said the first week was really basic - I remember I started to quite enjoy it - cause there were a whole lot of new ideas and thoughts and I had already thought a lot about nursing and what a nurse was and it made me think a lot more about nursing - as I remember, I don't know for how long it was but a whole lot of it was catered towards what the hell are you doing here. Why do you*

want to be a nurse. What is a nurse. What do you see yourself as. And that made me stop and think a lot. (Was that useful?) Yes I think so. Because I think if I had been unsure I think that would have made me really think about what I wanted - if I had just got into nursing - if I had just gone nursing because it was something to do I think fairly early on I would have been made to think enough to make a decision if it wasn't right for me.

Mary/3/34

The beginning of her nursing education established for Mary her desire to become a nurse and the nature of the nursing course she had entered. For example, tutor/student relationships and the requirements of "the system" as exemplified by the roll call procedure were identified as was the difference between nursing education and other types of tertiary education programmes such as teachers' college and university education.

Attitudes to course work

Mary remembers being determined to "prove herself" both to herself and her parents, and to the tutors. She appears to have achieved a high degree of self understanding about both her academic ability and her behaviour:

I can't remember the first nursing test - I know I passed. (Had you worked for it?) Yes I had actually. One of the few times I did. I'm not a very academically minded person - I cram, which shows on my school report and polytech report but I remember I did work quite hard for that one because I had to get off with a good start. (So you were out to prove yourself?) Yes.

Mary/3/34

She also appears to have had an understanding of the covert messages inherent in the course -

> *I can still remember the first A & P test - the thing which always stuck in my mind right through tech was our A & P tests - without mentioning any names but we always got A's, a B was like failing. As long as it was passable you got an A written on the top - I remember thinking I was doing really well getting an A for the first couple and not realising that in a way - I think after a couple of months everyone realised that a B was virtually a fail. (So you more or less made your own scaling system?) Yes we did.*
>
> *(What about your assignments?) I can't really remember - the emphasis wasn't as great on assignments because we were having those tests every two weeks I think it was that year, and I can't remember how the system worked, I think we had a test and we got the marks back a week later or something and everyone was curious - everyone knew what everyone else had got and you still didn't know everyone that well and you didn't want to be labelled as stupid but with the assignments - we weren't such a big class. Mine were always verging on being late. (Was that conscious - were you aware that you were always late?) Oh yes. (Did it matter?) I fooled myself into believing I was better under pressure ...*
>
> Mary/3/35

Mary was anxious to demonstrate that she could handle the course but at the same time wanted to retain some control over the amount of effort and time she put into meeting the course requirements. Mary identified the credentialling aspect of the course. For example, of the assignments required over the three year course Mary said:

I think some of the assignments were a waste of time. (In what way?) Just that it was all a lot of up-in-the-air stuff that half the time I didn't understand what I was writing - like I wrote - I remember spending hours writing this big assignment on food obsessions which was a choice of something or other - it was psychology - and it's totally irrelevant - the only good thing about it was I got an A and that went on my record. It was the only thing I got out of it. Some of them I didn't really understand the relevance. (Are they relevant looking back on them?) I've forgotten about them. Not really. Some were - I couldn't cite an example but I know I did some assignments where I felt like I really got into reading and I read more than I had to and I really researched it and was interested. But others I did a minimum amount of work and got the minimum number of words and got to hand it in on the last day. (Did you fail any?) I think so - I think I got a few D's here and there. (Did that worry you?) I've sort of always passed when I had to pass. (So you've been fairly careful about what you've worked for?) Yes I suppose in a way I thought I was using the system whereas if I'd worked harder I'd probably be a better person now - probably a much better nurse - well maybe not a better nurse as a person - maybe a better nurse like I'd have the answers to the questions that were asked of me. You know if I went to the eye ward - I've done three years A & P and I could not name the basic structure of the eye. I could fairly basic ones but I didn't have any in-depth knowledge from going through polytech. The general girls probably knew just as much if not more. (Is that just something that is particular to you or do you think all polytech students would be like that?) It depends. There were groups of different people

who put different amounts of effort in - you always knew who the real hard working ones were. (So you think that a hard working person would know the A & P of the eye?) Yes probably because it was part of the course and some of the girls - I was amazed at the amount of time and effort - I thought well basically I think I'll end up being a staff nurse and so will they, and I want to enjoy three years of being a student. I did enjoy it - I had a ball.

Mary/3/38

Perceived pressures to conform

Mary became aware of a "moulding process" midway through her first year. She describes this process in terms of both academic ability and pressure to achieve -

I think a lot of us that year - a lot of us were just out of school and it was a long winter, and for me I was seventeen and I suppose in a way I got homesick at times - you know you are under a lot of pressure - I always felt I was under pressure from tech - the whole three years. (Where did that pressure come from?) Tutors possibly. The system - I don't like the system - you felt like you had to conform into their mould of a nurse and you had to be of an acceptable IQ for them - (Did you know what that was?) Well you were pulled up pretty quickly if your marks started to go down a bit. You know I was really amazed I think it was my second report in first year said that I skimmed the course at an acceptable level which I thought fair enough, but then went on to write that it was far below my capabilities - I should be working harder ... They ought to be happy that I was handling the course at an acceptable level rather than skimming the course - I felt pressure on. (Why did you think that was unreasonable

for them to have added that bit?) Well because they didn't know - for all they knew I could have been working my butt off and I could have - they were making an assumption on my intelligence and my ability to work and they were saying that I wasn't working hard enough and I could do more which, whether its true or not is irrelevant. Whoever wrote the report - whoever decided on it - they were making an assumption about me and about what I was capable of and they didn't really know. I'd never performed outstandingly and they were making this generalised comment that I could do a lot lot better. (And you thought that that was unfair?) Yes. (Were you able to talk about it with anyone?) I couldn't be bothered. Well the botton line was that they had said I was acceptable and that is what I wanted. As far as the - I was more interested in putting my energies into being a person - being a nurse in that way and caring about other people than getting high marks in assignments and things. (So your main objective was to develop yourself as a person?) Yes.

Mary/3/37

Mary experienced inconsistent and, at times, conflicting expectations of her professional behaviour. For example, she became confused over the apparently conflicting values and attitudes expressed in the clinical area. On the one hand she had been taught to give individual holistic nursing care (based on expressed philosophical views of 'person' and 'nursing') and, on the other hand, she was encouraged to adopt the attitudes and behaviours expected from a member of the ward team in order to be acceptable to the clinical agency.

I was down in a ward once and there was an old man down there who - I'm sure he would have just shrivelled up and died, he probably has by now - but he was a grumpy old man - his wife had died

and he couldn't really cope, and he wouldn't get out of bed in the morning, you virtually had to get two nurses and lift him up and I'm sure in his mind he had nothing to live for, nothing to get up for and no-one bothered with him. I went in one morning and I took him in his breakfast and I was chatting to him and I asked him what he liked to do and he told me - he grinned at me and said - I hold a good hand at euchre - and I thought I don't know how to play that - and I said to him I'm looking after you today how about you get up and have a shower and get dressed and I'll sit down and you can show me how to play. I said I bet I can beat you, and he grinned at me and he was up by himself that morning. I helped him in the shower, he got dressed and I had to follow my end and - you know before that you had to sponge him in bed and dress him and everything and so I sat down and I played cards for about 15 minutes and I said to him - look I'm going to have to do some work but this has been good, I'll come back later and I did - but it comes back to the task orientation - all the beds were all ready for making and other patients being bathed and the tutor as well as staff there were really down on me about it, and I was really angry - I could understand why but you know it was the first spark of life I had ever seen in this man and all his reports every day - was difficult, grumpy, and he hadn't been - he had been - (He was responding really well to you?) Yes, I felt that that was really important - I thought stuff the beds, I don't care. (Did you talk about it to anyone? To the tutor?) I did a little bit and it was understood <u>but</u> you're still part of a team in the ward and you've still got this that and the other to do. But if it happened again I'd do the same thing. (Were you

able to talk to the ward staff about it as well as the tutor?) I tried to with a couple. Because I worked really hard all day - I felt, there was pressure on me and I felt guilty about it. But no - everyone else just considered this guy a waste of time - just a grumpy old man.

Mary/3/37

Mary is able to critically reflect upon this incident (and others like it) to the extent that she used these experiences to guide her practice as a graduate.

That actual situation arose with a student who was sitting talking to a patient when we were really busy and my initial thing was angry - what do you think you are doing - there's so much to do, the doctors will be here ... and I remembered how I felt and I really thought about it and I guess I was - I was still a bit up tight about it - I think because this particular patient was very friendly, good to talk to and I talked to this person quite a bit, and I don't think he had a lot of problems - I think that the student was getting something out of talking to him rather than helping with a serious problem but I could have been wrong and I knew that - maybe it was more important at that time to be with that person - I was aware of that but I had to give the student the benefit of the doubt.

Mary/3/38

Mary thought that there was little agreement between tutors and ward staff over which attitudes and values a student should hold. The discrepancy between those propounded in the classroom and those she experienced in clinical practice as a student was confusing to Mary and was not resolved to her satisfaction.

(When people talked about professional behaviour did you understand clearly what they meant?) I think behaving to acceptable standards.

(Whose standards?) A standard that is set by the Nursing Council. As far as clinical goes - I think we had well two or three sets of standards - one was what Polytech wanted us to maintain which were to be acceptable to them, and were to be acceptable to the staff of the hospital that we worked in - the people that we worked with - we did have to be acceptable to the patients - I think I would be a lot more up tight if a patient complained about me than another staff nurse ever did. It would really worry me. *(Did you think then that those 3 sets of standards were different?)* I think the standards that the Polytech set were higher than the hospital. I think the hospital standards - there was more lee way - I think basically at the hospital you were there - people were with you constantly for your 8 hours - and they would - they could look at things that happened within a context of the day or of the week and they saw it differently - like the tutor who came into the ward for half an hour and saw something happen and reacted to it. *(That's how you were for ever. If you behave like this for half an hour then you must be behaving like this for days?)* Exactly whereas people that you worked with - and also they knew the patients - like there was one criticism made about me being unprofessional - and I actually got to the bottom of what it was all about and I found - I thought maybe it <u>was</u> unprofessional. *(Can you tell me about it?)* Yes it was in this ward where I had worked for a couple of weeks and there was a lady up there who was a real hard case and she didn't really take good care of herself and you were for ever saying why don't you go and put your dressing gown on - because

it was so cold - she just used to laugh and go and do it and she was quite young and I got on really really well with her and I'd looked after her for a week or something when this happened and she was coming down the ward in her bare feet and I said to her - Slippers - and she grinned and trotted off and got them and I was talking to her later and just chatting and I actually thought about what was right to do and I explained to her why it was a good idea to wear something on her feet - and the same tutor when she was being very critical of me at that time and I asked her for an example and that was the one example - the only one she ever gave me, she said to me - "if I was walking down a ward in a hospital and a nurse came up to me and looked at me and said "Slippers" - (I pointed to her feet) she said, "I would turn round and say well up your nose lady. Don't talk to me like that." And I thought well O.K. from her point of view maybe it did look really bad but in the context of the relationship I had with this lady how well I knew her, the whole - the way she related to me - the way she talked - everything else - I didn't think it was unprofessional - I didn't think it was a big deal. (When the tutor gave the example were you able to explain that to her?) Well I tried but she just kept saying to me - I think that's unacceptable to talk to someone like that. I thought well yes, I could see her point. And I tried to explain that - but I think she would have had to have been there for a few days or talked to the lady for a while - got to know the patient to have understood the situation. (But that wasn't acknowledged by the tutor?) No. Actually from what she said I sat back and thought about it a lot and thought well yes from her point

of view O.K. it probably was - I could see exactly what she was saying to me and it probably was - but you're people you relate to other people - you can't always be the nurse, well you are always the nurse and the patient is the patient but you can't always put such a distance and ... I think it's quite a difficult one because it's very subjective.

Mary/4/52

Mary's recollection of this incident reveals a degree of self reflection and independent thought not evident in the other cases.

Adjusting to social expectations

Mary reports that from the first year she made determined efforts to be in control of her own life - to decide not only how much intellectual effort was necessary but also how many hours she should attend at polytech. Mary was well aware of the number of hours required for registration and used this knowledge to actively construct her student life.

(Were you aware of your minimum hours?)
Oh I had them all calculated. I have still got it - all written up about how many hours everything you've got to go to - how many I can have at 20% - how many I had left to take off before the end of third year - which I know sounds dreadful but we were told we were allowed 20% off in each thing and most of us did have it calculated out. I sat down and spent a couple of hours calculating all my hours and I didn't go under 80% in any of them but I was a bit silly in first year because in second year I had glandular fever and I was really sick - I got really bad asthma that winter. I went to a long stay psychiatric institution a week after I came back to tech and I think I was

more depressed than anyone I met there ...

Mary/3/38B/39

Mary recalls that there were many reasons for her absenteeism. She felt that in most cases her absences were legitimated by what she had been taught about stress -

In my first year I took days off when I'd had enough - there were times when tech was too much, I had had an absolute gutsful and I was not going back. (Can you tell me about those times?) Sometimes it gets really repetitive - you feel like it's just the same thing from a slightly different angle and you just can't be bothered. You've rehashed it and rehashed it. (Can you think of one specific thing?) Maslow's hierarchy of basic needs - the first year. (You had it from nursing?) Yes I mean in the lectures. And it was looked at from all sorts of different angles and you just kept going back to it - I sort of got quite sick of it after a while - that one stands out in my life but my absenteeism was - sometimes I was just overtired - I'd been up working or I'd been out. (So it was a conscious decision to miss days?) Yes. My whole first year I don't think I was ever sick. And I always knew the day before that I wasn't going. I'd wake up just feeling really tired - I do get a bit of asthma. (Was there any suggestion from the tutors that you needed to start conforming to what was expected?) Actually what I found was really conflicting because they used to talk about people needing mental health days and the whole thing about stresses and they might have been quite informal lectures that we just got round to talking about the stresses being at tech and different things and about that it was important that you could at times not go. But what they were saying was

completely conflicting to their attitude and the whole system.

Mary/3/38

As a student Mary's principal commitment was to finish the course and become a registered nurse. She found it impossible to think of herself as a staff nurse committed to particular patients, a clinical agency, or even professional goals. She thought of herself as a student. In her third year Mary realised that her absenteeism may have affected her chances of employment even though she was meeting the Nursing Council registration criterion.

We had this big thing hanging over us - it was if you don't come to tech who's going to employ you knowing you take all these sick days - waste of money and waste of manpower. It just got drummed into us from about June/July onwards when they first mentioned it. I thought then why didn't they tell us in the first year we might have thought twice - in the first year being a staff nurse seemed like a distant dream. We didn't think too realistically about it. In third year the whole thing - it was like if you could make it up out of the hours left you should be doing it. They didn't offer any <u>way</u> of doing it though. (So it was pointed out that as a student you had to learn to do what the system wanted because that's what you were going to have to do as a staff nurse?) But I don't agree with that at all. (Why not?) Because now - there have been a couple of times lately - I really enjoy work - I like going to work - but there have been a few times when I felt - like on the end of the seven days stretch, the seventh day, I thought I haven't had any days off maybe I'll be sick tomorrow. And I've always looked at the roster and found out who else was on and I've felt I'd be letting the other people down and I've

thought oh no there's nothing wrong with me I'll go. I think it's sort of the unity - you're part of a team and I think we are quite clicky in our ward really. (You look after each other?) Oh yes, and they sort of moan when someone new comes - when someone gets sent and you know - I just sort of felt - and also I'd have patients that I had continuing care with and I didn't just want to opt out. It sounds as if I find it quite hard on my days off!

Mary/3/39

Mary reported that the commitment to nursing she feels now as a graduate, was not possible when she was a student.

(Are you really talking about commitment?) Definitely not dedication. Well some definition of dedication. Yes probably. (You feel committed?) I do. Yes. (But you didn't as a student?) No, you had nothing to be committed to really. You were out for yourself in a lot of ways whereas like now you're part of that ward - you are part of the people in it - like if I decided not to go one day I'd be letting them down - because of the fact that they might be short staffed - have to work harder - although they get someone in for the day or else a lot of the time with your patients - they say what duty are you working tomorrow - and you'd feel really awful - you'd feel as though you were letting the patients down. I've got no desire to take any time off.

Mary/3/40

Conforming to expectations

Mary identified several episodes in her student experience which demonstrated in her view, an illegitimate use of power to encourage her to conform to the expectations of the tutor, the polytech and the clinical area. In the following extract Mary

explains a situation which occurred towards the end of her third year. She had chosen to go back to this clinical area because she felt she had not performed well the first time.

> *I went back to this clinical area and I was working two weeks there - two weeks of mornings and on the Friday I was chatting to the senior staff nurse who was in charge because the charge wasn't there, and she said to me - Are you working afternoons? I said, No, I'm working mornings actually and she said oh no you've got to work afternoons. So I said, Well I'd like to but I can't. I've got a roster and that's that. And she said - oh no she said look I'll check with the supervisor and we'll see what we can do. I got called away - I wasn't there. The supervisor came up to me later in the day and said I think it would be good experience for you to do a week of afternoons, so I have changed your roster - you're on afternoons all next week and I'll try to get in touch with your tutor just to check with her. I said O.K. and then at about 3 o'clock she came up to me and said look I've changed it on to afternoons but I can't get hold of your tutor, so I'll take the responsibility - you come in the afternoon. Anyway because I didn't really want to get myself into hot water - I went down to tech and I explained what had happened and she said fine - that's quite all right. So I felt good that I'd gone through the channels - I hadn't gone outside what was acceptable. I got to work on the Monday afternoon and the charge nurse called me into her office and really went to town on me about changing my duty - and making a comment that the tutor was angry about it as well - and I was told I was on short change and to be back at*

> *7 in the morning. I just felt - (You were pretty upset?) Oh yes. I was really upset about it. And it came out in my report that I'd played senior staff off against each other which I thought was really really unfair. And the tutor never discussed it with me - as far as the tech side of it went I think we looked at our tutors as being advocates and on our side - who would stand up by us - and I felt like I had just been - that she had swopped horses in midstream and that was one of the things which really upset me because she had agreed - approved and then the charge nurse was saying to me - well your tutor's very angry about it you shouldn't have done it.*
>
> Mary/3/44

Mary left that clinical area feeling personally inadequate and that she was to blame for what had happened.

> *They said then when I was talking about doing something about that - I had to look at the fact, perhaps it is me. Perhaps I am just hopeless in that sort of situation. Basically it's put - I don't think I'll ever work in that area. I thought I would like to until I went there.*
>
> Mary/3/44

She felt unable to explain to the charge nurse that it had been the staff nurse's idea, unable to explain to the tutor who had apparently taken the charge nurse's view of the situation, and unable to take it further because she had already been accused of "playing senior staff off against each other." Mary had had difficulties with this tutor throughout her education which she put down to a "personality thing." Mary felt she was often manipulated to conform and to accept the tutor's account of her behaviour. For example, at the end of one clinical experience

she received an unfavourable clinical report:

> *I went to talk to her, and I asked her O.K. you've written this about me, it's sort of airy fairy you know could you give me some examples so I can do something about my work. And she - I don't know if I was threatening to her - I don't know why but she sat there and said - "are you saying that I can't evaluate you and I shouldn't be a tutor." She turned the whole thing round whereas I was left - where I felt my only option was to finish and leave. (How did you feel about that episode?) Really up tight. Because I felt that I couldn't go back and that I would get nowhere going to anyone else. (You said before that you'd always been taught to take it further if you couldn't get anywhere with the person involved - that you could take it on further up the hierarchy - did you feel that you could do that?) No the main reason being that when it all came out it was about the same time as the experience I told you about and I felt that O.K. the comments had been made that I had played senior staff off against each other and to go higher than this would give them the perfect - I mean to say well look you've done it again you know. (So you felt -?) I felt trapped that I couldn't do anything at that stage. I would have liked to go to someone else but - and I felt that there were a few people I could have gone to who would have - I would have been able to discuss it with - but I didn't want it to be misconstrued or turned back on me.*
>
> Mary/2/45

Mary was aware of the sanctions which could be imposed upon her to help her meet the requirements of the course. A probationary period for students to identify a lack and to receive extra

assistance was seen by Mary as:

> *To me probation was always a real punishment - that if you didn't get your act together and shape up you could get put on probation and it was one step from being asked to leave. (What does getting your act together mean?) Shaping up to the standards. Like with probation the two times is when you're - like sitting those end of each term exams - if you failed the first one, that wasn't too bad you could sit again, which I did twice, on two different lots of exams - and if you failed the resit then you went on probation but you still had one chance and so that was - by getting your act together there - doing some work, passing, putting in a few assignments, settle down a bit I suppose ... if your work wasn't up to scratch. I sometimes wonder why this tutor I had problems with didn't suggest that I went on - she may have done to others - suggest that I went on probation because she was really critical and I felt - I was quite aware of the fact that she could do it - which really bothered me a lot.*
>
> Mary/3/50

Mary identified a hierarchical relationship between tutors and students and their relative positions in "the system". Mary reported that students were unable to change these relationships even during classroom discussions.

> *Some people - we used to get into really heated arguments over different ideas - we were being taught one thing and someone would question it and as I remember the outcome was always that the tutor was right. We may have had discussion and some of us might have left thinking that the students - that their ideas were better or more correct but it always got back to the point at hand and that was what we had been taught and*

that was what was right. (Can you remember instances where the tutor said yes, there is another way of looking at it and yes, perhaps that is better than I have presented?) Not really. Sometimes the tutor would acknowledge - "Yes you could look at it that way but anyway as I was saying" - that sort of thing. It was still very much - I liked most of the tutors - very much, but I still think they had to have that being a bit above us and that they were the teacher and they weren't there to learn from us, we were there to learn from them.

Mary/3/45

By her third year Mary recalls being confident in her knowledge of "the system" and her ability to move within it - and was aware that her three years at polytech had influenced her attitudes to education and to nursing.

We knew what you could do and what you couldn't do - when I went into Polytech I went in thinking it was really wonderful - you know after six months thinking this was great and the way of teaching was so up to date, and was modern and it was amazing and by the end of third year I was really cynical about a lot of things - you lose your enthusiasm - I don't know I think when you are in that frame of mind where you think its all wonderful you glide along with it - you don't really question as much but like by third year from our own personal experiences and from what often you talk about things and you all agree on something - then you felt that you could maybe challenge something that was said, not that anyone ever really did in third year but a few of the more outspoken ones mainly, I think also by third year you felt a lot more confident that you wouldn't be picked out or anything like that - I

think that hung over us. I think we were all scared. (Probation?) Probation or being asked to leave or suggested that we leave. By third year you felt quite secure. You were just about finished. You know they wouldn't dare. Not now.

Mary/4/45

NURSING AS A GRADUATE

Adjusting to social constraints

Mary began her career as a registered nurse in a large base hospital two months after she graduated. She had some difficulty obtaining a position as a staff nurse partly because of the staffing situation at that time, and partly due to the comments on her confidential report supplied by the polytechnic:

The hospital was evidently overstaffed at that time and the other reason was that my polytech report was very uncomplimentary. (Can you tell me specifically what it said, what you mean by uncomplimentary?) There was a comment about me having superficial relationships with patients - I don't know why it said that - all my other reports said my relationships with patients and communications - were good - some said I got too involved. The other thing was by absenteeism - (So the confidential report was different to other reports in that respect. Can you think of any reason why?) I think it's going back to that same tutor who must, I think, have had a big influence on my final report - the one I had trouble with before. (The only indication you have that the report had some bearing on your appointment was the principal nurse's comment on your absenteeism. Well she had a file on me on her desk which she opened - (What did she say?) The principal nurse, I'd rather not repeat it. Actually she said to me - I know

you'll laugh at this because right through tech we were told about our absenteeism - she looked me up and down and said I thought you had gone to another town. I thought My God! And I said - No, I haven't and she said, I hope your attendance record is better than it has been in the past - you can go now. I stood there for a moment and then left. She apparently welcomed everyone else and all the rest I started with were people who were experienced and were coming back to work. I was the only new - I was the only graduate.

Mary/1/13

(How do you feel about people having access to your record as a student and being able to draw inferences like the principal nurse did?) I suppose if I had 100% - I'd been present all the time - I'd want her to. I'd want her to see how good I was but it's just that the boot was on the other foot and I wasn't really good. I think, fair enough. But if she's going to make a comment like that to me about my days off I think that I deserve to be given an opportunity to - for her to say well is there any reason because O.K. I did take a fair few off for no reason but there is a big hunk of them that - there's no way I could have been there.

Mary/3/43

The formal orientation to the hospital left Mary feeling "confused and disoriented."

(Tell me about your orientation to the hospital?) We had a lecture - we got to meet each other and we all went in to see the principal nurse, one by one and then we were all taken to our respective wards and left there for an hour. And I virtually learnt nothing, especially where everything was

because it was a Monday morning - what with consultants buzzing around everyone was busy and it was just on meal time. (So how did you feel about that?) *I felt - I was really sorry I was there, because I thought it was a bad way to start. I had to work with these people and I just got thrown in - they were all too busy to stop and sort of show me round or do very much .... I had my polytech badge on because I was asked to wear it. Oh you've come here to teach us a few things have you? I think I said I've come to learn from you. They looked quite pleased - it was the right thing to say.*

Mary/1/13

Establishing a professional identity

The following day Mary began her nursing career as a staff nurse in a specialised ward. She began at 7 a.m. with a "full patient load" - responsible for the nursing care of five patients and the routine staff nurse duties such as drug rounds - and unsure of her relationship with other staff.

It was quite horrific really because I didn't know where anything was and I got so uptight because I had quite a big load - we were busy at that stage, we were really busy, and I was slowed down by the fact that I didn't know where anything was - I would stand in the linen cupboard and try and find things - everything slowed me down - I didn't know where the things were - quite a few drugs were kept in the fridge because they had to be refrigerated - when I went to the drug trolley I couldn't find specific drugs and I was running around you know ... (Did you know how to do treatments?) *No, well I knew what I had been taught at tech - we have got an enrolled nurse who is brilliant - wasted as an enrolled nurse - she's lovely -*

really really good and I went and said to her, Look how about I watch you do yours and you can teach me - because I haven't done these for a long time - and she was quite rapt about it so she went over and she told me - she was a really good teacher, she told me exactly what she did why she did it and the only reason I asked her was because on my first day she was the most approachable person I met. She was lovely. (She made you feel welcome.) It took me an hour to do the drug round. Someone suggested that perhaps I would like to do the drug round and quite seriously I have got this thing because of what we had been taught at tech - I collect the medication book when I go and do the drug round and I won't give a drug out because I don't know what it is - which is O.K. sounds great - I stick by that because I really believe it - I want to know what I'm giving that person - consequently it took me - I knew it was going to take me a long time anyway as I didn't know my way around the drug trolley - didn't know the patients - but I thought oh well. (So you think it annoyed them. How do you know?) I've got nothing to base that on. Basically I'm saying that if there was a new staff nurse on the ward who fluffed around with the drug book and we were busy, I would probably be annoyed.

Mary/1/14

From her first day Mary felt under pressure to be an accepted member of the ward team, to demonstrate to herself and others that shecould cope with a demanding workload, and as a comprehensive graduate that she was "as good as" a general graduate. Mary began to understand what was expected of her, mainly through trial and error. She learnt, for example, the nature of her relationship with the doctors in the ward.

(And if the consultant decides there's a change

in treatment or anything what does he do then?) He will turn around and tell me or tell the staff nurse - and I didn't realise this the first week I was there but we will go and write it up and get the house surgeon or registrar to sign it or we'll go and tell them. As far as he is concerned if he says to you I want such and such then it's done. It's as good as him going and writing it in the chart. (So it's your responsibility to write down what he says and get the houseman to sign it?) Yes. (How do you feel about that?) I don't mind now - when I was first there I just thought he was going on like a friend telling me what he was going to do. No-one told me that I was then expected to relay the information on. I just wasn't quite aware of that. I didn't do anything about it. (Are you worried that you may not get the right message?) No, not really - initially I would have been but not now. Because they chart their own drugs and they are very standard and - there's a range that we use often and you know a lot of them we'll write up before they even come because we know what they are going to put them on. (So they are standard pre and post op medications?) Yes. We start without - there aren't any signed - they are signed the next day.

Mary/1/4

Mary accepted the responsibility of commencing medical treatment as a part of established nursing practice. Just as she had an enrolled nurse to teach her a specialised nursing procedure, she accepted the responsibility of teaching new house surgeon's their specific duties.

We have one registrar and one house surgeon. It is a specialist area and it's really hard - I didn't realise how hard - our house surgeon has been on holiday and we have had another

guy last week and we were telling him what to do all the time and he was just doing what we told him and he trusted us. (Quite a bit of responsibility for you?) *Yes, but we have also got a little cardex with all the standard things - we've got the consultants' names and what they always do and what drugs they want and we can usually safely start those - knowing that somebody will sign it for you.*

Mary/1/6

Exigencies of nursing practice

Mary found that she became caught between the individualised holistic nursing care that she would prefer to give, and the established beliefs and practices of the ward. For example,

At the moment I've got a patient who came in as an acute admission last week - he tried to hit me when I told him he couldn't have a smoke half an hour before he went to the theatre - and he's been a real problem. He was found one night in one of the ladies' rooms and he said he was lost going back from the toilet which, O.K. we'll accept that. He has just been a real hassle to everyone - he bails people up - stands in the doorway and talks to them - especially with the younger women in the ward, we just say - excuse me I've got something to do in here and shut the door. The other night, I knew he was really depressed and he was pacing and then he sat down to have his cup of tea and so I went and sat down with him and said you know do you want to talk - something's really bothering you - and there were two things with this - one was that - I sat and talked for about half an hour, meanwhile the other staff were doing the ward tidy and I felt - I had, the enrolled nurse was on this night, the staff nurse had actually been sent away and I had a 3-striped student who's a really good

lady and I had a 1-stripe enrolled girl and I think she in particular was very anti-me. I think she got the feeling that I was just shirking off, you know sitting chatting while they did the ward tidy - whereas the other two knew what was going on and understood. And that was one thing about which I found - I had a talk with this girl later and said - Look, I felt it was important to talk to this man - he started hyperventilating and clenching his fists and he got himself really worked up and then started to cry and cry and I was really quite frightened. (It sounds to me as though you handled that situation pretty well.) I was pleased with the outcome. It could have been different. I had to keep it really low key - at that stage if I'd said the wrong thing, he would have hit me I'm pretty sure of that. (So you felt good about it?) Yes I did. But on the other hand I did feel bad - I tend to get a bit task orientated when we're busy and I thought that from everyone else's point of view - well not from everyone's - this one girl in particular all she saw was the staff nurse sitting down chatting while she was doing the ward tidy.

Mary/2/20

SELF REFLECTION AND PROFESSIONAL ACTION

During the first two interviews Mary expressed dissatisfaction with the task-related nursing care in the ward. She decided to change this aspect of her practice.

Last week I went away and I thought about what we had talked about and I think it made me more aware - I think it - well as we go on particularly I'll be more aware of what I'm doing and what my reactions are and you know ... (It sounded from what you've told me as though you are pretty tied up with physical care.) Yes. (Have you thought

any more about the emotional and social needs of people in the ward? We did talk a bit about this last time and I just wondered if over the week you had.) I have actually, that is one thing that I have been a bit more aware of because I found on afternoon duty you do have a lot more time and this week I have spent quite a bit of time sitting talking to people. (Is that something different that you perhaps might not have done if we hadn't been talking?) Well it's made me more aware of it because the ward - I suppose it's quite clicky really - everyone's really friendly - it's very easy to stand round the office and chat - and I have been more aware of people who may want to talk about things - it has paid off.

Mary/3/37

Mary found herself in charge of the ward on an afternoon duty during her second week. This was the first time she had had to be responsible for the nursing care given on the ward. Her description of that duty was as follows:

It was dreadful - it was the first duty I had by myself - a full ward - a lady with blood going through - had three admissions, two had to have drips put in and one was a diabtetic who went hypo and she was going to theatre. You know one of those duties. And I had an enrolled nurse who had just registered, a male, and I had a second year general student - and that was it, a Friday night - the lady having blood, the blood stopped running and the enrolled nurse went in and undid the chamber and it filled up with blood so you couldn't see the drip rate and then he came to me after doing this - after going in and playing around - then he came and said to me, oh that blood's not running. So I walked in there and I said - how come the chamber's full and he said, I loosened it to get some air in, and I said, well,

I wish you hadn't done that - you should have really come and told me it wasn't running - he just looked at me and said what would you have done. I told him what I would have done and he realised that it was the right thing to do and he sort of - off he went. And there was another small incident where he sort of - he turned round and said, well what should I have done. Really aggressively, really on the defensive. And I tried not to attack him or attack his nursing, I just said it would have been better if you had done such and such. And after that we got really busy and he came right - I think he realised if we were going to get the work done he had to sort of fall into line and fit in. I was really angry with him - I wanted to yell at him. But I knew it would do me no good, I had to be - I couldn't attack him as a person because he did what he thought was right, although it wasn't right, he believed it was. I was really angry because I had been rung up to say there were 2 admissions coming in - we were really busy I knew we were going to get busier and as I said it was the first night I had been on my own. (So it was quite scary as well?) Yes I was really frightened in a lot of ways. (Did you see your supervisor that day?) Yes because I had a lot of problems with the blood running. I think by about 10 o'clock every time her bleeper went off she thought oh no Ward ( ) - I had to get her down quite a bit. (What was the reaction?) She was good about it - she didn't seem to mind - actually I meant to ask her later but I don't think I ever got her down when I didn't need to.

Mary/2/25

Mary felt it was her responsibility to ensure that the ward was adequately staffed since she was responsible for the management

of the ward. Having a meal break was often difficult on an afternoon duty -

> *Afternoons you sometimes don't - racing off 10 minutes for tea. It's ironic because afternoons are really the better duty - a lot quieter - but they cut your staff by half. (So you are just as busy?) Yes, there are times, like last night I just raced up to the cafe for coffee and came back. But I probably could have taken half an hour ... but I was very conscious of the fact that I had a student on the ward who had worked there for 3 duties. Although she was very competent she was a good nurse, 3 striper, I wouldn't have liked to have been left on my own in a ward I had worked in for 2 days. (You felt responsible?) Yes.*
>
> Mary/1/8

> *(What would happen if you rang a supervisor and said look I want to go off to tea and I have only got a student on?) Well, I have done that a few times. I have had to because by about tea time I know whether I want to leave the student on her own or not. And you can judge fairly accurately. I had it one night there was just me and an enrolled nurse who wasn't a registered enrolled which means she had only had a few months up to about a year's experience and I wasn't happy to leave her and it wasn't fair on her to give her the responsibility of the hospital ward. And I rang the supervisor. By the time she fluffed around and sent someone it was too late to go up to the cafe anyway. (What was the reaction when you first rang?) She said, Oh fine, I'll send you someone. You should have rung. She was right I hadn't realised. I said I'm sorry ....*
>
> Mary/1/10

Organisation of staff

Mary frequently explained the difficulties of low staffing levels in the hospital which she and her friends experienced. She knew (she said) that there was little anyone could do about the heavy workload or the distribution of staff in the hospital, but this remained a source of frustration and stress. For example:

> *Just today, my flatmate came home for lunch and she just walked in the doorway and sat down and burst into tears - I'm not going back - and it was one of those days. (Is she an experienced nurse?) She is an enrolled nurse - it's her second year since she registered. (So she's fairly experienced?) Yes, she's been in the ward for over a year. (And is it just the short staffed situation that is causing the stress with her do you think?) I think so. She had ten patients today - I think about seven of them were completely bedridden. At lunchtime she hadn't finished doing her morning washes, sponges and things. The girls that are sitting states - they have got holidays and that's taken a lot out. (You are not getting registered staff to replace them?) No and no polytechs.*
>
> Mary/2/18

Even when her own ward had sufficient staff Mary felt uncomfortable because -

> *It's dreadful though because up in Ward [ ] they had 32 patients - a charge nurse, staff nurse and enrolled nurse and that's it. That was the same morning as we had five staff, who all had about 2 or 3 patients. (Can you ring up and say I've got too many staff. How about taking one?) Well you could but it's sort of a bit unheard of - I thought about doing this a couple of times - but no-one wants to get sent - and it's so busy throughout the*

whole hospital that it is quite a relief to be somewhere quiet.

Mary/2/18

In a later interview Mary explained that she had started to ring the supervisor when her ward had more staff than she thought was required. Subsequently the supervisor had started to ask Mary if she needed extra staff which delighted her because that meant she was beginning to learn to "use the system" and establish a working relationship with "the hierarchy".

(So its pretty important to learn to use the system?) Yes that I'm really learning quickly - and what you can and what you can't do and I've tried to get away with things which I can't get away with and learnt that. (Can you learn that sort of thing before you start?) I don't think so. (You have to learn it on the job?) Yes I think so.

Mary/2/31

INTERPRETIVE PROFILE : MARY

Mary entered nursing education aware of the ways in which organisational structures constrained her own action. She was aware of the contradictory nature of assessment practices (pp136-137) and described them as both a ranking, and a sorting device irrelevant to professional competence, and a way of rewarding "hard work".

Mary often asserted her commitment to professional values (for example, holistic care pp139-141) by actively resisting the pressures of "the system". She became aware of the contradictions between education and practice - education presented her with ethical standards to which she should aspire, practice presented standards of conduct to which she should conform.

Mary consciously attempted to manipulate the system during her education but also attempted to prevent her resistance from becoming self defeating. Mary perceived the structured roles independently of the people who occupied them but was not always able to view herself this way. The reflexive nature of the interviews had some influence here. (pp160-161)

The incident reported (pp139-140) demonstrates the tension between professional autonomy (deciding what to do in the interests of the patient) and meeting expectations arising from a hierarchical system of duties and obligations. Mary described her professional duties and obligations as being task related (pp158-160) but seemed to be aware that autonomous professional conduct needs to be responsive to situations.

One of the unintended consequences of Mary's polytechnic education was personal strategies of resistance which comprised a form of personal knowledge (tacit knowledge). In the hospital context Mary could direct this against "the system" in order to preserve her professional integrity. She was able to separate ethical (professional) responsibility from the expectations of professional conformity (socialisation).

CASE STUDY THREE : KAREN

EDUCATIONAL EXPERIENCE

Karen entered a Comprehensive Nursing Course when she was a mature student with an adult family. She had wanted to be a nurse for some time but had delayed until her children were older.

> *I came because I always wanted to nurse - I knew that I wanted to nurse and also quite a few people had suggested to me that I should train but with the family younger - I feel quite strongly about full time mothers and young families and I wouldn't do it while I had young children. When the comprehensive course came up it had the advantage that I could train but I wouldn't have this worry of what to do with my children in the holidays. Obviously I didn't really know all about it and if I could do it and I'd have a better qualification at the end of it anyway. (How did you feel when you were accepted?) Thrilled. (Were you surprised?) Yes because when I went for the interview they interviewed us in groups of three - there were two other girls with me, one was very quiet and one was a very chatty sort of person - there were two people that did the interview, one asked all the questions and the other one just sat there with an absolutely impassive face the whole time and you couldn't read what she was thinking - and listening to this other girl talk she seemed so assured and so positive and I came home thinking oh there was that woman sitting there with that impassive face and oh no that's me, and then when the letter came and I turned up the first day, and lo and behold out of the three of us, I was the only one that was there. So that was good. I really wanted to ....*
>
> Karen/4/52-3

Karen can remember being conscious of her age during the first few weeks:

> *Probably my feelings were not any different to a lot of the others - in some ways I think I was lucky in not having just left school - I think I had it harder being older - I think in some ways it was harder because you are a bit of a majority of one sort of thing. I know these girls weren't in the University hostels but it's just that same thing, leaving home and getting into a certain atmosphere - it's a fair bit of a culture shock I think. (So you were pretty aware of the social things that were going on for the first few weeks). I didn't know every little thing they were doing or anything like that but it was quite interesting - actually everybody was getting to know everybody else and making friends. (Was the time allowed for that during the actual structured class time?) To a certain extent yes. I think the way people teach at tech is very low key - you don't get that feeling that the pressure's really on - I think it is but it's very skillfully done so that you're not under this tremendous pressure and people are encouraged to talk in class and if you've got something to ask they're only too happy to answer you. Its a very good approach to students.*
>
> Karen/4/53

Karen remembers that the course, for her, was intellectually demanding.

> *(How structured was the first few weeks do you remember?) Very much so - punctuality was ground in - rolls - roll calling. The Course Supervisor came in and made a couple of speeches about how important the nursing tests were. We had this 60% pass thing. (How did you feel about that?) I didn't mind. I really didn't mind because I felt that if I was going*

to take on this course I had come in to the course on tech terms - therefore if I had come in and been accepted then it was up to me ..... I feel in some ways, looking at it, they are easing up quite a lot - we were tested till our eyes were nearly crossing that first year - we really were - and when the second year came along obviously the tutors had had another look at the whole thing and changed things - less assignments, far less testing for the first year than us - we were having just so many tests. There was a nursing test about every month and then - I could show you my report - one week we had three different tests.

Karen/4/54

Attitudes to course work

Passing tests and assignments was important for Karen for several reasons. She felt she needed to "prove herself" as an older student:

(You said earlier on that you felt that you really weren't under a great deal of pressure at tech and that things - there was lots of discussion and so on.) I think I was under pressure. (Can you tie up for me what you mean by pressure?) I think I was under pressure in that - I think that perhaps some of the pressure is induced - I think it's like anything else you can work as hard or as little as you like - with me I wanted to get good marks - I wanted to pass well. (You had pretty high expectations?) Yes. I tried to set myself a high standard because I didn't want to always just scrape through - I wanted the satisfaction for myself perhaps of proving to myself - that I could cope with it and also I felt if I was going to go in for it I wanted to look down my marks and think, well yes I don't mind the tutors seeing that. (If you didn't have those marks to look at - how would you know how well you were doing?)

I'd come and ask. (But you didn't feel the need to come and ask?) Didn't need to so much because you had the marks there to see. (Would you know yourself, though?) Yes, also at the end of that first term when we got our reports the course supervisor saw everyone individually and had a talk to them and you had your chance then to talk to her and ask her how you were doing - question anything that was on that report.

Karen/4/56

Karen recalls that she wanted to find her level in the class, in relation to her test marks:

(So you felt under considerable pressure to do well in the tests?) Yes I did. One thing I wanted to pass them. One thing I didn't want - I felt it would be ghastly to have a fail mark there - I felt that would be so embarrassing. (Did you fail any of them?) I failed one along with about 19 other people - I think it was. (Was that a nursing one?) Yes, it was the second test and I can remember hearing one of the tutors come up to one of the others and say I've finished the marking and it is absolutely dreadful. And then there was a big meeting among the tutors about that test and then they standardised everything. They decided they'd set too high a standard - it was only the second test they'd set us anyway and when they standardised the marks I got 78%. And then, from then on, things were standardised, the tests were all standardised, you got your raw mark and your standardised mark, so you could compare yourself with others, which I thought was a very good way of doing it.

Karen/4/56

She recalled that she was very conscious of competing with a younger age group -

(Was it important for you to know where you were in comparison to other people?) Yes it was, and I think probably being older and being out of the education system for so long, I felt that was important - to get an idea of how I was coping. (So you could find your level?) I was coping alright with the marks and with the work and I was functioning at a level that was acceptable to tech - if you like gauging it on a mark basis - with the other people that were in the class, and when I found that I was usually in the top third of the class then that was very reinforcing because it showed me that if I kept on working like this, I had a good chance - over the three years. I think once I had got that reassurance that I could cope - fit into a class - and manage intellectually with people that were a lot younger than I was and that had come out of an education system that was different and a whole generation later in a lot of cases - I found then it was the pleasure of getting a good mark both for my own self respect - I liked the satisfaction of working hard and then finding I'd achieved - and also I liked the tutors and I think if you like somebody and they're teaching you, I think it's a way of perhaps saying thank you to them, if you do well by them and get good marks.

Karen/4/58

During her first year, Karen felt that she used a lot of time working to pass tests when, she thought, she could have broadened her knowledge in other ways. This appears to have been a common feeling in her class.

The tests used to annoy me because I felt that I wanted to do some reading and I wanted to do other things. (Did you feel able to talk to anybody about that?) I think there used to be quite a lot of discussion in class about it and also I can remember one person telling me one time that it just seemed to

be swotting frantically from one test to the other - just to pass that particular test. (Did you discuss it with your tutors at all?) Not me personally but as a class we used to complain about the number of tests and it was always a test coming up. (If that lasted for the whole year - did people take as much notice of them towards the end of the year?) Yes, I think they did. Because it was all going to be on your report at the end of the year. You see we were graded on those tests as to what sort of bursary we would get - what our overall mark would be. Sure there was an exam at the end of the year but all those other things counted too. (Was there pressure from the tutors to continue to work for the tests?) Yes, I think so. Not hard pressure but obviously if you're lecturing somebody in something, and there's a test coming up - if everybody in the class failed the test, then it's not going to make the tutor look very good is it?

Karen/4/55

Karen reports that she found that she often under-rated her own clinical performance and appreciated the tutor's comments on her clinical reports.

(What were your clinical reports like?) In the first one they said I was too modest and under-writing my performance - I was assessing myself against a higher level and I had to look at myself against a level I was at. I had done better than I'd rated myself because I was assessing it against the way they had performed in a situation not me as a first year student. And the second one, they said I had done the same thing. Not as much but I was still tending to under-rate my own ability. (Do you still do that?) I think I probably do. I think it's probably just me as a person. (Did you accept what the tutor was saying, could you see when they

explained to you what you seemed to be doing? Yes, mind you it's very nice to be told that you are better than you think you are, I found that encouraging, but I suppose I don't like the trait in people that plunge in all over confidently and think they are doing a marvellous job, and everyone says - they're not ....

Karen/2/28

There were only two instances over the three years of her education where Karen felt that tutors had been unfair:

I found on the whole the tutors were very fair. There were only a couple of instances in the whole three years that I didn't think were so fair which is pretty good over a 3-year period. (So in the main you, apart from those one or two things that were probably not very shattering ....) To me they were. (For you they were at the time?) Yes. (Were they overwhelming at the time to the extent that you really couldn't think of anything else until you had got them cleared up?) One was, I think it was a Friday and I went home and I stayed upset all the weekend. (When did you fix that up?) The following week. I had sort of had time to - if I'm not happy about something, I don't believe in going and sailing in boots and all, right then anyway, because I think it's better to stand back and go home and sort out your own feelings at home and then if you still feel like it a bit later on, then go and do something. But I think also you can see the whole situation a lot more clearly then.

Karen/2/28

Karen thought that, in the main, tutors "encouraged discussion and asked for feedback."

I think part of it was the tutors and a lot of their attitudes - I think that was it - a lot of it

was the fact that things just weren't put to you that you had to accept what they said and that was all there was to it. I think it was the way that even in lectures discussions were encouraged. (Did you take part in those discussions?) I wouldn't say every discussion, but - I didn't just say something because I felt I had to say it but if I felt I wanted to contribute something, yes I did. (Do you think then that the students had quite a bit of control over what they did?) Quite a bit. In that we are asked to give feedback. I think that's a very good way of controlling things. I think if you weren't interested in the students' wishes and their needs you wouldn't ask for feedback. In its way it's a very big way of student control. (So you were free to criticize or praise what went on?) Yes I felt I could. Provided you felt you could justify what you were saying. I don't think you should do it just mindlessly but I think if you felt you had a good case either way and you could explain it how you felt - I think they were very fair.

Karen/3/33

Karen recalls that she felt that sometimes the discussions held between tutors and students did little to change the situation:

Say a group of students or a class of students are objecting to doing something and you end up having a discussion about it, and then it ends up with doing it the way the tutor wanted it done anyway so you have just gone right round - you're right back at where you started from so what was the use of bringing it up and objecting in the first place. (Did that happen very much? Can you think of occasions when students have objected and they have been able to do what they wanted?) Yes, not so much what they wanted right then but it's been interesting that because they have objected that time,

at that particular time we've ended up doing it the way the tutor wanted, we've gone through and had the big discussion and come right round again and we have ended up doing it the way the tutor wanted. But it's been interesting to me that the next time something has cropped up that the students' feelings were taken into consideration and you find - not that it's exactly pointed out that way - but you find that the next time it's done differently, so obviously the tutors have taken note of it. They haven't given in or anything that time, but the next time that particular instance hasn't happened again. (It hasn't been obvious that the students have had some control but it has been there?) Yes it has been there.

Karen/1/31

On one occasion Karen wanted to clarify a comment on her test paper:

I wasn't cross but I felt that I had answered the question as it was put and she had written something - I can't remember the exact words now, but it was virtually to the effect that I hadn't said so and so in my answer and I felt I had. (What was the result of that chat?) She said she was pleased that I had come. I said I haven't come to argue about my mark and she said - oh, I would be very pleased if you had, that's alright. And I said no, it was just that she'd said I hadn't answered this question and I felt I had and I felt just for clarification for myself I should get it sorted out so that I didn't have the same situation happening again. (Did she change the mark?) No, she didn't but after we had discussed it I could see that I had answered it but not quite in the way she wanted. So I was quite happy then.

Karen/1/58

Karen also thought that tutors were "helpful and considerate."

> *(You said a moment ago about tutors' attitudes being helpful. Can you give me an example or explain what you mean?) I remember one day I had to go to a funeral and I went and said could I have time off for the funeral, and it was really really short notice, and she had made these arrangements for a day out in the community, and I worked out how I could do it and yet not miss my day and she was just so nice - I explained the whole problem to her and she got straight on the phone to the agency and the first thing she said to me was, well do you want the whole morning off, and I said no, I have worked out that I can stay for two hours and then go home and get changed and then go to the funeral, and then go home and get changed and then go back - I had it all worked out and she just said, right, that's fine, but she rang through and there was just no hassle - I just put it to her and she was just so helpful and so nice. (Is that an example of what happened throughout the three years - that you always got that consideration?) Yes. Mind you I think probably when I did go it was the genuine thing and I didn't go very often. That afternoon when I needed some time off to take someone up to the hospital when she was sick, I went to the tutor and the same thing happened. She just said if you have been giving that sort of support you can't stop now, off you go - and I went.*
>
> Karen/3/34

Karen felt that because she was older than the other students she was more able to accept criticism and to use it to improve her performance as a student.

> *(So on the whole you generally were fairly happy*

with the way that the tutors saw you as a student?) Yes, because I think I accepted it in the idea that I wasn't perfect, that I was there to learn - they were more experienced than I was, and if that's how they perceived me, if it was a critical thing, then it was up to me to try and improve that. And they were very fair. I think in the whole three years I only felt twice a tutor had been unfair. (Was that over a test?) No it wasn't over tests. But that was the only times. And compared with some of the remarks that I heard from some of the other girls - but I think younger people are apt to - they don't like criticism - can't take it as well.

Karen/4/60

There was only one set of lectures, in Karen's view, which were a waste of time. She considers that the students were badly behaved and that "the tutors weren't used to handling a group of girls."

One set of lectures I thought were a waste of time - I thought the people that they got into teach it - I appreciate that they were very good in their own field, but I think they weren't used to handling a group of girls, that's the impression I got, and I felt very sorry for both of them, my heart bled for them, because they had an anti-feeling in the room before they even walked in. Some of the girls used to bring their tapestry and sit up the back and their knitting - honestly to me some of them started dodging it and not going and the attendance got so bad the course supervisor came in and brought the rolls in herself and marked them, and quite honestly that wasn't even very accurate, I can say that now, I wouldn't have said it at the time. Well it was a matter of how many hours that you'd had to go down on the roll - a lot of the girls sat and did tapestry or knitting, and

brought it along for that two hour session. (Did that happen with anything else?) No and those men didn't know with the names being called out who was there and who wasn't because anyone could answer for anybody. And also I felt it was rather a waste of time too in that what we were learning then was going to be really specialised work and I felt it would have been far better if you were going to work in those areas and use that sort of knowledge, then I felt you'd have training in your orientation surely, to be taught it if it was something like coronary care or intensive care.

Karen/2/29

Karen felt "good" about her education. It was an "excellent experience" for her, which she "would not have missed for anything":

It's not just nostalgia or anything like that - but I wouldn't have missed it for anything quite frankly. (It was a good education?) Yes, I think so, excellent, and I think it's also excellent in the fact that if I ever wanted to say work in a community or perhaps work as a practice nurse, that with the course that I've got, I can do that too. I think it's really good. I think a lot of tech is what you make of it yourself, I really do, I really feel that. (How do you know what to make of it?) Maybe it's the old saying that you put in what you get out - I don't know, but I didn't go with the idea that I was just going to get through my three years so as I could get out and earn money. (Do you think people do?) I think some do. I think perhaps people that try around - try nursing as one of half a dozen different things. They want a job with a capital 'J' that will bring them in an income. (So they are there for what they can get, not necessarily for what they can

put in?) I think to a certain extent. I'm not saying that's everybody but I think yes there are people like that. Some perhaps when they have actually got into it it's not that - the lady with the lamp aspect that they envisaged, and I think maybe disillusionment has got a lot to do with it. (It's not what they thought it was but they can't get out because they need the qualification?) Yes, and I think in this world today you do need a qualification.

Karen/3/38

Karen reported that, in her opinion, there were aspects which could be improved.

I think there are gaps - quite honestly. (What kind of gaps?) I think quite honestly it's the lack of practical experience - I know it's supposed to be a better qualification and I know theoretically we are supposed to have the knowledge - but when it gets down to the nitty gritty - and you are in that ward and you are up against a girl who has worked in that hospital for three years and that knows where things are automatically because even if she hasn't been there as a staff nurse she's probably been there in her training, and it's who to ring and what to do in a certain case and even just those practical tasks which I know can be taught and I know the technical skills but by the same token it can make an awful lot of difference if you can do them. And you are not having to ask - it really can. (You say that with feeling.) Yes I've got to the point - maybe my skin is a bit thicker, if I don't know I ask and if they think I'm dumb asking, well so be it. Blow it. If I can't take it now it's tough. (Are you asking questions as much now as you were before?) No, but I know there are things I haven't done, that sooner or later I'm going to have to do.

Karen/3/35

NURSING AS A GRADUATE

Adjusting to social constraints

Karen was appointed to a position in a large base hospital as a staff nurse in an area of her choice soon after she graduated as a comprehensive nurse. She remembers her first day well:

> *Well first of all I was very conscious of the fact that I had a very new white uniform on that still had the creases in - that was the first thing and everything seemed to be so new and so shiny - you felt as if you stood out. You just felt everybody else's uniform looked so sort of well worn and here you were with your creases. I felt very conscious of the fact that it was white when I had been used to wearing blue. (So you felt different?) I felt very different - and very new. It was a good day. It was an orientation day - with two other women - both very experienced women who were coming back to nursing after raising a family - one of them had heaps of qualifications which made me feel even newer. The other one was an older lady and she had been nursing and she was starting part time nights. I think that made me feel even newer - just the fact that they were experienced nurses and they had their medals and the questions they were asking were completely different questions to the way I was thinking.*
>
> Karen/1/1

Karen did not feel particularly confident in contrast to the two nurses with whom she was orientating.

> *(Did they appear confident to you?) Yes one of them even seemed a little bit cynical I thought. She was obviously comparing the two - where she had worked before and where she was going to work here and just looking at the hierarchy structure*

of the hospital - a little bit too aware of the channels that she was working through. She'd been there for years. Because while they were new they had a wealth of experience to draw on as well. Both from that hospital and others. That was quite interesting. (Did you spend the whole day with them?) Yes pretty much, except for the time when I went over to my area. One came with me but the other one they left her in her ward. They take you on a tour of the hospital and we left her in her ward and she was to meet us again at lunchtime and then you see they didn't know where in the clinical area I would be working any more than I did.

Karen/1/1

Karen had a one day orientation to the hospital and to her ward. She feels that this orientation period did not meet her needs at that time.

(So you had a one day orientation. Did you see the people who orientated you - did you see them again?) Yes that was the one day orientation just to show us around the hospital and get us started but after that I had a three week orientation - that comprised really just working in the wards and then the inservice charge nurse would come down usually once a day but on their days off they didn't. In the main it was once a day and they popped down and said how are you going and they gave us these sheets to read and things to work through - just checked off how we were going with them. (Did they watch you giving out drugs?) No they didn't. Nothing like that. I haven't done my I.V. course at all yet because they feel that it's a low usage area and you don't do it until you go into an area where you are going to use it more. Which I think is very sensible. Except for the fact that

sometimes, well I have had three instances now where people have been busy and patients have been sent through with I.V's and one had to have I.V. drugs.

Karen/1/2

(So your orientation then consisted of a day being shown around and three weeks of being kept an eye on.) Yes. (How did you feel about that, do you think that was adequate for your needs?) It was in some ways but in other ways no. I feel quite honestly because of the fact that those inservice women are orientating for the whole of the hospital and I feel - the specific areas it doesn't cover - I think to that extent no, but I think you are very dependent on having helpful staff in the ward. Plus you ask questions - I look back now and think the questions, I mean I know I've still got heaps to learn and compared to some of those women there I'm terribly new and I'm very raw but it's quite interesting, now, other people are asking me things and I'm able to tell them things and I just know the answer. Things that I was having to ask and it's not until somebody asks you and you can answer that you realise - yes, I have progressed. You think I haven't progressed, but when that happens you realise you have come along the road a little way.

Karen/1/3

Karen thought she would have liked to know more of the routine staff nurse responsibilities during that orientation phase.

(Looking back now at that orientation time - can you think of anything specific that you would have liked to have known then that you didn't get an opportunity to know?) I think a lot of it comes with just working in the ward. I find the worst thing is knowing what piece of paper to fill out

when, and which Doctor to ring when, and knowing when you have to ring those Doctors and when you haven't got to ring them. But with us over there you have your private patients and you've got the unit patients and you've got a roster to work to and you've got the house surgeon roster to work to - then you've got your evening rosters to work to. (So it's pretty confusing?) That's the confusing part, yes.

Karen/1/3

Establishing a professional identity

Karen was anxious to make the point that in her view the comprehensive course gave her a "good basic grounding" and it was now up to her to add to that basic knowledge.

One thing I would like to say before I start - I think I'm fairly aware of the fact that when you do your three years' comprehensive training, tutors are teaching us and training us to go out into the world and work as a newly graduated staff nurse or community nurse or whatever. We've had a wide training for three years - but when you actually start in a place it narrows down to just the more specialised work in that particular area - now the three years gives you a generalised training if you like but a much wider spread. Now you've got to look at increasing your skills and your knowledge - take one particular area from that training and broaden that aspect of it - I think now you're into whatever you're doing whether it's a surgical ward, a general ward, psychiatric - you have taken the knowledge that you've got from that three years which is more generalised and you are focussing on one piece of it and that's what we are trying to broaden and that's where I feel that

I want to gain more skills and more knowledge because I have plucked that little piece out and that's the piece now I am concentrating on and trying to broaden. This is where I feel the need for more knowledge and skill comes in. (So the biggest gap then is knowing your way around the ward - practical experience in the fine detail really?) I think so. (Are there any other gaps?) I think as far as giving us an overall view and with our lectures that we had been taken out to have these experiences and had so many people into speak to us I think it's a better training, far better - but I think when reality hits and you are put into that ward ... (That's when the crunch comes?) And you take all the theory you want but it doesn't help you find something that the doctor wants and that sort of thing and to do it fairly quickly.

Karen/3/37

Karen found that she had missed parts of the practical experience (such as procedures and techniques) that she needed to feel competent as a staff nurse.

(All the work you did in labs during the three years was that real at the time?) Yes it was. (Did you cover most of the techniques you would have covered in a ward, do you think?) Yes I think so. But it's the same thing you find with going out with the district nurses, they say - have you done so and so and you say no, and they say, oh well I'll go and do that, and I'll drop you off to do so and so. So it means that you don't get a chance because you haven't done it, therefore they can't leave you to do it, and they can't spare the time to come with you, so they leave you to do something that you've already done that you are skillful in and they

do that one. (You miss the opportunity?) Again.

Karen/3/36

Karen was concerned about these gaps in her knowledge and skill and worried about how she would cope compared to a general trained staff nurse.

It worries me a little bit. It does. I guess it's like anything else - there's probably things you know one day you are going to have to do and you have never done and you think, how will I cope. (Where do you think the responsibility should be then - do you think it should be Tech's responsibility to give you that basic grounding in the practical skills or do you think it should be part of the in-service that you get when you go into a graduate job?) I think it's a mixture of both. I honestly think there are things that the inservice - it hasn't occurred to them that we don't know or haven't done because a lot of them are basic things that a lot of these girls have just done as part of their training. Not that anyone's made a special issue of it, but because they have been there when it's been done - at least maybe they've watched and the opportunity has just - I think it's improving - I think the fact that the students are getting more opportunity from what I've seen this year - they are getting more clinical experience and I think that's a big thing.

Karen/3/36

Karen thought that the hospital demanded efficiency and proficiency from staff nurses which was sometimes in conflict with what she was taught in the comprehensive course. Karen appears to have been reluctant to share her "thoughts" with other ward staff:

I think it better that the more efficient and proficient that you are with those things, then looking at you all round as a person, in the role that you are fulfilling, then I think you are going to fulfil that role better. (Is that what tech taught you?) I think tech taught me to think about what I'm doing and not accept things at face value. (Is that what you are doing now?) To a certain extent, yes. There are times I don't say what I'm thinking - whoever does all the time - but there are a lot of times I sort of think about things and keep it to myself I will admit, but tech did teach me I think that you don't accept things at face value. And to think about things, and I think that's very important. I think that's one of the really big things I got from tech. (What is the hospital teaching you about your job?) Hopefully to do it better. (What aspect of it better?) I think the whole thing - I think - to a certain extent I feel I am being moulded - I feel I am being moulded the way they want me to go, but I have no complaints about that at all.

Karen/3/41

Although Karen reported that she was aware of a "moulding process" she felt that it was to her advantage:

(Can you describe the kind of mould you think you fit into?) Part of the team. That's a very big thing. I think - and the supervisor has been so good to me - she said a couple of times - do you mind, you know she's sent me off to work in other places, and she said some people don't like being asked to go, but I've just loved it - I really have, because it's giving me experience - I wouldn't like it if she sent me to work in other parts of the hospital but round the unit I'm just

loving it, because it's giving me those opportunities. (You see the whole picture?) Yes. I said to her one day, I really appreciate it, and I really like it. And she said - you're very accommodating. But I do, I am really pleased that she feels she can come and ask me. (So the hospital is suggesting to you that you are part of the team and that you can be moved around?) Which I think is a very good thing. I really do. (That moving around though is based on the number of people they need in certain areas rather than your learning needs?) Oh yes. Well I feel so, yes. (Your learning is a sort of by-product?) Yes, I suppose so.

Karen/3/42

Karen also felt that she had a responsibility to her employer to fulfil her position as staff nurse in the way in which the hospital demanded. She felt that by doing this she was adding to her knowledge and skill:

But I think it's teaching me the role that I'm to fulfil there as a staff nurse and I think it's a very good thing myself that they do, because alright if you're going to employ somebody you want to employ somebody that's going to give you what you want from them. I think fair enough that they do that. As I say I do feel to a certain extent that I'm being moulded but I feel if I'm learning what they want me to learn and I can build it on to what I learned at tech, then I can't do anything but profit from it. (Is any of what you are learning as a part of that moulding process replacing what you learned at tech?) No but I think it could if I let it. I've got my own beliefs about a lot of things, it's not that I'm just putting the blinkers on - I don't do that - but if I have learned something that I feel is good at tech, I hang on to

that and I try and build on to it. I don't just cast it aside and then just pick up the new things. I try and graft them together if you like. (So you are building on what you already know?) That's what I am aiming for. How well it's coming out, they'll be the only ones that can tell you. But that's what I'm trying to do.

Karen/3/43

Karen explained that she was just beginning as a graduate and "had a lot more to learn" in order to nurse people in the way she would want to -

It's been different in some ways to what I expected but then I think perhaps when you're newly qualified it's a whole new ball game anyway. Particularly I think coming through a polytech course and you haven't had a lot of experience in these wards. If say I had gone through a general course I might have three months working in an area - some of these girls have gone back to the same area two or three times, then that mounts up and I think, yes, I would have much more idea of the type of work I'd be doing. I was very lucky, I think to get to the area I wanted, and I've tried to take it as it comes and look at it that I'm there to learn - try and improve my own skills and my own knowledge, to try and apply what I have learned. (Are you conscious of increasing your knowledge?) Yes, when I look back now to what I was when I started work I feel I have increased it. (What kind of knowledge have you increased?) I think it covers a fairly wide sphere actually because what I have tried to do is if I've come up against something that I haven't come up against before, I've gone home and read it up. I think a lot of it is voluntary. I think I've tried to build on my own knowledge that way and I think

just working in the ward and seeing what happens with different patients listening to what the doctors say and watching some of the other people at work just seeing what they do, I think it all - it's all the little bits going to make one whole really.

Karen/1/21

Karen reported that she felt she was "nursing differently" to the way that she had been taught. She reported that nursing practice in her ward was largely based on technical skills which Karen considered was something she had to improve in order to be seen as "competent" as a staff nurse.

(Are you nursing people in the way that you thought you would be able to while you were doing your training?) No I'm not nursing them the way I want to nurse them. Because I think that I'm aware of the fact that I've got a lot more to learn. And I think I'm very much aware of the fact that the more I learn, the better my nursing will be. And I want to improve myself. I want to improve my skills - I think when I come home I always think about what I've done through the day and think well I'll do such and such tomorrow. I do a bit of self analysis because I want to do well. (You've talked a lot about you want to be a good nurse - you want to be better, you want to learn more, you want to improve. How do you define good or better nursing. What is it that you're doing now that makes you want to be better?) I think better in learning more skills. Better in - perhaps better in that seeing how some of these other women that have been there for years can move from ward to ward and just be slotted in - I'm thinking of one particular person that helps out round the unit and she can just go anywhere in the unit wherever she's needed and just work and I think it would be really good to be able to be that sort of nurse - to be able to have those skills and the

knowledge to be able to do that sort of work. (So you are really defining "good" in terms of increasing your skills?) Yes and my knowledge.

Karen/4/49

Evaluating her own professional actions

Karen found that she relied on three sources for evaluation of her performance as a staff nurse (a) the patients, (b) her colleagues and (c) the charge nurse.

Karen's assessments of her patients provided some feedback on her professional nursing care:

(What sort of things do you do to find out how well you are getting on?) I often go back and check up on the person that I have been looking after - (So you check on your patients?) Yes. That's one way of doing it. To see if they are happy, if they are settled, how comfortable they are. (So in effect you are measuring your own performance against your own judgement of what it should be?) Yes I think perhaps I do it with the idea of seeing if it has been successful. (You get some good feedback from patients?) Yes you do - very much so. That's where my big rewards come in actually. I really like that. (Do you depend on that?) No I don't think you can because I think you have to look at what you're doing for the overall good of your patient - (So what you actually do for the patient in terms of nursing care might not necessarily mean that she thinks you are a brilliant nurse?) No - and it mightn't be particularly what she wants either. Because if she wants to go down to the lounge and smoke when you really and honestly feel she should perhaps have a rest on her bed for half an hour.

Karen/1/22

Other staff nurses were used as a "yardstick".

> *The other way is I try and measure myself against women that I know that are achieving very well and that have been on the staff for a long time. (So you watch what they do?) As much as you can when you are busy. (Do you imitate what they do? Do you learn from them in that way?) I try to - if there's time after you've given report and you are going off and they are coming on - and if it's quiet - often there is one particular nurse there if she's on she's a staff nurse, and I try and have a talk to her. She's really good to talk to about things. (Do you ask them for feedback about how you are getting on?) No, not so much, I see that more as the charge nurse's role. If you want to talk about a patient to them and say well how do you see it or what do you do in a case of such and such, somebody who has been nursing for a lot of years in other hospitals, it's very good to see how they perceive these things.*
>
> Karen/2/24

Karen reported that she felt "uncomfortable" in her relationship with the charge nurse and was reluctant to discuss this aspect of her work:

> *I have requested feedback. (Who from?) From the charge nurse. (And what was the response?) She gave it to me. That was alright. Then also I have had comments from her - I think you get them from the other staff too. (What sort of things do they say?) Well if you've done something and it comes out in report they say oh that's good. Or sometimes they say why didn't you do so and so. This type of thing. It's a mixture.*
>
> Karen/1/25

(Has the charge nurse written a report for you yet?) Not to my knowledge. (What sort of things will she say?) Well if you have done something well she will tell you. And she will also criticize you if you haven't done something well. (Do you ask her for that?) When I first started I did. The first few weeks, but I don't now because I have noticed if she doesn't like something she will let you know. Smartly - and if it is something - like if she said oh that was good or yes O.K. that's fine - I'm glad you picked that up, she's not lavish in her praise, or anything like that - whether that's just her or whether it's because I don't deserve it, I don't know, but I guess it's a mixture of both. If you have done something - she'll say that's good, you've used your initiative there.

Karen/2/25

Karen felt quite confident with a relieving charge nurse whose approach was "more relaxed" -

(And you feel quite confident with her?) Oh yes she is really nice. (Do you notice any difference at all between the way she runs the ward and the way the regular charge nurse runs the ward?) Yes I do. (What are the main differences?) I think she's younger - I think you haven't got the authority figure so much there. You know the uniform and the authority figure - I think she is very relaxed in her approach. I think also being younger - some of the things that would normally be done with the charge nurse there - the charge nurse gives talks once a week and things like that - well because she is acting charge she hasn't - some of those duties have been taken away and they are getting another charge nurse to do them each week rather than alternating weeks. Things like that. So she's not

taking over - this is just my impression, I don't feel she's taking over the total thing and perhaps some of the long term planning and meetings and things she is not going to because she's only there for a fortnight, and I think some of that type of thing they are shelving until the charge nurse comes back. So it's more or less just a holding thing for a fortnight I felt. Nobody has said anything but this is what I have noticed. (So in general the atmosphere is more relaxed?) I think she is in the ward more. Because of the fact that you know yourself a lot of the charge nurses - an awful lot of their time, poor things, seems to be spent in trotting off to meetings. (Administration?) Administration things. Whereas a lot of that has obviously been left. She's not going to the same meetings I notice that the actual charge nurse - nobody has spelt it out but I have just noticed normally the charge nurse says - look I've got a meeting at such and such I'll have to go - and this is part of her duties but I've noticed that for this fortnight this hasn't been happening as much.

Karen/1/6

The responsibility of ward management

When it was her turn to be in charge of the ward Karen reports that she felt "nervous",at first;then realised that she was "sharing the duty with other staff nurses".

(When the charge nurse is off in your ward who relieves her?) We have two staff nurses on and one does charge. (Have you had a chance to do that?) Only once. (How did you feel about that?) I was a bit nervous. I wasn't really charge nurse because there were two of us on, and the other staff nurse has been there a long time so it was just what had to be done and we just did it. One

didn't actually do charge - we just did the work. We found that it works a lot better because if one is tied up with her patient the other one - just what happened to come in, we did. And we just worked it out like that. (Did you know beforehand that you were "nominally" in charge?) Not till I found that I was rostered - no - my hours were 8-4.30 and I thoughtwell maybe thats me but we didn't make it one was charge because I was so junior and she was so much more experienced so we just sort of did it. It worked out - I thoughtthat was better actually because with her experience and knowledge she could do the parts that I didn't know about and we just got through the day that way. (Were you aware of the implications of being charge nurse for the day. That the ultimate responsibility of the ward was yours?) No not really. Because of the fact that we shared it and she knows very well that I hadn't been there very long so we just did it together. (So you didn't really think about if anything dreadful had happened it would have been your responsibility?) I did - but as I say, I realised it was out of my control what was going to happen was going to happen and the best thing I could do was to get my head down and just cope as best I could at the time. And with two of us we more or less just divided the work and it was only for the one day.

Karen/1/5

Karen reports that she liked being able to help students and saw teaching students as part of her responsibilities:

(Do they come to you for help?) Yes to some extent they do I think. I think it'shaving - somebody that you know that has been through the same thing and I like to try and make them welcome and show them round, because having been

through it myself I know what it is like to be put into a ward - it is different to a hospital trained student because you are there working every day and when you are a polytech student you are brought up and sort of popped in - I like to try and make them welcome. (So you make them feel a part of the place fairly quickly?) I try to - I don't sort of rush round after them like a mother hen but I show them around in the mornings and then try and make it very clear to them that I'm approachable and if they want anything for goodness sake come and ask. Because that's what I'm there for. (Do you feel good about that?) Not so much - no I wouldn't say good about it - that sounds a bit smug. I don't feel good about it but I think that as I said having been through it myself I know what it's like to feel strange and feeling that you're the only one in blue in the ward and you are the newest one there and you are only there for a very limited time so I like to try and make them feel welcome - and let them know that there is somebody there if they want to ask anything. Go and ask the charge nurse or if they don't want to make it as formal as that because they don't know her to come and ask me and then if I don't know I can go and ask her. (So you try to let them know that part of the job is teaching?) But not to overlap with the charge nurse. She sees her role as a teaching role. But more or less to make it that there is somebody there that is approachable and sympathetic to their problems and if they want to know anything for goodness sake don't hesitate to come and ask. Because it's often - it's just really little things and if you know it can halve that job.

Karen/1/10

Karen also reported that she felt patient education to be an important part of nursing practice:

(So a lot of what you do is informal teaching and encouragement?) *And you get an awful lot of that if you have a few spare minutes and just talking to the patients - a lot of it comes into that. Chatting to them while you make their bed. A lot of it you can make very very good use of that time I feel. If you do it then you are educating them and helping them. I see that as a very important part of nursing.*

Karen/1/11

- as long as this did not overlap with "the charge nurse's role" -

In a lot of cases the charge nurse likes to do that - she likes to - with students coming into the ward and she likes to go around and do that with the students. So if she is there we don't do it she does that. And that way she says there is uniformity and she feels part of her role as a charge nurse is a teaching role. She likes to do that. *(It gives her the chance to see every patient too doesn't it?)* *Yes. Well this is why in a lot of cases if she is on she likes to go round with the students as she says it gives her a very good opportunity to meet the patients. She is very conscientious and she's really good with the patients.*

Karen/1/9

Karen was careful to keep within the boundaries of her "role" as she saw it and to check with, and support, the charge nurse where possible.

(What about the other things like the confidential information - who would normally have that?) *The charge nurse would have it. Do you mean if somebody comes in and wants to discuss a patient. Well normally if the charge nurse is there that's done - for an example say it's somebody that the social worker has seen or that the charge nurse feels that it would be a very good thing for that person if*

the social worker did go and have a chat with her - as a follow-up, not just in the ward but for when she goes home - when the social worker has seen that person she would come back and give a verbal report to the charge nurse and then later on she would send a typewritten one through later but of course that could take some days but a lot of it is done verbally. (Would you have that kind of information. If the charge nurse wasn't on?) I think she perhaps wouldn't go into it in such depth with me but if it was something that was relevant to the patient at that particular time, yes I think she would.

Karen/1/6

Karen felt she could, perhaps, initiate that kind of professional contact in the charge nurse's absence.

(Could you initiate that contact - could you ring the social worker yourself?) If the charge nurse wasn't on, yes I could. (Would you?) Yes I think I would because - now let me think - if the charge nurse was going to be on the next morning I wouldn't because we've got a little communications notebook and if anybody wants to leave a message for anybody else you write it in the book. I would write a note to the charge nurse in there and I would also put in report that could this person be seen by the social worker. But if it was a case where the charge nurse - say she had days off or something like that and I knew she wouldn't be on till the week-end when the social worker wasn't working, then I think I would. At least I would ring up and say to the social worker - what my problem was and perhaps ask her if she felt she should have a talk to her. It's one of those things being fairly new at the job I think at that stage I

would tell her the situation and then perhaps leave it to her to decide whether she felt a visit was necessary. And then I would leave a note for the charge nurse both in report and in that book as to what I had done and why.

Karen/1/16

Karen found that she often "felt very responsible" for events which occurred in the ward.

I can remember an instance where a woman did something and I was upset because I had felt I had done everything in my power to check that that wouldn't happen and still when you turned your back she did it and I was upset and I talked it over with this nurse who was going off duty and she called in on her way out to the carpark. I said I feel just awful about it and told her and she said for goodness sake don't take things so much to heart, she said they are grown human beings, and you can't hold their hands all the time. She said, I think some of them would like people to do it, you can only do so much. (And you found that quite .....) It made me feel better. (You still felt responsible?) Yes I did. But as this nurse said, I needn't. Don't take it so much to heart but I still felt responsible. (If that circumstance happened again would you still feel responsible?) Yes, as it turned out nothing happened but I thought of what might have happened if I hadn't gone in just to be sociable and say if I had not bothered, not gone in to say, hi are you O.K., is there anything I can get you, which was all it was, just a little sort of social drop-in visit through the evening, I wouldn't have picked it up. (So you are still in effect evaluating your own performance?) Yes I guess I am. (Is that

something you learned to do at tech?) Probably, I think tech to me taught you to be self critical - I don't know if everybody found it like that, but to me .....

Karen/2/20

Karen felt uncomfortable with the word "power". She thought that the charge nurse was the person who was (and ought to be) "powerful" in the ward.

I don't have great feelings of power. Never have had. (What sort of things make you feel powerless? It's a difficult question for you?) Yes it is. I have never had feelings of great power - I don't think I'm - in any aspect of my life I don't feel - I don't like pushing people around. (Well let me ask it a different way. Do you feel as though you're in control when you're on duty in the mornings?) No not really because it's not a question of - I think the charge nurse is in control - I think she's the one with that sort of power and she's the one in control. (So you see her as being powerful?) Yes I do - I think she's got authority and she's got knowledge and she's got management skills. I think all those come into being a charge nurse.

Karen/1/19

Karen explained that she herself preferred to "request" co-operation rather than give orders.

Power to me is - if you like, having the authority to tell people what to do when and the wherewithal behind it to make sure that they do just that. (So that when you don't really feel powerful - you don't really feel able to tell people what to do?) I try and never tell people what to do. I ask them. But no I don't know if that's how it always comes out - I like to think it does - I don't like saying

you go and do so and so. I like to put it as - would you please or do you mind - it would help me if you would .... (By saying that, you really mean go and do it?) Yes I guess I do but I would imagine there's a lot of us that do that but I think a lot of these things - I think it's much nicer to put something as a request to somebody than it is to order. (What happens if they ignore that request?) I don't think I have ever had that happen. (So you would expect that if you said would you mind doing something that they would go and do it. Have you just remembered an instance....) I think where I work nobody is - I think if it was a student nurse she would go and do it but I think if it was another registered staff or registered enrolled nurse - a lot of them have been there a long time and they would perhaps say do you really think it's necessary to do that now or ... there was one instance today about a lady and she said oh she's only 5 days we needn't worry about it until tomorrow - so something like that - yes. (So even though you had politely requested that something be done ....?) I politely requested then when she pointed out that there was no particular hurry - it was no great urgency - it would be perfectly alright to wait until the doctor was in the ward and ask her then, then O.K. I went along with that. That was fair enough, and we weren't going to put in a beep for her right then we were going to wait until she came down to the ward and then mention it.

Karen/1/19

Karen did feel, however, that although she was coping with most aspects of her practice, she did not really feel "in control".

(You've told me an awful lot about your practice area and looking back through the transcripts it's

all very very positive, that you are on top of what you are doing, although you'd like to learn a bit more, the kinds of things it said is that you are learning, and you feel as though you are in control, to an extent ...) To a limited extent. (That is acceptable to you?) No not always. There are times when I think well - like today we had discharges - we had one patient discharged - we had three patients transferring, and another patient transferred into the ward, the charge nurse's desk was just covered in paper. Because there were doctors and forms to check and I just looked at it and I thought - what if she wasn't here and that was me. I really don't think I could have done it, I don't really feel in control, I feel I'm doing my best in my own little corner, but no I don't feel in control like that - I couldn't have done what she did today. I was just about on my ear because the phone never stopped and I had a - mind you she didn't have patients assigned to her, which is a help and I did. (It would make a difference). One patient took up an awful lot of time, in fact I felt a bit guilty a couple of times because I could hear the phone ringing and I thought hello - there's three others in the ward, I'll let them answer it. I knew it would be worse when I got back, with this patient - I thought, no that's fair enough, I do my bit and I was right up just about as far as you could get from the phone anyway, but it just never seemed to stop ringing.

Karen/3/40

SELF REFLECTION AND PROFESSIONAL ACTION

Karen thought that she deliberately used her knowledge base to enhance her practice.

(Last time you were here you mentioned about

feeling competent and you were a bit envious about the people who could just get in there and do everything without seeming to hesitate. Have you thought any more about that?) Yes - I think that's one of the good things with the polytech course - I think you have got that knowledge base and I think the envious part with me comes in seeing women that have been nursing there for years and seeing that they can do things automatically that I've got to look at now what will I do and then work out when and the things that I will need and then go and do them but I'm finding that each week that goes past that's becoming easier, which I guess is just being there and the familiarisation of the job. (When you are busy and doing all these things that have to be done do you consciously link it back to the kind of things that you did in the classroom in the past three years or is it just you sometimes stop and think - ah I learnt something about that once?) I do try and link it back. You have to talk about certain procedures to patients about why they are doing things, yes I do, I try and link back and not just say something because I'm saying it but try and give a reason why I'm suggesting that they do certain things. And use that knowledge base, explain to them, not just say you do so and so because - so that I feel that they have got something out of it other than just copying certain movements. That they know why and they have learnt something about care for themselves.

Karen/1/11

Karen felt very uncomfortable during these interviews for several reasons. Firstly, she was aware of the confidential nature of the material she was entrusting to the interviewer:

(Do you go away from here and think about the kinds of things we have been talking about?) Yes I do. (Can I ask you what you think about?) It's a bit like taking your clothes off actually. (I'm very aware and very appreciative of how honest people are being. Does that affect you very much after you leave here? What sort of things do you think?) Well there are times - I think that's why I asked you those questions last week about just where those tapes are going to end up and the transcript. Because I wouldn't like to think that O.K. it's a confidential thing - what I'm telling you is confidential between us - I wouldn't like to think it was being passed back and around and used for a teaching thing and this type of thing, but I know and admire you as a person and I've got confidence in you and I trust you and I think that's a lot of it, if you tell me that it's confidential. (Well I think I have probably reassured you on that point.) That's right but I mean you can show me a piece of paper that's fine - anybody can show anybody a piece of paper but I think its a matter of how I feel about you as a person. I respect you as a person and I like you and if you tell me it's confidential then I guess it's the old gentleman's agreement between ladies. As far as I'm concerned if you tell me that's so then I'm quite happy to accept your word on it. (You're reasonably comfortable?) I trust you.

Karen/1/23

Secondly, Karen felt that she was being disloyal to both the polytechnic and the hospital by "focussing on the negative aspects" -

(When you said that you went home and thought about it and we'd talked about the negative aspects, were you angry about that? Or how did you feel?) No I wasn't a bit angry about

it but I just felt it was a shame to just focus - it was out of balance, that's what I felt. That was the main thing and I think - I feel myself that if you are going to talk about something that you don't like about a particular thing or a particular place, then if you are going to do that then you should also give bouquets where they are deserved too. I think it's a matter of just balance.

Karen/3/35

Thirdly, Karen thought that there were aspects of nursing care which, if she felt strongly enough about them, she could change. She did not wish to discuss these aspects, however.

I think if there was something I really felt strongly about and that I really felt wasn't right then the way the hospital is structured these days and the way I have been taught through tech that there are other channels you can go through. No I don't feel powerless, because I know that I have got those reserves there if I need them. (So you are fairly confident that if there was something that you felt pretty strongly about you could actually make some changes?) I don't know if it would result in making changes but I could certainly take my problem to somebody else and talk about it to somebody else whether that would result in a change is really a matter for them. (Who would you take it to initially?) I think I would go to the supervisor. This is always presuming there's something that I am very unhappy about and that hasn't resulted yet.

Karen/1/20

Some of the discussion which Karen had with the interviewer was not taped as Karen wished to discuss aspects of her work which she felt were confidential. At the final interview Karen had decided

that she could express some of these feelings on tape. She was still uncertain, however, that she was meeting the interviewer's expectations and how she "measured up" to other participants in the study.

> *(Have you thought about the kinds of things we have been discussing?) Well I tried to fit it in with where I am going and how I feel about these things. And are my feelings any different to - try to get it from the questions you were asking - are my feelings any different to maybe the feelings of the other girls, the other nurses. Though where I'm at perhaps - in the number of weeks that we've been qualified.*
>
> Karen/5/61

Although Karen wanted to focus on "positive" rather than "negative" things she describes a "good day" as when she feels "less hassled".

> *(What sort of high points have you had in those three weeks - can you think of anything really good?) Really good things - let me think. I think really as far as I am concerned it's just sort of trying to take each day as it comes - and you know it's either a good day or a bad day and if it's a good day - you come home not quite so tired and hassled if you like. But on the bad days - (A good day would be when you have got through your work?) When I got through my work - when I didn't come home thinking now did I do this and did I do that, you know more or less a mental check when you start to relax - when you have had a good day with your patients - not so much things have gone well but when you - its not as if you expect the patients to be good patients - its not that - its just that you come home feeling yes I achieved something today. O.K. that was difficult but I achieved something.*
>
> Karen/5/61

Karen saw nursing as "helping people" and became frustrated with her inability to provide this kind of nursing care.

> *(So when you have nursed someone in that helping role you feel better about that?) That makes me feel better. I feel maybe that's part of what I'm there for. (Yes. Can you think of other things that make you feel good?) I think maybe when you have finished your duty and you feel that everything is done - I find that I can go home and relax - I find it very hard to relax afterwards. (What sort of bad days to you have?) Bad days - well I think when everything comes at you at once - when you are trying to do things and the phone keeps ringing - and people keep coming to the door - and you think if I could just have five minutes to myself I could clear this lot up.*
>
> Karen/5/61

Karen found that after six months in the same ward she was still feeling "new" and still having to check out her actions as a staff nurse -

> *(Is that the time thing intruding again?) I think it's time and interruptions. The constant interruptions I think that get to me and also I think being new something that somebody else that is more experienced will know just what they've got to do - you've got to take a lot longer working out what you've got to do and therefore it takes a lot longer because I've got to ring somebody and ask them - check up what you've got to do whereas somebody else will just home straight in on it and consequently it takes you a lot longer anyway when you are slower at it to start with. (Are you still doing a lot of that checking? Remember when we first started talking you said because you were new you had to make sure that you did things the right way and through the right*

channels, are you still doing that?)
I think I still am but not over the same things. I think I've sort of shifted from those things and got on to other things.

Karen/5/62

Karen found it difficult to resolve the tension she felt between the kind of education she had had and the demands, as she perceived them, of the ward and of her colleagues. She had been taught to care "holistically" for individual patients but the ward was organised around "tasks to be achieved" by a certain time.

(Quite a long time ago - about our second session - I asked you if you were nursing in the way that you would want to nurse - has this changed at all?) No there are times - I think I'm going through a period of really thinking about it and wondering if I did right. Wondering where I am going - wondering if I am achieving what I should - I guess it's because I'm coming up to my six months. Sort of having a good long look at what you have achieved and what if it's what you wanted, and not just what you wanted but if you're achieving what you should have achieved in that time and whether you are at where you really should be at. (How do you know what those goals are?) I guess you tend to measure yourself up against the other people that are there. (But a lot of those other people have had a different education than you.) True and you are expected to measure up - it's all very well to say they have had a different education - it sounds fine - but when you are out there in the whole cold reality of the ward - that's what you are expected to perform to - to measure up and be like them. (Are you like them?)

In a lot of ways - some ways yes and some ways no. (Were you at the beginning?) *What like them? No I was too new.* *(You were too new, O.K. well we'll let that pass for a moment. Let's put it another way. Seeing that they have had a different kind of education and they are more proficient in different kinds of things are you still trying to be like them?)* *I think I'm trying to be like them in that when you are in that ward and you've got to achieve certain things by the end of the duty - the whole work shift is geared for that sort of thing. Well the ward is run to fit in with that type of work load - to fit in with those type of tasks - if you like. And if you can't fit in, then you fall by the wayside.* *(So you've got to change as quickly as possible to fit in with what is expected?)* *Yes.*

Karen/5/63

Although Karen felt that she was learning new skills and gaining knowledge, she felt rather disillusioned about the "reality" of nursing in a busy ward.

I think the big shock comes when you are all enthusiastic and you pass your exams and it's your first day and first week, and you go in there and all this you have learned for three years - you are just dying to put it into practice right - there's the patients and there's the hospital - and you get started and then you find out that the phone rings, and somebody wants something, and instead of being able to spend the time you want to with that patient you had to go away - you have to come back, that might happen two or three times, I think it's the constant interruptions - you can't give that patient what you want and I

think - I feel sometimes that they feel that they are second in priority to the calls that are on you - just going and answering the telephone - because you can hear it ringing and you think I had better go now - nobody else is answering it. Because they are busy too. Or there's a doctor coming. Or somebody wants you to sign for something - and you say excuse me I'll be back in a minute. Excuse me I'll just pop back and then somebody else will buttonhole you and want something and instead of popping straight back that other person whose needs are there wants you too, so it might be 5 minutes or 10 minutes before you get back. I feel, to me, that makes a person feel that they are not as important - that they can be left. And I think - whereas we have been taught that the patient comes first and it's the patient's needs that are uppermost, and I find that's very hard. Because I often wonder how the patient feels about it. Having to wait while there is - the big machinery of the ward keeps going.

Karen/5/65

Karen felt the burden of responsibility and the changes she was making were worrying her.

(Have you noticed yourself changing?) Yes I think I have. In some ways I like it and in some ways I don't. Because I feel I have been pushed into it. (What are the things you like about it?) I like the fact that I've learnt some new skills. But what I don't like is - I find it worries me quite a lot - it worries me that you can be the only staff nurse on and you are responsible - that I don't like much. I find it is a big responsibility. I guess being

older you think of all the awful things that could happen - whereas a younger person doesn't. They just sort of breeze in and they don't think like that. I think it's a bit of a strain. I find I get very uptight when I am going to work and - particularly on afternoon duty - it takes me - I go to sleep but you keep waking up in the night with what happened in the ward still going round in your head, as if you haven't been to sleep. (So the sense of responsibility is very ..?) Yes and wondering if you have told everybody all the things you should have and passed on all the bits and pieces that you should have so the next duty will go smoothly. And not only that you might have passed that message on to the nurse whose patient that was, but did they write it in the notes, did they give it in report. And yet if you go there and start reading their notes and asking, you get accused of checking up all the time. And undermining that person's role so you feel you can't ask you just have to hope to heaven that they did write it in report. That they did pass the message on. Because if they didn't then next time you come on you get taken to task - and that happened the other week and I was very upset about it actually because I felt - I was told by the charge nurse, there's not a word in the communication book and not a word in the notes about it, she said. And yet I had told that girl and she was an enrolled nurse, and furthermore - not only had I told her, I had seen her write it up on the board as well. But I'd had two days off and when I came back it had been rubbed off. So I got the notes checked and she hadn't written it in. And yet she obviously got the message. Because

she wouldn't have written it up on the board - (And you were held responsible?) Yes. So this is it. One minute you are told not to check up on people and leave them to their patients - that's their patient - and the next minute if it doesn't all work out then they say but you're in charge which is where I find it is not really fair.

Karen/5/66

Karen often felt caught up in circumstances which she was unable to control (e.g. the emphasis on task achievement in the ward, the relationship she had with her colleagues, her "lack of experience" for the job.) One such circumstance, which she was determined to change, was the professional dilemma she experienced in taking verbal orders from a doctor for a restricted drug.

(You were having some problems about verbal orders, do you feel able to talk to me on tape about that?) It doesn't happen very often. It's just that instance I told you about - a couple of instances - that was a while ago. (That was a consultant charting a drug over the phone?) Yes. (Are you able to refuse to take verbal orders?) It would take a lot of courage - I didn't that particular night, it was 11 o'clock - we had taken the 10 o'clock obs - her blood pressure was going up - we checked it again at half past 10 - still up, so then we asked the night supervisor who comes round, on her way through, and she said well you had better ring up hadn't you, so we rang - everybody had a little talk about who was going to be game enough to ring, and I thought oh well what have I got to lose - somebody has to, so it was me. I rang and this very sleepy voice gave that

message - as it turned out I think I told you it didn't need to be used - with the sleep her blood pressure settled down, but that wasn't what worried me. But there haven't been a lot of instances - this particular batch of house surgeons are very good - they pop through and sign things - there haven't been so many instances.

Karen/5/66

Karen was in no doubt that she was expected to accept verbal orders for drugs.

(In a hypothetical situation if you did refuse to take a verbal order from a consultant or from a registrar, what would happen?) I would hear about it the next morning. Probably from the charge nurse or the supervisor, because I would imagine there would be very loud complaints made. (They would expect you to take verbal orders?) Yes. I have made up my mind - I was so worried that night about that, that I'm not going to do it again. Because I just rang up and said I thought he should be told this lady's blood pressure was doing this particular thing and he said oh do this - and told me what to give her. Again I think having been through it once and having seen what it did to me when I got home - I think well blow them. I shouldn't have to be expected to put up with that. And hopefully next time I'll have the courage if you like, to say look I'm not going to take that - because thinking about it there is no reason why he couldn't ring the house surgeon and tell the house surgeon to come down and chart it. (It's his responsibility not yours?) If I had given that drug - I think what has brought it home too the same particular consultant - a few weeks later had a woman on

antibiotics which he charted and he stopped it - a few days later she started getting stinging again when she passed urine so it was told to him and he started to get really upset - I wasn't on duty it was my days off luckily, about this women's antibiotics and he vowed and declared he had never stopped them, and yet his initials were in the book against the stop. So what hope would I have had. What hope would I have had on a verbal order if he did that with one that was written. So that was actually perhaps for me a good thing, because hearing about that - just the talk in the office - I'll never take anything from him over the phone.

Karen/5/67

INTERPRETIVE PROFILE : KAREN

Karen perceived the structured learning situation at polytech as a personal challenge. The repeated testing, for her, was not related to learning itself but presented a set of challenges (pp 168-170).

For Karen the distance in time from formal school experiences seems to be significant and apparently helped her to more readily accept organisational structures (e.g. p167-168). Karen was so conscious of her age and the implications of the gap between herself and the other students that this coloured all her educational and practice experiences. It became a measuring device:

> *being older and being out of the education system so long, I felt it was important to get an idea of how I was coping ... once I had got that reassurance that I could cope ... manage intellectually with people a lot younger ....*
>
> (Karen, p170)

and a reason for her feelings of incompetency -

> *seeing women who are my age that have been nursing there for years ... they can do things automatically that I have got to ... work out ...*
>
> (Karen, p201)

The military imagery (e.g. uniforms, p191) authority vested in positions etc.) became much more obvious in Karen's case. She relates to people not as individuals but as occupiers of particular positions, and accepts as commonsense her own feelings of powerlessness and incompetency as a function of her subordinate position within the hierarchy both at polytech and in the hospital.

For Karen, ethical responsibility is exercised always in the awareness that there is someone with higher authority (pp196-197) and it is not until Karen is faced with a moral dilemma that she is forced to act in a way that she knows will bring uncomfortable consequences. (pp 211-212).

CASE STUDY FOUR : CATHY

EDUCATIONAL EXPERIENCE

Cathy decided to apply for a position in a Comprehensive Nursing Course when she was in her final year of Bachelor of Science degree.

> *I was doing a Bachelor of Science and I made the decision to go after receiving a terms test worth 15% and I got 45%, and I was so slacked off - at that stage I had thought I might go back and do some postgraduate work - (Was that in your final year?) Yes. I decided then that I wouldn't go back to Varsity - I finished that year and I passed - got my degree - (So you were in your early twenties?) Yes.*
>
> Cathy/3/38

Cathy was too late to apply to the polytechnic of her choice, the next closest required "too many forms to be filled in" so she applied for and was accepted at the polytechnic of her third choice. She remembers her first few weeks well -

> *I remember thinking how young everybody seemed - because they had just come from school. And in a way how much it was like being back at school. The first few weeks were quite good actually because we got off a lot of lectures. (It was really relaxed?) Yes, it was pretty relaxed. The staff tightened up later on. (In what way?) Had to attend all lectures. (Did you get any credit for having your degree?) Yes, I managed to get out of science subjects. I remember it was quite easy coming to tech - it wasn't too difficult. University is much more high pressure - the work was harder - you had a lot more - you had to read journals and you had to make the old brain tick - and I think we were treated more*

like adults at University even though we didn't have so much contact with the lecturers as we did at Polytech. (You were treated like adults at University - in what ways were you not treated like an adult at tech?) I don't know - mainly the roll call and things like if you were late for class you weren't let in. That kind of thing just reminded me of school kids. (Did you consider that that roll calling was necessary?) Well I did when I saw the logic behind it. (What was the logic?) Well to make sure you have got the correct number of hours up your sleeve for sitting States. I realise that they had to do it and there was no way around it.

Cathy/3/39-40

Academic Preparation

Cathy describes herself as being "very conscientious" and she reports that she worked steadily throughout her education to ensure that she stayed near the top of the class.

(Did you compare yourself with other people?) Yes, quite competitively. (So you felt quite good about being in the top 4 or 5 people?) Yes. (Were you surprised?) No I wasn't. (That's where you expected to be?) Oh I don't know. I always compared myself with another girl who had a degree. I was mainly a bit above her - I think I used to do more work than her. I always like doing well.

Cathy/3/41

Cathy saw the class work as being very important and was reluctant to take time off -

I don't know - too conscientious. I don't like taking days off for nothing. I see nothing too useful about that. Besides I don't want to do extra work - it takes a long while having to

catch up on lectures.

Cathy/3/40

Cathy was anxious to meet the formal or academic requirements of the course, particularly in attending lectures and passing tests.

(So you saw the lectures or the class content as being pretty important?) Yes. (Why?) Especially in the third year. And the second year. It was important. We were going to get a test on it. (So it was tests that were important?) The test shows you what they really wanted us to know and it gave us practice to answer them. Especially when they started giving us state questions. (Did you always see the point of having a test? Or an assignment?) I don't know - what made the tests especially - right through - they gave me an incentive to make sure I read through my notes. At least I knew what I was studying for in the last two years. In that way they were really good. (Did you agree with the marks that you got for your tests?) Sometimes I thought they had marked them miles too easy. Getting consistently in the 90s - really to me, after being at University - they'd been marked too easily.

Cathy/3/41

Although Cathy measured her academic performance by her test marks and her assignment grades, she appears to have identified the credentialling nature of these aspects of the course.

(What about your assignments?) I never did quite so well in those. (Why was that do you think?) Some of them were so waffley - you didn't know what they wanted. I could never motivate myself quite so much as I could for tests. (You would have liked more structure in your assignments?) Yes. I remember once getting an assignment back in my third year and I hadn't discussed with anybody

else how they were doing the assignment, and obviously I didn't do it how the lecturers wanted it, and the tutor said to me - I was displeased with your assignment. (How did you feel about that?) I think perhaps - they obviously wanted it in a certain way which I didn't get through just from the sheet of paper they handed us about the assignment - if I had known more what they wanted I think I probably would have done a better job. (Were you able to say that to her?) No. (Why not?) I couldn't be bothered. (Are you an assertive person?) No not really. (So you accepted it?) I wouldn't have said I accepted it - I probably ignored it.

Cathy/3/42

Cathy describes her education as "boring" and although she attended conscientiously throughout her three years she says she often felt she was wasting time.

(You spent hundreds of hours in classrooms over the last three years (laughter, grimace) *- with me just saying that - what's the first impression that springs to mind?) Boring. (Boring - what in particular was boring?) In the first year I remember we repeated so much material I just got really - I knew it, the stuff that we were going over and I just got fed up to the back teeth with it. (What sorts of things? Can you think of anything in particular?) Going through Maslow's hierarchy - self care - we just went through that heaps and heaps of times. (Could you tell anyone about how boring it was. Did you talk amongst yourselves?) Yes, quite frequently. (What could you do about it?) I guess we could have approached the tutor about it but - (But you didn't. Did you think of that?) I thought partly it was me in that I'd come from University and I picked up things fairly quickly, and*

other people were still learning through those repetitive sessions - so I didn't really want to say too much then.

Cathy/3/45

I remember specifically one morning when we were doing assessment and principles of management of the billiary system and the assessment just - we did the principles first and then we went back and did assessment, and the assessment - it was just an utter waste of time because we had basically gone through everything in the principles of management so that to me - I just sat and gritted my teeth throughout the session. (Was that 1 hour or 2 hours?) It was just a 1 hour I think. We had one hour on principles of management and then one hour on assessment. (In any typical week how often would you sit and grit your teeth?) It's hard to remember back then, probably one a day. (One session a day? So in a week it would be about 7 hours?) I would say so.

Cathy/3/48

Cathy supported her classmates who at various times attempted to change the course content and presentation. These attempts were unsuccessful during the first two years and by her third year Cathy reports that she and her classmates had decided that nothing could be done.

We probably could call a class meeting and get a general consensus about what people feel and then bring it to the tutors. (Did you do this?) No, because then they would say well what would you like to do and that always left us blank when tutors said to us now what would you like to do that is interesting. (Why was the blankness there do you think?) I think partly because we didn't know what we needed to know about what would be interesting. (Well if you didn't know what you

needed to know why is it that you weren't prepared to sit and listen to what they were telling you. Why did you switch off?) Generally because I thought some of the stuff we were doing just wouldn't help me. (Can you think of an example?) I remember being particularly bored with community health. Whether it was - I don't know it was just boring. (Was it the way it was presented or the content that was being presented?) A bit of both. Probably more the way it was presented. I think because Community Health stuff is quite abstract expecially in the first year - it was just running through all the various matters of the health system. (So there were round about 7 hours a week that you considered that you could have done without. Or you could have done it differently or you could have done it on your own. But it was a waste of time being in class. Was that something you felt, or did everybody feel like that?) Most people felt like that. In between classes you often ... you know boring tech! (But no-one was prepared to do anything. What prevented you from doing something about it?) Apathy I guess.

Cathy/4/49

Cathy considered that the Comprehensive Course bore little resemblance to the nursing care she was carrying out as a graduate. On reflection, she describes her education as "idealistic", "unreal", "irrelevant" and "theoretical" producing "non-assertive" graduates. She considered that the theoretical aspect of the course did provide her with "good goals" however.

It seems a very unreal kind of nursing that you are taught at tech which in practice can't be done because of how it is in hospital - short staff and time pressure - tech has it's good points - it does prepare you theoretically I

think for nursing but .... (For what kind of nursing? The kind that you are practising now?) No, it gives you - no it doesn't. But it gives you good goals. It does give you an idea of what the ideal kind of nursing should be. Like when you spent hours and hours doing nursing care plans and sometimes they used to end up about eight pages long, and some of the little things that you used to write in just to make it appear good - (To the tutor?) Yes, and to get that bit higher mark. All that sort of stuff seems so irrelevant now. You want to know whether they can all walk, eat, dress themselves, are they continent, or incontinent, and that's about it. A few other details. We used to write great long objectives - I mean it is good in theory but in practice you just haven't got time and you want to keep everything down to the bare minimum.

Cathy/6/62

Personal and professional development

Cathy suggested that the course did not encourage students to be assertive and confident. She says she often "ignored" adverse comments and did little to change the parts of the course which frustrated her except to support her classmates.

(What about you as a person? The sorts of things that happen to you at tech in terms of developing you as a well rounded person - does that have relevance for how you are nursing at the moment?) No I don't really think they do much to build you up there at tech. I think partly because it's this structural bit for your clinical and theory, you are never in a place long enough to feel confident in that area, you have tutors popping in to see you - specially in your third year and you kind of see that as a threat which immediately puts you on the defensive

so you are not feeling so confident anyway. Although tutor visits can be good too. The classroom situation - roll calling and also the fact that you have to go to tech, whereas like at University you are not required to go to all the lectures .... (Was there anything that you learnt at tech that would indicate to you that you had to attend every class?) Not really but you had to attend 80%. (You said that tech didn't really build you up as a person - did the tutors or the structure of the tech course itself attempt to teach you in any way as to what sort of person you should become?) Obviously the ideal that they were trying to get through was a very assertive confident - I think they were the main qualities that they wanted us to come out with - assertive and confident. But I don't really think they gave us much chance to be assertive and confident.

Cathy/6/64

Cathy felt unable to do anything about the comments she received on her end of term reports which, she thought, were unfair.

(What about your end of term reports?) I remember at the end of my third year - no in my third year at the end of the first term - they said - 'doesn't seem to be as motivated this term' or something like that. Obviously I was like that - I wasn't so motivated as I had been in previous years - I think it was 6 years of study and I got married and just really wanted out but I didn't take any days off that year - I was still getting consistently high marks and in assignments apart from that one, I think. I didn't really feel that it was a completely fair comment. (Did you do anything about that?) I was going to but then - all of us complained about it - remarks

at the end - we kind of had a meeting - all complaining about our reports - I think they stated that they wouldn't change any of the comments. (What was the general feeling in the class about the reports?) Everyone found that they had received more negative comments than positive comments - in my one it said - 'motivation hasn't been very high - but she has maintained a reasonable standard of work' or something like that. I thought also that 'reasonable' wasn't fair because I had done well. I could have gone further with it I guess.

Cathy/3/43

Although Cathy saw lectures as being very important and says she conscientiously attended classes, she often felt the material presented was irrelevant. She was reluctant to do anything about this, however, as she thought that complaints about individual tutors would have repercussions for the student.

(What would happen if you decided that a tutor was quite wrong in the things that she was saying - that her knowledge was inadequate in the classroom. Did that happen to you?) Yes definitely. (It did - O.K. what could be done about that?) I guess it would have been a worry. I'm especially thinking about a tutor whose nursing knowledge seemed to be so outmoded or she wasn't confident enough about it. Yet we didn't really do anything. Although I think the year before had said something to the H.O.D. about her. I guess if we had got our act together we would have said something. (What stopped you?) I don't know. You would have been black-marked. (By whom?) Everyone. Because that kind of thing gets around so quickly. (You mean all the tutors, or do you mean the students as well. You would have

been blackmarked by tutors?) By tutors. (What would the students have thought?) The students would have got behind the person. (They would have supported you?) Yes.

Cathy/6/64

NURSING AS A GRADUATE

Adjusting to social constraints

Cathy obtained a position as staff nurse in a large base hospital immediately after she graduated. She had a one day orientation to the hospital and her ward which had recently been set up for primary nursing. She describes the "reality of nursing practice" as a graduate as follows:

I don't think I'd realised completely what it was going to be like. Being a staff nurse, and as I said I don't think I saw that as a problem last year when I was a third year student. (Last year you thought of yourself as a well educated nurse - a good communicator - a person who could cope with most situations. Has that changed?) I think it has a bit. Last year I was confident in communication generally but it's just changed because of the reality of the ward. (So what are the things in the ward that prevent you from nursing in the way that you know that you can?) Time. Being distracted - just having a talk with someone and - 'Nurse, can you come and give me a lift' - 'Have you got the keys' - that happens so often. Ward routine, telephone, other patients, trying to work out the balance of what you should say and what you shouldn't say.

Cathy/4/53

Cathy thought that as a staff nurse she would be more involved in ward administration rather than the bedside nursing she found herself doing.

(What sort of things did you think you would be doing as a graduate in your first job. Did you think

it would be like it is?) On the whole, yes. Perhaps not entirely because I didn't envisage going to a primary nursing care ward - I thought I'd go to a place where there were a couple of staff nurses on - or just one - so I thought I'd be doing more kind of staff nurse duties - but (What do you mean by staff nurse duties?) I thought I'd be doing more things - like ringing up doctors and stuff like that. (Ward administration?) Yes. But because there's somebody more senior on our wards - because there are so many staff nurses generally you just ring up the doctor for your own patients - whereas if you're the only staff nurse on the ward you'd be ringing them up for all of them. My nursing care for individual patients is what I thought I'd be doing - just the same. (Did you think there'd be the time pressure that there is?) I knew that we kind of live in a bubble when you're at Polytech because you don't get full allocation, so I suspected that I'd have more patients.

Cathy/3/34

At the time of interview Cathy was concerned that she seemed to be unable to provide holistic nursing care in the way she had been taught. She identified the "task orientation" in her ward, and the staff's need to receive positive feedback from patients, as two aspects which prevented her from nursing in the way she would want to.

(What do you think it is that makes you feel like that and stops you from nursing the way you want to. There are obviously things that you can do. You can sit and talk to patients for instance. What stops you from doing that?) I don't really know exactly. I guess it could partly be being so task orientated. That you kind of forget that your patients are humans and they need talking to and listening to. (Would there be times when you see other staff in the ward sitting with patients or

sitting with relatives?) Not very often. (So it'snot a common thing. But they do sometimes?) Yes, there's generally in the ward two or three patients that most nurses feel comfortable going to talk to, and they're the ones that get most of the attention. Ones that give you a positive feeling when talking to. So there's usually two or three people that get talked to. Apart from .... (So you respond to the people who give you good vibes?) Yes.

Cathy/2/24

Another aspect which affected Cathy's ability to provide "good" nursing care was the daily routine of the ward.

I feel very limited by time and by all the routine things round the wards that interrupt our nursing care - you get really fed up with them - talk about cups of tea and those stupid ward rounds - when you tidy up the ward - that kind of thing. (Ward tidies?) Yes I don't like those things. (Do you think they are necessary?) Yes they are. (Why?) Because the rubbish tins get full! Nowhere to put the rubbish. You could just do your own room which we all used to do but now it's quicker to just do the whole ward. Cups of tea - someone still has to give them out - (Who normally does that on other wards?) It'susually the nursing staff. I wouldn't mind starting up a petition - (What would it say?) Nurses shouldn't have to do cups of tea. This hospital is apparently about the only hospital that nurses still have to give out cups of tea and dish out meals. (What would happen to your petition do you think?) I don't know. Go to the Principal Nurse and get screwed up.

Cathy/3/34

Really I see nursing as nursing the patient and all these other things that have to be done extras and I

don't consider them nursing. I see that they have to be done - (By somebody?) Yes. Once some things slip then your whole day is behind and you're fighting against time all the time. They do have to be done but to me they are just things that take me away from my patients so they are a real pain. (Would the rest of the staff feel like that?) I don't think all of them would. Some of them might see them as a chance to get away from their patients.

Cathy/3/36

Cathy thought that there was a difference between what was considered to be a "good" nurse during her education, and what she experienced in her ward.

I think the ward might consider a good nurse someone who does give good patient care but someone who is also very efficient - gets things done around the ward - whereas at tech just generally looked at patient care more than routine things - oh you do look at efficiency but no - perhaps you don't get to see it quite so much because you haven't got so many patients. (How aware of that difference have you been? Is this the first time you have thought about that?) Yes it is really.

Cathy/3/35

This emphasis on "tasks" and "routine" was frustrating for Cathy.

(Do you get much time in all of this to actually sit down and talk to your patients or is it mainly getting things done?) Very little time to talk to patients. Very little - just only in the shower, and then it's- will you wash yourself here please - (An instruction?) Yes. (How do you feel about that? Has there ever been a time that you would like to have sat down and gone through something with a patient or helped a patient do something or other,

rather than getting on and doing the jobs.)
At the moment there's this patient in our ward who's a 50 year old man with CVA and it has affected his speech and so he needs a lot of time just encouraging him to speak and I have sat down with him a few times just to try and get him to talk and I really enjoy doing that because he's young and he's motivated and he wants to get better, and I want to get him better, and though I really enjoyed that but with a lot of them it's difficult - you know the ones that rave on - that kind of thing.

Cathy/1/8

But on days which were "quieter" she was able to provide holistic nursing care -

(So you had four patients? And your 50 year old CVA patient went quite well that day?)
Yes, it was really good nursing on that day. It took me about three quarters of an hour to get him ready for bed but I made sure he undressed himself completely and dressed himself, and I felt really good that I hadn't been hassled - because when he gets hassled you just start doing it yourself but he did it all himself and felt very pleased.

Cathy/1/13

Giving medications

There were a number of aspects of her nursing practice that Cathy was concerned about and would have liked to change. In particular the system for checking and giving out medications bothered her.

It's really easy enough in our system to make mistakes. I've made two mistakes. (Do you want to tell me about them?) Oh yes. I'm

not very proud of them. (Oh well everyone makes mistakes.) I had given out the 9 o'clock pills which was marked sedation and one lady refused hers - she wanted to take them at a later hour so I didn't really think I should just leave them on her locker so I took them away and went to the next patient to give her her pills. Our system is that we have little strawberry punnets and have 4 medicine glasses in each punnet and we have the name on a bit of cardboard stuck on to the medicine glass. And I forgot to check the name and I just handed her the previous patient's who had refused to take them - just handed them to her. And this patient said to me - "I get different pills every night." And I thought she was a bit confused and then she said I usually get round ones - oh help she had swallowed one by that stage and I grabbed the other one from her mouth - that was my fault. I knew who the patient was - it wasn't the wrong patient it was just that I didn't look at the cup. The other time was when I was giving out the pills, usually I have one medicine cup isolated - that's the one I'm doing the pills for and for some reason I was just doing one patient's pills and then I popped it in one of the medicine glasses in the container. So she got another patient's tablet. (Did she know?) No she didn't know what she was getting. So I had to fill out an incident form for both cases. (How did you feel about that?) Oh I felt really stink. Really terrible. (Did both those things happen at the same time - around the same time?) They were about three weeks apart. (Do you have to check night sedation with another staff nurse?) Well again in the ward - there is about two people check out all the night sedation - about 7 o'clock we put them

in little medicine spoons with their names attached - then we just pick it out of the medicine glass when we do our pills. (How do you feel about that system?) *It's quicker - than if everyone tried to check out all the night sedation at once. Generally you know what a Noctec looks like and you know what a Halcion looks like so you are always checking it on the chart anyway. The only disadvantage is that if a patient doesn't want night sedation you, with the two people checking it out, don't know if the patient doesn't want it or not.* (O.K. if they refuse it do you return it to the bottle - or do you chuck it out.) *Return it to the bottle but it makes more work for the staff nurses.* (So the pills are checked out at 7 and given to the patient at 9. Where do they stay between 7 and 9?) *In the drug trolley.*

Cathy/1/3

Cathy, with her colleagues, wanted to change this system to something that was safer, in their opinion.

We are going to - at the moment we have got all the drugsheets in two ring binders - well we have to discuss this with the charge nurse when she comes back, but each room is going to have its own individual ringbinder and instead of having the medicine glasses - have envelopes which you can just attach to a drug sheet so you can put your drug in, attach them to the drug sheet and just take the whole ringbinder with you to your room so you can check the Bradma and check the number of drugs that you should be giving out. (Yes, so you would have the Doctor's order written out for each patient on each sheet, and your drugs right there, so you check the Doctor's order and the drug and the Bradma?) *Yes, whereas now a lot of people - well since I have made my mistakes I have started taking the drug sheets with me to the bed. But a lot of people don't and so it will be a lot safer.*

Cathy/1/5

This change was not made because the charge nurse had been away for some time. This was a source of frustration for Cathy and the ward staff.

> *The staff supervisor has changed again, but the previous supervisor used to decide who would be charge in the morning and she didn't make any decision for the afternoon. That was just generally the most senior person but I'm not sure about this last week - whether the new supervisor has decided or not. (You said last time too that you can't get on and make some changes that you wanted to make - I think you talked about drug rounds that you wanted to change that, but you couldn't really because the charge nurse wasn't there.) Yes. (Has that still not been changed?) No, partly because it's far too involved - spend a lot of money - and also just don't feel happy doing it while she is away.*
>
> Cathy/3/33

Although Cathy thought that it was a nuisance that changes could not be made because of the charge nurse's absence, she found that she was "more relaxed" and more involved in the management of the ward when the charge nurse was absent. Cathy reported that she was unable to relate well to the charge nurse who seemed to react to questioning with a "personal attack".

> *I think I have talked to one of the staff nurses about the blood pressure book and she agrees with me. (Is it something you could take to the charge nurse? To be changed?) I think if we had a meeting about it we could because I wouldn't like to go up with just me as a new staff nurse. I'd like to get a general consensus about it. (It's not something you could talk to her on a one to one?) No. (You couldn't go up to her and say this is dumb - let's change it?) Help no. (Why not. What would she say?) I think she would attack me first and then ... (Attack what about you?) I don't know exactly. I have forgotten how she does*

it. She's been away.

Cathy/2/29

and, for example, during report time -

In the morning we read the afternoon before's duty and the night report. (Do you get any questions in those sessions or are they just sort of a note-taking thing for the staff coming on?) You do get questions where you discuss the nursing care of patients. (So it's fairly relaxed?) It's relaxed when we read reports but our charge nurse doesn't - we're a bit hesitant to ask questions. (Why is that?) Because she gets threatened really easily and if you ask a question and she doesn't know the answer she doesn't feel happy to say - I don't know. It feels like she attacks you, for kind of asking the question. (So you have to be a bit careful about how youask?) I'm not going to ask.

Cathy/1/20

During the charge nurse's absence Cathy reported that -

Everyone is so much more relaxed. Even though we are still doing just as good nursing care of the patient that people feel more relaxed and there is more communication I think between the acting charge nurse than there would be between her and us. (Are you saying that there is less distance between you and the charge nurse now than there would be if the regular charge nurse was there?) Yes, but that's because we are all on the same level anyway. (Does that mean that you share more information about your patients?) Yes, much more. I know much more about what is going on with Mrs. R. down in Room 6 than I would normally. (That probably would make you feel more involved in the whole ward - would it?) Yes. Well in some ways it does - last week - I don't know. Last week I felt quite isolated because there was a girl who was

acting charge and another girl and they had been in the same class - general class - and so they tended to share information more and I felt out on a limb and I didn't know what was going on but this week it has been different because we have all known each other better, and so we tend to share information more.

Cathy/1/4

Accepting Professional Responsibility

Cathy had a turn as 'charge nurse' when she had been in the ward for about two months.

At the end of the day the supervisor said as she was arranging who was going to be charge next week - you girls do realise that when you are charge it means that you are the one who is ultimately responsible for the whole ward. I think that really hit me because I had been fairly casual thinking well there are four of us staff nurses on today - thinking you know, oh well we will kind of all share the load and just one person's got the title 'charge'. It doesn't really mean anything. (So you were really just playing at it?) Yes, I don't think it really hit home at all until she said that. (How did you feel when she said you could do it?) Nervous. I have been charge on afternoon duties but that is different from a morning duty. I could have imagined a day where everything was going to go wrong - patient would have died and to get about four admissions in two hours or something. But it was quite a good sort of day really. I felt reasonably happy at the end of the day. Another staff nurse said you have done well. (Did you feel good about that?) Yes. I don't know - she was just saying it.

Cathy/1/19

The ward staff decided that they wanted a permanent relieving charge nurse as they were "fed up" with coping with their own work as well as the ward administration. Cathy says that the ward staff "prompted the supervisor into action" because -

> *We were just all getting really fed up with having different charge nurses every day - there are five of us - during the changeover from morning to afternoon - and we decided it just really wasn't on, because everyone was getting fed up - doctors were getting fed up - nurses were getting fed up - and messages weren't being passed on - nursing care not done, and so we rang up the morning supervisor and said will you come up we've got something we would like to talk to you about, and she came up and we said we need a charge nurse, someone to work 8 to 4.30 - not to take any patients at all, and she said yes, I have noticed when I come into the ward things don't seem to be quite as tied up as they can be - well don't you see there's no-one there. So she said the most senior staff nurse on could be charge nurse but she said to the staff nurse who was going to be charge, make sure when you work out your roster don't leave the ward short. (How are you going to do that and be charge nurse too?) I don't know. (So your most senior person is now a charge nurse? Relieving charge nurse?) Yes, she was and then we just heard last week that the morning supervisor had arranged for another relieving charge nurse to come in so she'll be starting this week. (So she's almost a permanent reliever?) Yes, obviously it prompted her into action of getting the staff nurse to be charge and then she obviously didn't think that was quite good enough so got the relieving one in. So that's really good.*
>
> Cathy/4/55

This situation had an unsettling effect on Cathy and her

colleagues but it helped to maintain the status quo in the ward. For example - of the changes Cathy would like to make to her practice, she said -

> *I don't think I've sort of got complacent about that kind of thing. There are still things that we would like changed but we can't because the charge nurse is still sick. (Is she?) Yes. I guess you do lose a bit of your enthusiasm to change things as time goes by though. Three weeks ago when we all talked about changing the drugs we were all very enthusiastic then but now you don't feel quite the same as you did then. (So the moment's gone?) It's gone but it will come back again. I guess I've just stopped thinking about it.*
>
> Cathy/4/54

Dilemmas of practice

Cathy had several experiences which demonstrated to her the nature of the relationships she had with other members of the health care team.

(a) Her inability to act in an ethical dilemma distressed her:

> *We have got a lady in who on an ultrascan showed that she had some sort of liver something and they assumed that it was an infection but they weren't sure - they did a liver biopsy and found nothing and so they decided eventually to do a laparoscopy and she went down to theatre and meanwhile the house surgeon charted really high doses of antibiotic just in case it was some sort of hepatic inflamation which requires massive doses of antibiotics - anyway the report came back from theatre on the patient saying that she had a large growth in her liver and so the other staff nurse and I discussed whether it was necessary to give her these antibiotics which weren't going to do anything for her and*

she rang up the house surgeon on call and he discussed it with her doctor I think and he decided that we should give them and that would give her a free weekend without being told that she had cancer. The staff nurse and I thought this was a bit off but she gave the antibiotics and the patient said - progress at last. (How did you feel about that?) Both of us sort of when we talked about it, had tears in our eyes, thinking that she thought that they had decided on something she was going to get treated for. (And the implication was that she was going to get better?) Yes. (What did the Doctor say when he was rung?) He said that her Doctors wanted to give her a weekend when she wasn't aware that it was cancer, which we thought was really on the nose. (And you weren't able to say anything?) No there was nothing we could say. We can't read out the op report to her. (If she had asked you what was wrong what would you have said? If she had said - progress at last, what is the infection I have got? What would you have said?) I probably would have blurted out something like - I'm sorry I can't .... I'm not in a position to tell you.

Cathy/1/15

Cathy could not remember anything specific from her education which might have helped her in this situation.

(Do you remember doing anything on the theory behind ethical decision making as a student?) Laugh - You're joking - (O.K. laugh out loud. No seriously do you remember anything about being a patient advocate - did you do that?) Yes we did it. But I can't remember really. (So you aren't able to link back to your education - it's too far away?) That's right.

Cathy/1/15

She reported that she was distressed over her inability to act as the patient's advocate or to provide holistic care for her patient.

> *I think the consultant came in. Or the person who had done the biopsy. He told her the diagnosis on the Monday. (And how did she take it?) Initially she was quite upset but I think she was ready for it - she wanted to know. (Do you think she already knew?) I am sure she suspected it. (So in fact giving her a free weekend wasn't really a free weekend because she had an idea beforehand?) She had an idea beforehand but I think giving her a weekend of possible hope may have stopped her thinking about cancer. (What about you though, and the other staff nurse who was involved? Have you been able to work through that feeling of anger that you had, or whatever. What was the feeling that you had?) Well, we thought it was really unfair that the Doctors weren't going to come and it was being false to the patient. I guess I still cringe when I think about it.*
>
> Cathy/1/16

She could not think of anything else to do except to talk to the nursing supervisor about the dilemma.

> *(Would the supervisor do anything?) Well if the supervisor felt as strongly as we did she probably would. She would probably go to the senior supervisor and then she could probably contact some sort of doctor. But I don't think as staff nurses we could do that sort of thing. (Could you as a staff nurse insist that the supervisor ring somebody else?) No, I wouldn't really feel confident to do that. (What would you not feel confident of. I mean you're confident that that was the wrong thing for this patient. What is it that you wouldn't feel confident about?) I wouldn't feel*

happy telling the supervisor what to do.

Cathy/1/16

(b) Managing new procedures and nursing responsibilities meant that she had to rely on colleagues as well as her own judgement:

It's the first time I've ever looked after anyone on blood transfusions - I've gone to pick up blood, so it was good, really good experience. (Did you know what to do?) I asked the other staff what to do. We had report till about 3 o'clock then the two people who were looking after the blood transfusions before I came on told me what was going on and then I went to go and see the men because I hadn't met them before, and one of the blood transfusions stopped while I was looking at it. (What did you do then?) I yelled out to the other staff nurse who is more experienced - it's stopped! And so we fiddled around with it for about half an hour trying to get it going and then the doctor of those two patients came and saw them. (Did you ring for him or did he just come?) No he just came. And he noticed that one of the patient's transfusions was running a bit late and I told him that we had fiddled around with it and he said make sure it's got done in half the time next time. (Great, how did you feel?) Well I was a bit annoyed that he said that because I had explained to him that we had had difficulty getting it going and he said it should go - he obviously thought he had got a good vein. It was up in the tubing - that was the problem - it just needed a bit of an extra push to get it going. (Were you able to tell him how you felt?) I didn't really bother. It didn't worry me that much. I knew it wasn't my fault that it was running slow so I didn't take it personally.

Cathy/2/25

(c) Coping with the daily fluctuations in ward routine and staff nurse responsibilities.

I worked last Friday - a morning duty. That was a really grotty day. (Do you want to tell me about it?) *It was a day I got quite a light list and I decided that I work much better under pressure than I do if I've got a light list - I tend to muck around a bit. And I did one shower and then I had to do a Doctor's round and by the time I had finished passing on information about the Doctor's round it was time for morning tea and then we had to transfer the patient that I had showered up to another ward and still had one sponge to do and another girl did that for me. I felt - it was a yukky day.* (You weren't in control?) *I wasn't completely in control - no. There are factors outside which kept on calling for my attention - like the Doctor's round, people asking me for a lift and ...* (When you say that you were mucking around, what sort of things were you doing?) *Well just - like passing information on from the doctors' rounds, about the various patients - what needs to be done.* (Was that a complete ward round or just your patients?) *That was all the patients for that particular doctor. I had to write up what the doctors had said as well just on a piece of paper so that people could include them in their reports. I also talked with the O.T. for a while about doing swallowing exercises on another patient. Had to check out drugs with the enrolled nurses. All that sort of thing just took time and in the afternoon I just couldn't kind of motivate myself I think partly because it had been such a funny day - I realised some things, when I got home, that I hadn't passed on to people - things that weren't life threatening or anything but things that*

doctors tell me and then I forget to tell others (What kinds of things. Do you remember?) One was the doctor said to me - you'll make sure that this lady who was going to have a bronchoscopy in the afternoon - that she has her pills at lunch-time won't you. And I said O.K. and then I just completely forgot about him telling me that and then someone from the day before had written in on the calendar, Mrs. so and so is to have her pills at lunchtime and she just glanced at that and saw it and she said, oh, she's to have her pills, and I said, oh yes, she is too. I just felt really awful because obviously ....

Cathy/2/21

SELF REFLECTION AND PROFESSIONAL ACTION

Cathy found these interviews useful as she was able to discuss many aspects of her education and her work. She found it was easy to discuss her work:

(When you are working in the ward do you think about telling me about these things - the things that you are doing?) I generally think quite a lot about what I am doing and so what I'm telling you is just an extension of what I'm thinking.

Cathy/2/30

After the third interview (when Cathy discussed her education) she went on holiday, then night duty. At the following interview Cathy explained how tired she had been.

(It must be four weeks since I've seen you then.) It has been ages - longer than that I think. (Have you, in that time, have you missed coming to talk to me. Or have you been quite relieved that you didn't have to?) I think in a way I was quite relieved because I was just getting a bit down I think, by the end, before I went on night duty. I

was so busy, I was feeling so tired, I was feeling a bit rotten I think. And so just to come to you to point out my rottenness doesn't help. (Wasn't helping you. Did it make you think about the things you were doing?) Yes, I guess it did in a way. (So that you seemed to be concentrating on bad things?) Yes.

Cathy/6/59

Cathy often thought about her patients and her responsibilities when she was off duty.

(You were telling me about going home and remembering some things that you should have done at work and you hadn't done and you were feeling guilty about them. Do you often take work home like that?) Yes I do. I often dream about work. Last night I had two men on blood transfusions and I just kept on waking up and thinking about the transfusions. (What - things that might have gone wrong or things that you hadn't done or did do?) I felt that I had nursed them adequately while they were on it but obviously my mind was just still active - I just kept thinking about it. (Do you talk about it with anyone?) I talk to my husband about it. (Does he understand what you are saying?) He's getting to understand it more. He used to say I don't want to hear about that, especially if it's something revolting that you have had to do for a patient but he is much more understanding now. (What sort of frustrations do you take home. Are they things that make you feel angry or upset?) It's not so much that. It's more thinking what have I missed out - what haven't I done that I should have done or what haven't I passed on to somebody, or feeling frustrated that I haven't spent time talking with patients - they've said things that you've known that they have been cues which you should have picked up but you are too busy and you rush on. (So it's

more to do with your own performance rather than other things?) Generally it is. Sometimes I might get a bit frustrated that someone isn't pulling their weight.

Cathy/2/28

(Did you think about work while you were away for those four days?) Yes I did because I had that grotty day on Friday. (So it sort of stayed with you - what sort of things were you thinking?) Just little things like a doctor, our house surgeon, said to me - make sure the patient is having his daily blood pressure and pulse done - he'd changed his medication. And I had written it down on the thing where we write Doctor's rounds and all their bits and pieces - I'd written it there - but I hadn't actually told that patient's nurse. And I kept on thinking - did she get that information, and I didn't write it in - we've got this blood pressure book - that people's obs are written in, and I didn't write it in there - and I just kept on thinking about that because the doctor really wanted them done and he made it quite clear that if they weren't done he would be pretty upset - (So you felt pretty responsible?) Yes I did. (Would it have been her responsibility to look up that information?) Yes, when you write reports you always look up the doctor's rounds book.

Cathy/2/28

Cathy enjoyed her time on night duty because she was able to give her patients the kind of nursing care she thought they should receive:

It has changed quite a bit now that I'm doing night duty. Because then we have got much more time and I feel that anything that you do for the patients at night is going to be something that

they enjoy having done like bringing them a cup of tea or making them comfortable - so I feel that nursing at night is much more positive and there's nothing there to hold you back from giving best care. Before that when I was still on days I still felt I wasn't nursing in the way that I wanted to be, because I was still very busy.

Cathy/6/58

She found that she coped well with the additional responsibility which boosted her confidence:

I think I needed a spell on night duty to get some of the confidence because during the day there is always somebody else to make the decisions for you and on nights you are the only one who can. (When you go back on days you will feel more confident?) Yes I think I will. (So night duty must be quite a relief in lots of ways, to get away from that very busy thing, you seemed to me anyway to feel that you didn't really have much control over what you were doing because of the time, and number of patients you had and all the rest.) Yes. It is really. It's also quite difficult ... (Yes sleeping ... Do you worry about the responsibility that you have on nights?) Yes it was especially pertinent because the first week we had a cardiac arrest on nights and after that I was just living on tenterhooks for at least a week afterwards, any time a patient jumped or - I was just a living wreck then. So I was particularly worried in the week after that. (But you coped with the cardiac arrest?) Yes, I was pleased with the way I handled that.

Cathy/6/59

For one interview Cathy was asked to write down all the good and bad things that happened during the week before the interview. Her notes appear to be a reflection of her perception of herself

and of the care she was giving her patients.

(You told me last time too that when you first started you really felt awkward because you kept having to ask questions about where things were and how the routine went and that sort of thing. And in here you have a little bit about feeling a bit inadequate because people expect you to know things because you are a staff nurse - is that changing at all, that feeling of inadequacy because you don't know.) Yes, I feel much more confident about the way the ward is running. That was just more things about other patients say down in the ward room. They might ask me - How is Mrs. so and so from Room 6, - I don't know. *(Should you know?)* Well I guess people expect you to know. *(Further on you've got about a third of a page about the good things that happened. Two thirds of feeling inadequate and a third feeling good. It's easy to focus on the bad things isn't it?)* Yes it is. *(But it's interesting because the things that you have described here about feeling inadequate etc. are all things to do with you, and your performance, whereas further on you have got good things and it all comes from the patients. You've got Mr. B. is more co-operative - Mrs. Mc. was continent all duty. Those are good things that happen and yet they are all patient centred.)* They are a reflection of my nursing care though. If I keep somebody continent that's good because that means your nursing care has been adequate. *(But you haven't said that here. You haven't said - I felt good because <u>I</u> did such and such - you've said I felt good because Mrs. so and so was more co-operative.)* I guess it was Mrs. R. was more co-operative because I felt I was getting on better with her. *(It's not easy to say - I did a good job).* Not for me.

Cathy/1/12

INTERPRETIVE PROFILE : CATHY

Because of the continuity of learning experiences (school-university-nursing education) Cathy was a well socialised student and accepted the structured formal instructional context uncritically. At the time of interview she realised with hind-sight that during much of her nursing education she passively resisted attempts to encourage her to conform. There were many instances where she could have taken some action but, for instance, she explained she:

> *couldn't be bothered ... I wouldn't have said I accepted it - I probably more ignored it.*

Cathy unquestioningly accepted the academic requirements of the education system and developed a "banking" concept of education, (Freire, 1970:58) where the teacher makes 'deposits' of knowledge and information and the scope of action allowed to the students extends only as far as "receiving, filing and storing the deposits." For example, Cathy explained that the lectures were important because:

> *we were going to get a test on it ... the test shows you what they really wanted us to know and it gave us practice to answer them.*
>
> (Cathy, p216)

and of the assignments she said:

> *... if I had known more what they wanted I think I probably would have done a better job.*
>
> (Cathy, p217)

Cathy was aware of the espoused aims of the polytechnic course and was aware of the contradictions between these and the lived experiences of students of acquiescence and conformity to rules.

As a graduate Cathy appeared to accept the hierarchical structure of the hospital as natural, and perceived the constraints as intrinsic to the system (pp 224-227).

She joined her colleagues in the ward in supporting the status quo arrangements for a relieving charge nurse, even though it was personally unsatisfactory to her (p 230). Cathy's experience exemplifies the problem of legitimation - responsibility must be endorsed by power before the authority is acceptable to individuals - hence the demand for a permanent relieving charge nurse.

The ethical dilemma which Cathy reported (p 234) demonstrates that moral judgement requires personal autonomy, which she and her colleagues in the ward did not have.

CASE STUDY FIVE : JANE

EDUCATIONAL EXPERIENCE

Jane began her nursing education before her 17th birthday. She applied for the comprehensive course at a polytechnic some distance from her home town, when she was in the sixth form. Jane says that her mother found it difficult to let her go so far away from home.

> *(And you got a letter saying you were accepted?) Yes. (How did you feel about that?) Excited except that Mum wasn't too pleased. They all had ideas that I'd do a 7th form and go to University and because I'm Mum's baby, she just didn't think I'd get in because I was too young but I think the criteria was more U.E. than whether you'd turned 17 in the last few months or not. And I got accepted straight after I let them know that I'd got U.E. (Did you do fairly well in U.E.?) Well I got accredited. 6th form certificate was pretty lousy but ... (What was your School Certificate like?) Pretty good.*
>
> Jane/3/30

Jane remembers feeling "distressed" for the first few days because she didn't know any of the other students. She also remembers being "excited" and "bored" -

> *(So you went in and met a whole lot of other people going into first year? What was your first week like?) Quite good because I was in the Nurses' Hostel so socially it was quite good - you see there was no-one from my home town - I was the only one - I didn't know anyone else and everyone else seemed to know each other and I didn't. Very distressed at that. But after the first few days I got to know people mainly. I can't remember very much about what we learnt in class - I know we went over the word "Health" for about the first few days and everyone was bored -*

I think everyone was too excited about it being all new to be bothered learning anything. (Being away from home and ....) Yes, just meeting different people and all that sort of thing.

Jane/3/30

Jane considered that she "did not do very well" academically during her first year in the course. She had difficulty deciding what was wanted in test and assignment questions:

(If you think about first year what are the things that spring to mind?) I didn't do very well. (In what way?) My assignments and the exam marks were all very average - pretty ordinary in fact to the stage where I got a bit worried really. But then in second year I did pretty well and then third year I did even better. So it was alright. (Maybe your first year was a settling-in year?) Yes I think it must have been. (Did you think you could have done better?) Yes I do. I got really worried because I thought I was learning all the wrong things - I used to do a lot of work - I used to study quite a bit and in the Nurses' home we were all pretty good because we'd all go off to our rooms at a certain time and do our work - I thought I did quite good things - after talking with the others I just thought perhaps I hadn't clicked on as quickly. (Did you talk to the tutors about that?) No, because it wasn't really until the end of the year that I was noticing that it wasn't really very good. (It was really mainly your own judgement then?) Yes. No-one else thought I wasn't doing very well but I just - probably because I felt I could do better.

Jane/3/31

During her second year Jane found that her classwork was "less waffley and more factual", and her test and assignment grades

improved. Jane remembers that her third year in the course was 'disappointing' because the class had been scheduled for less clinical experience than they thought they needed.

> *(What were the highlights in the third year? What was the over-riding feeling?) Disappointment - it felt like a backward step. Having the clinical the way we did. Not like we had it in the second year - a decent stretch of theory and a decent stretch of practice instead of flitting from one to the other and not worth having them together. (You had week in and week out?) Yes, I didn't like that. And it was only 4 days. I don't know - you felt like you were jumping here, there and everywhere. You had your two weeks in the ward but if they had been two weeks together it would have been fine. So at least when you went back to the ward you had the same patients. Or similar patients in the ward. It felt like going to a new ward. You had to get to know everyone all over again and chances are you'd have completely different staff.*
>
> Jane/3/33

Jane reported that she and her classmates could not make any changes to this aspect of the course -

> *We complained bitterly right from the start about the way we were placed. (You couldn't do anything about it?) No. Probably the tutors couldn't at that stage either. We complained at the end of second year too - when we got told that that was to be done. (Who did you complain to?) Everybody. To tutors and I think we had a discussion with someone then - a course supervisor, I think. (And you couldn't make any changes? Did you try anything else?) I don't think so. Just complaining all the rest*

of the year. Complain, Complain! I think we probably moaned a lot really. (So you didn't feel ...) Everyone just thought it was a backward step. From what we had been used to like in second year - three weeks in an area at once.

Jane/3/34

Throughout her education Jane 'enjoyed' her clinical placements and was satisfied with her clinical reports.

(And your clinical reports were O.K.?)
Yes, they thought I was too shy and quiet but that's too bad. I still am. But I think it's to an advantage that I'm like that - well for me it is anyway. I get along with all our patients that we have - no-one seems to bother. I'm probably not really assertive enough when it comes to talking to people on the phone - they are more assertive than me. That's the only time it really bothers me. But otherwise I don't care. Too bad - I'm not going to change.
(It doesn't affect your nursing practice?)
No I don't think it does. (Did you think so at the time when they were telling you that?)
No, I thought it was an advantage. (Did you tell them that?) Yes I remember - I probably have still got the first report somewhere in my box of goodies. The tutor said I was very very quiet and confident - that possibly that it was to an advantage and I remember writing at the bottom - yes I think this was an advantage. So that was fine. And I've had comments like that all the time. But it doesn't worry me. That's your personality.

Jane/3/32

Jane complied with the course requirements throughout her education. However, she says she did not always participate in

class as often as her term reports indicated:

> *(So mostly at tech you were in class doing what you were asked to?) Yes, sometimes being a bit naughty probably. (What do you mean by a bit naughty?) Not concentrating. That sort of thing - just being there as a body. Not really though. (Did you participate in class?) Oh not bad. Not always volunteering though. One tutor always used to ask me for things. There was me and someone else - she always used to ask - we couldn't decide if it was because she could remember our names easiest. But at least I always gave an answer. So that was something. I've never been one for participating in class right back to primary school - it doesn't really say you don't think though. (Was it noticed by the tutors that you weren't participating?) Oh - they put on my reports that I participated quite well. I don't think I did though. Because I knew I didn't. I think in our class we had quite a few really domineering people that always did the answering and sometimes they used to complain that they did it but they could just sit there and be quiet but they had to open their mouths and say what ever they had to say.*
>
> Jane/3/36

Jane thought that those students who worked out their mandatory hours were 'stupid' as she thought students needed every hour of tutoring available.

> *(Some people have told me that they very carefully worked out how many hours they could miss.) Well that's stupid. (You didn't do that?) I think some people did but no-one ever took any notice of it. I think it was in about the third year that everyone clicked that you could do that anyway and then it was too late, you wanted every hour of tutoring that you could possibly squeeze in.*

(So you went to most of your classes?) Yes the second year I guess I would have skipped a few. Wagged a few. (What sort of things did you not go for?) I can't remember - only probably about a total of a day or so altogether over the year. Pity you can't do that when you are at work. (Would you want to?) No, I like to finish off what I have started.

Jane, 3/35

Jane thought that she, as a student (and now a staff nurse), had little power to change things.

(How much control do you think you had over your own life as a student at tech?) Probably not much. I think probably because you were scared. (What were you scared of?) Scared to be lazy because you knew you wouldn't get where you were supposed to be going. I guess because you are a student you think that you haven't got much power. You are labelled as such. (That you are powerless?) Yes. (Did you feel like that right through the three years or did you feel as though you had more power as a third year student?) I think really the third year was better. I think probably because the attitudes of those that you were working with changed too. (The clinical people?) Yes, because in our third year I was teaching and helping hospital students - they would come to me and I thought well that's a step in the right direction. So that makes you feel a bit more - (Confident?) Yes, but I think any student whatever course you are from is pretty powerless. In a hospital they are anyway. I think even a staff nurse is. (Powerless to what - change things?) Change yes - I told you about our roster, we can't even get changed - I mean how ridiculous. A silly little thing like that and it's us that has to work it and it's the hierarchy that make it. Well - I won't complain.

Jane/3/39

Jane remembers that her class had some "really good discussions" particularly about ethical questions. She says she can now apply her knowledge in the clinical setting.

> *Those are the ones that I used to participate in because I enjoy those. They were ones about who should be allowed to die. We used to have a lot of those - we used to have that in our second year and that was one of the best times. And professional role - that was really good. (So you can remember ethics quite clearly?) Yes. (Can you apply that knowledge now as a staff nurse?) Oh my goodness yes. Now there's a thing that really bugs me and I sometimes ask why if I'm game enough. Some people that come into the hospital absolutely on their death bed and should be allowed to die - I'm quite sure - and doctors will just try to the bitter end - it really makes me wild and then other people will come in and they are just allowed to die and I want to know what is the difference. Or you'll see written down in the patient's notes not for resusc. and someone else is and there's nothing different between the two - why should one be revived and the other left to die peacefully. (Who could you talk to about that in the ward?) Oh we all talk about it. Most people feel the same way. (The nursing staff?) Yes, like I said to our charge nurse - we had this man in the C.O.R.D. he was about 80 something and they were draining his chest and sticking needles in his back and I thought it was really terrible - he was just about dead and he died that night. Doing all those horrible things and they must have been able to see that he wouldn't last whatever they did. (Were you able to talk to doctors about that?) No. They were around for five minutes*

of a day just about. (Do you often make links back to tech with things like that?) Yes, because I don't think we did get taught - like just looking on that resusc. again - I think the impressions that we got were that everyone was resusced no matter what because no-one had the right to say otherwise. But they do have the right. Doctors do write in their notes and tell everyone not to jump on someone's chest.

Jane/3/37-38

Jane remembers that her class had many arguments - mainly about aspects of nursing practice.

We used to have lots of arguments in our class. (What were the results of those?) Like often if you got told something in class and you go off to your clinical and you find that they do things totally different - I remember being told about the operation they do for prostates - we got taught some irrigation thing that they do - and they don't do anything of the sort and just little things like that for example. (Did those things annoy you?) No, not really, we soon found out what's right. And they might do it like that in other hospitals, you don't know.

Jane/3/36

NURSING AS A GRADUATE

Adjusting to social constraints

Jane began her career as a registered comprehensive nurse in a large base hospital immediately after she graduated. She had a one day orientation to the hospital, followed by two study days three weeks later.

On the very first day that we had an inservice all day. That consisted of a supervisor coming

and talking to us. (What did she talk about?) Oh just their role. How they can help us. And then we had two study days, and we had the lab. staff come to talk to us and pharmacy people - just from the departments to talk to us. That was it really. (What did the study days consist of? Just those people coming to talk to you?) Yes, they were two full days. (When did you have those?) One was while the three weeks, that supposedly the orientation was going on, and one was two weeks later and that was for everybody. All new staff nurses.

Jane/1/1

Jane thought that her orientation to the hospital and her ward was 'hopeless':

The first day I was just with the in-service people and I spent a few hours, between morning tea and lunch time just getting to know some of the patients and staff and that - sort of pottering around really. Helping out and then the next day it was right into it. (What about your in-service orientation?) That's not a very good topic. Hopeless! Next to non-existent. Well our orientation more or less consisted of one day - it was actually said to be three weeks but over the three weeks all that happened was they popped in to see how I was going and that was all and the only time I went down there was to do my IV course and that was it. (So your introduction to the hospital was being taken to the ward you are working in?) Yes. (What would you have liked to have had in your orientation period?) Well I think they should have gone more into a staff nurse's role in their particular hospital - like all we sort of seemed to go over was forms and things like that and what most people knew

about or could decipher for themselves. It seemed all so unnecessary. They weren't getting into any nitty gritty and what was expected of us. (So you would have liked to know more about your responsibilities?) More about the hospital as it runs. I guess most of it that I didn't know then I have probably learnt now just from trial and error. But at the time it was pretty - I don't know. (Is that just a feeling that you have or do you think other people felt like that too. About their orientation?) I know talking to another new graduate - she wasn't very impressed. I'm not sure about the others because they started later than us - I don't know what they got compared to us but when I went for my interview which was only a few days before I actually started, I was told that there would be no proper orientation that we would be right in the deep end because they hadn't organised anything. We were all starting at different times. I believe last year's group all started together and they got a pretty thorough orientation. But this year they didn't seem to be very organised.

Jane/1/2

Jane found herself feeling envious of students working in her ward because they seemed to have more time to provide holistic patient care.

(Are you conscious of doing the same kind of work that you were doing as a student?) No, not really. Sometimes I look at the students and envy them. (Envy them? Did you think that way when you were a student?) No goodness me no. (Why do you envy them?) You just envy the way that they can do all their bits and pieces and look after their patients and not worry about anything else. Whereas you do. Even if you

don't worry about it you have to worry about it. It's your responsibility - you've got the medal on your chest - you have to prove that you deserve it.

Jane/3/26

Developing a professional identity

Having to "prove herself" was an aspect of practice that Jane encountered in several ways - exercising her authority
- justifying her comprehensive education

Exercising her authority with other staff

I find it quite hard to tell people to do things. But that's only because I'm new at the job I suppose anyway. (You mean other staff? What sort of things would you want to tell them?) Just if you are trying to get things organised and you say - can you do this - and while you're doing that you say - can you do this - and while you're doing that you do this and that - sort of thing. (So you'd like to have more control?) I just find it hard to say - go and do it. I don't want to sound bossy - and I don't want to sound stupid. I want to sound somewhere in between. But that's getting better too. (You don't have that trouble on afternoons?) No, because you are the only one on and everyone - the good thing about that is that everything that is going on you know about because you're boss. And everyone comes to you with their little problems - when you're on morning there is - you know - like the two staff nurses, and the charge probably, well you and Charge and people often go straight to Charge with things - if you don't hear about it then someone comes to you and asks about it and you don't know anything about it and that sort of thing.

Jane/2/15

Justifying her Comprehensive education to her colleagues

(You were telling me that people react to you according to what they think of comprehensive nurses. Do you want to tell me a bit about that?) Yes, well when I first started I knew that everyone - I talked to another new graduate about it - we went to lunch and morning tea together, and she said to me - you know you walk in here - I feel as if I don't deserve this - I feel as if everyone is looking at me saying - my God is she a staff nurse. That's how we both felt for the first few days. Sort of felt like other students - as though they're sort of looking and looking - oh no, not her, sort of thing, but I suppose that it was just because you felt so unconfident. And you went in knowing that people were going to be against you - I think that people look at you because you are different - and they are looking for you to do things wrong. (So you start off with a negative feeling?) I think they are looking for you to do things wrong and they pick out some little thing that anyone from anywhere could do. (Can you give me any example? What sort of things?) Not really but perhaps just being a bit slap happy about something that you could be just because it's you, not because of what course you come from.

Jane/2/10

Another delightful day I had - that was a lunchtime too. I was sitting with a staff nurse for lunch and two other women - I think one was a charge and one was a staff nurse - and did they go to town. And a friend was there with me too - and a particular lady was going on about our course - they always bring up this argument how it didn't work in Canada and we always try to explain that they

just had to rearrange it all. (Ours isn't like Canada anyway.) Yes exactly. This is New Zealand and going on how it would convert back to the old way and how there's not enough staff and all that - oh it just went on and on and on. (What did you do?) My friend and I fought to the end. We tried. I think both parties gave up after a while.

Jane/2/10

Jane found it particularly difficult to accept the judgements made by her colleagues about an appropriate workload for a comprehensive student.

I get quite angry in our ward - the comments that fly - I get really angry. In the mornings when we are allocating our patients someone has done it all and I'll guarantee someone will want to change it all. And they always seem to think that because the students are first years that they can't cope with all this, and I reckon that just going by what I experienced when first year polytech students only have one patient - she needs that patient to have the most nursing care and the most experience she's going to get from him and quite a few of the other staff don't think that they should have even easy things. It's ridiculous - then they'll criticise them for being inexperienced, and we don't have enough experience on the ward - no-one seems to be prepared to give them that experience while they are there. (Are you able to say those things?) Yes, this morning. It really makes me sick. (What sort of response did you get?) Fairly silent one, but tough! I was sitting in the boss's chair, so they have to go my way. And I think they're all being quiet because they know I know what it's like because I've been there. I think sometimes even the tutors have to realise that

too that they've got to let them do as much as they possibly can on the wards - it doesn't matter what level they are at - because you miss out otherwise. There were girls in our class that - someone said they hadn't even done a BM stick when they were in their third year and that sort of thing. They're just basic things - that they've missed out along the way because someone had said - No give them an easy patient instead of leaving them patients that were very interesting.

Jane/3/28

Jane thought that comprehensive students throughout their education needed all the clinical experience they could get in any particular setting.

Those that have tutors guiding them and even in the first year - I don't see any reason why they can't cope with one patient who needs full nursing care. We had two and we managed. I used to get bored if I didn't have enough to do and getting bored in your first year - it's not very good. I think the senior ones - I think you should give them as much responsibility as you possibly can. Because you can't just overnight become a staff nurse. Because you've got a slip of paper that says you are. (Did you have enough preparation?) Probably not. (What else would you have needed?) When we had our electives that was supposed to be preparation but that was really just preparation in one area. That wasn't really preparation as a staff nurse fullstop.

Jane/3/27

Evaluating her professional actions

Jane found it difficult to evaluate her own performance in the ward. She attempted to get realistic feedback from the charge nurse and from her colleagues.

That's what I found really hard. No-one said anything - I've had no feedback at all as to what anyone thinks of me and I've been there four months - I wouldn't have a clue. (Have you asked?) I have asked the charge nurse. Oh you're fine, you're fine, you know. You're coming along and all this sort of thing. That's all I get. She sits me down and asks me if I want to talk about it - but then there's nothing to say. (Did you use self evaluation forms at tech?) Yes. (Would that be useful for you now?) Yes I think you need to do that and then have them do the evaluation like the tutors used to do it to you. (When you were at tech did you like doing those things?) Oh they were a bit of a fag but then when you are away you realise all the things that you did that you thought were slack - you realise now why you had to do them. The only feedback I've had as to how people think I'm coping - how I'm getting along - is from fellow staff nurses and enrolled nurses. (What sort of things do they say?) Well, lately I've had real positive things because I think - for a while I went through a stage of being real down in the dumps and I think everyone knew it - I got a lot of positive things said to me and I felt quite good about it especially coming from other staff nurses that I worked with. (What sort of things made you feel unhappy?) I just felt a bit hopeless. I think it was because I didn't know how I was going and one day I would think - oh I'm doing fine and the next day I would hate the place. Hate work and that. (Can you remember what made you hate it?) Not really - it wasn't as though anything went wrong or anything - it was just how I felt for the day. Then I try constructively to sit down and think about anything that I do wrong - things that I don't do properly and there's nothing specific.

(Just a general feeling that you're not quite on top of it?) I think I"m getting better - I'm sure I am because I don't have as many days where I come home hating work. As I used to.

Jane/2/11

Adjusting to professional constraints.

Jane had some initial difficulty in her orientation to the ward and in understanding her relationship with the charge nurse -

The charge nurse doesn't have any problems in delegating or anything like that. She's quite reluctant to reprimand - I mean not that anyone needs reprimanding but she's quite - not soft - soft isn't the word, but she's a very kind person, she always likes to tell people how to do things and that they're doing things wrong in a very nice way. (That ties in with your experience with evaluation that she says everything is fine.) Yes, that probably is too. She sees me work every day - she must be able to see my good points and bad points by now and I would prefer it if she was a bit more specific. And also I think it's quite hard because when I first started she had three weeks holiday and I never met her until three weeks after I had been there and the girl that was taking charge - you know she's a good nurse but it was all quite stressful for her doing charge for three weeks and so she didn't really have much time for me and so my first three weeks were just a bit of a bumble. Then by the time the charge came along I suppose she expected for me to be nicely orientated and fitted in and I hadn't been as much as shown around the ward - I just found my own way araound. (We talked about your orientation time last time.) But the orientation I got from other staff - even when I was in there - about where

to get things, where do you send for things, all those sorts of little things that are a big bugbear. I didn't really have anything of that but then when the charge nurse came back she sort of went through every item and where you get it and what you do if you haven't got this in the middle of the night and that sort of thing which was a help.

Jane/2/12

Jane would have liked more responsibility - particularly with the Doctors' rounds -

But we don't even do doctors' rounds really, the charge nurse always does those. But I often tag along on the end - I like to hear what's going on but sometimes things get missed. (So the charge nurse really controls the knowledge about people and about treatments and so on?) Yes. (Would you be able to do the doctor's round on your own?) Oh yes, she's really keen to let you. But she likes to tag along too - because she's going to miss out on something - fair enough too.

Jane/2/20

Jane had worked a number of morning duties with one particular staff nurse with whom she had difficulty. Working with this person seemed to decrease Jane's confidence and she reported that she was very concerned about her relationship with the staff nurse and the effect on her own nursing practice. Jane was aware of the effect this staff nurse had on other members of the ward staff, but felt unable to approach her.

And she's nasty to the students that come on - it really makes me wild. (What sort of things does she say?) Just sort of - when they ask her things she snaps at them as though - how stupid you didn't know this. (Is she aware that she does that?) I don't know.

She does it to some other junior ones too not just the polytech ones. (Would you feel able to point that out to her? Say are you aware of the effect that you have?) She'd jump down my throat. I feel really sorry for them because I know how I felt and it's not just our course - it's any junior ones that come in - because we have got a lot of junior enrolled ones at the moment and you try and be as nice as possible to them because what are they going to think of you and how are they going to think that nursing is nice if everyone bites their heads off - everytime they ask a question. And here's our charge nurse and our staff nurse meeting and saying how we have to help the students as much as we can. (You said that if you said something like that to her she'd bite your head off. Are you a little bit afraid of her?) Not really afraid of her - I'm just afraid of the scene. Because if she argued back I'd be scared of what I'd say back to her - I'm probably scared of what I'm going to say. Because I get quite angry the way she goes on. But everyone does, it's only once in a while that anyone will ever say anything.

Jane/2/19

Jane found the staffing situation in the hospital added to the responsibility and heavy workload but she was unable to get additional staff.

I don't find a morning shift so bad but in the afternoons when you are the only one on and you are really busy and you have only got a few students and you can't pile them up totally with patients so that you have none and you can get on with your work. You have to take a fair load too. That's when it's hard. (What's the hardest thing about it?) When you are on the

drug round - on our ward there is a lot of drugs and you have I.V. additives and everything well you just don't seem to get to see your patients as much as you should. (So you are pretty busy doing all the jobs that have to be done?) I have rung up for staff at night before when it's been, you know three admissions all at once, and you have got you and three juniors on. (Did you get staff?) I did once. But usually it's, you know, the whole hospital is busy.

Jane/1/3

Jane began to phone for extra staff more frequently -

(Do you ever see anyone from the duty office?) No but I ring them frequently and they take their phone off the hook at 7 in the morning - I'm sure they do. (Do they?) Everybody knows that. (What sort of response do you get when you ring?) They are not really concerned but sometimes they are. Perhaps if you have got four or five on and you know you are going to be busy so you just ask for someone extra - at one stage we had about six really heavy straight patients in a mixed ward - so hectic - and we used to ask for extra staff - sometimes we got it and sometimes we didn't. But you know it didn't even really matter what level they were - it was an extra hand. An extra pair of hands. But usually they'll say if they can't give you anyone - they'll say the rest of the hospital is very busy today. That's the usual answer.

Jane/2/15

(Has there been any time when you would have liked to have rung the supervisor and said - look I'm frantically busy, will you come and help?) A couple of times I have - and we've got staff just

for an hour or two hours or something, just to relieve us over a period but usually it's the other way around - they take staff off you. There were a couple of nights - like there's only usually one staff nurse on in the afternoon and we had this - we had lots of people in - a few with pneumonia and we had this man that was on 6 I.V. antibiotics and they just came one after the other and they just drove all of us crazy. So that was when you really needed an extra staff nurse on for that because it was just impossible. (What did you do about that?) At the time? (Yes. Did you ask for extra staff?) No, we just coped.

Jane/2/14

Jane thought that the ward needed at least two more staff nurses. She was concerned about the enrolled students' workload and their "inadequate" educational preparation.

(How many staff do you think would be a reasonable number for your ward? How many more staff nurses would you like?) Staff nurses - I reckon you need a couple more so that you always have two on an afternoon and always have two on in a morning. We always only ever have one on at the weekends - one staff nurse - that seems to be when you get your admissions. Because if they are not your admissions they're Ward ( ) or ( ) because they are full. While you are involved with those things - you need someone else to keep an eye on everyone else because there's a lot of junior staff on - ones that have only just come out of prelims and that. (You mean enrolled?) Yes, enrolled and they need an eye kept on them really. It's not fair on them if they're not going to be learning

anything. I sort of think that the students miss out a bit because of the way we are - because you are scraping for time to get everything done for your patients and you are running out of time to teach them things. (How do they cope - the enrolled students?) Amazingly. They're ones that have been in prelims mainly. They're not very enthusiastic. Funny that. I don't know whether it's our ward but they don't seem very enthusiastic.

Jane/1/6

Jane explained her responsibilities in relation to the doctor and his orders for treatment.

(So if the Doctor wanted to alter any treatment he would write that down?) Yes, if they're good they'll come and tell you and if they're not you'll just have to discover it for yourself which makes me very angry sometimes. (Can you give me an example of when that happened? That he came in and saw a patient, wrote new orders and no-one found out about it). Just like if you have got someone on a different pill and you come to give it at half past 9 or whatever and there's nothing in the ward and that time you've got to go running for it and if he had told you at 3 o'clock you could have just rung up and got it. That sort of thing. If sometimes they change their I.V. time and that sort of thing. (Can you do anything about that? Are you able to say to him - look last night this happened, would you mind making sure you tell me next time. Would you be able to say that?) Some of them would. (What would stop you?) Probably, a couple of particular ones would turn araound and say - tough or something. What you do, you do yourself - you just keep you eyes peeled if they

come in the ward and see what they are up to. See what they were writing in the little book. (So you really regard it as your responsibility to find out what is going on?) It is to a certain degree I think. (What about their responsibility?) If they are making major changes they have a responsibility to tell you - they can't just write it in a wee book, put it away and hope you're going to find it.

Jane/2/21

Developing professional autonomy

Jane had several days in charge of the ward after she had been there about two months. She enjoyed the additional responsibility and the feeling of being "in control".

(What sort of things did you have to do as charge nurse?) The ward wasn't in chaos so ... To start with it's just getting everyone organised really and I spent quite a lot of time helping the junior girls because they're still pretty unconfident and this other particular lady doesn't seem to have much time for teaching them and I rather enjoy it so I assigned myself to that job. On a Friday we always have a ward meeting. (And you take part in that?) Yes. (Who runs that meeting?) The registrar. And he goes through each person to see what's happening on the nursing side, on their side and the O.T. side. (That must be very good.) Yes it is. It's a good idea. It's a pity they don't all do it. (Is that a learning time for you?) It is, yes, it's good. It lets you see where everyone is going. Because you have patients in the ward that you see there and you wonder when are they going home or what's happening and that sort of thing.

Jane/2/20

On another occasion Jane enjoyed organising the ward.

> *Well I had a good day today because I was doing nearly all the organising. Although I got into a real tizz in the afternoon - everything got done. (Was the charge nurse off?) No, but she's been on holiday for two weeks - she doesn't know too much of what has been happening. The last two weeks we have had a relieving charge nurse who was a totally different sort of person from the person we are used to, very loud coarse woman - and not quite the personality the charge nurse - the whole ward seemed different, not better or worse, but just her way of doing things was different. You were obviously aware just in two weeks that it was someone different. (So you enjoyed your day because you were more in control?) Yes, I felt that I was doing a bit more than - like often when I come home and I wonder what I've done all day and don't really sort of think, well what's the difference today from being a student. Not much. But I guess there is a lot of difference. Being sent away to other wards made me realise how well I know my ward.*
>
> Jane/3/24

Jane was often sent to relieve other staffing shortages in different wards. She did not enjoy these experiences but they were a boost to her confidence when she returned to her ward.

> *Last night - I got sent to a ward which was utter chaos. (Busy?) Oh yes - you're just a body really. Well that is all I was last night. I didn't really know much of what was happening. I just had to do these thousands of dressings and go home again. I didn't really feel very like I was doing much. (You didn't get a chance to get to know the patients or anything?) No,*

I was on 11 to 8 yesterday and I worked to 2.30 in our ward and then I was just there from 2.30 till 8 in the other ward. All I just seemed to do was as many dressings before tea as I could and that was it. I was like a wee robot. (It sounds as though you didn't enjoy being sent away very much.) I don't really. I don't like the way people expect you to know things. (You think that's unreasonable?) I think it is. When it came to going there I didn't - I just had a quick report and there's no extra for me and you know have a look round the ward and get into it. Just a verbal explanation of all the techniques - I mean you're not taught that sort of thing - even in training or their little ways. (Did you know much more when you left?) Oh yes I'll be a bit better next time I go to work there. I'll know how to do things.

Jane/3/25

Jane found that her nursing practice changed when the ward was "quiet". She was able to practice as she thought she should -

(You remember last time we talked about the task orientation of the ward and that sometimes you got to talk with patients and sometimes you didn't - has that been any different?) It's been quite good actually. Only because we haven't been very busy. We've actually had some empty beds in our ward. Six at the weekend there was. We do the little things that don't get done when you're busy. Catch up on all those little things - update our nursing care plans - they usually get done anyway. Whether we are busy or not.

Jane/3/26

Although Jane discussed the staff shortages and explained the difficulties she and other staff nurses had in providing

adequate nursing care, she thought that it may have been her lack of organisational skill which contributed to her workload. She and her colleagues had tried to get some recognition for these difficulties through requesting additional staff and through requesting overtime.

> *(Do you think your workload is realistic?)* At times it is. At times it isn't. It probably is 50/50. At times it is just ridiculous. Things don't get done which probably should get done. *(What do you think will happen if a whole lot of people ask for overtime?)* Probably nothing. Stamp it out and not let you have it - they do now anyway. *(Have you actually requested overtime before?)* No everyone says you don't get it. If you don't get off till 12 it's your fault. *(Have you been able to talk with anyone like the charge nurse or anyone like that, about working late? Does the charge nurse know that you get off late?)* Yes, she knows but I think she probably thinks it's because we are disorganised too. But then they don't know what it's like on that shift. *(Or have they forgotten?)* Yes. *(I remember as a student getting off after midnight.)* Oh yes we frequently do - if there's nothing else to do but write up my patients I always kick the students off home. Because I don't think it's fair that they have to stick around.
>
> Jane/1/5

INTERPRETIVE PROFILE : JANE

Jane entered nursing education with the necessary knowledge and understanding of the education system from her school experience to make this a smooth transition. Jane appeared to be a conformist in a structured learning situation (pp 250-251)

At the time of this study, Jane reported that she was fitting well into the hospital routine and practices and, although she was irritated by some aspects such as the duty roster (p251) she generally accepted as common sense the practices and procedures she saw around her.

Jane's comments throughout these interviews indicate that she was very conscious of the status of people within the hierarchy of the hospital, and the relative power that went with these positions. She regarded herself as being "pretty powerless" (p251) as a staff nurse but being able to "teach and help hospital students ... was a step in the right direction". Jane reported that she enjoyed organising the ward and her colleagues when she was deputising for the charge nurse (pp267-268) but seemed unaware of her subservient relationship with her medical colleagues.

For example, Jane readily accepted the responsibility for ensuring that the doctors' orders were found and carried out:

> *if they're good they'll come and tell you and if they're not you'll just have to discover it for yourself ...*
>
> (Jane, p266)

Although this situation "made me angry sometimes" Jane accepted that this practice could not be changed - it was part of her job ...

> *What you do, you do yourself - you just keep your eyes peeled if they come into the ward and see what they are up to.*
>
> (Jane, pp266-267)

Jane's comments about her education (pp247-251) indicate that she was often rewarded for conforming to the expectations of tutors and that she expected that conformity as a staff nurse would bring its own rewards of status and power.

The ethical dilemma Jane discussed (p252) demonstrates her lack of knowledge about ethical decision making and its applicability in this situation, as well as her lack of personal and professional autonomy. As a result, the possibilities for action or change did not occur to her in this situation, as it did not occur to her in everyday practice situations.

APPENDICES

TABLE 23 REGISTERED NURSES AGED 20-24 BY FUNCTIONAL AREA OF EMPLOYMENT

Functional Area of Employment	Comprehensive		All RNS	
	N	%	N	%
Hospitals				
Med./Surg./Orth./Paed.	460	67.6	1501	51.7
Maternity/Obstetric	19	2.8	73	2.5
Intensive Care	35	5.1	247	8.5
Operating Theatre	16	2.4	112	3.9
Geriatric (non psych)	19	2.8	114	3.9
Psychopaedic	14	2.1	86	3.0
Psychiatric	40	5.9	155	5.3
Departments/Clinics	6	0.9	54	1.9
Sub-Total	609	89.6	2342	80.7
Administration				
Hospital	-	0.0	1	..
Non-hospital	1	0.1	2	0.1
Sub-Total	1	0.1	3	0.1
Teaching				
Tech. Inst./University	-	0.0	1	..
Hospital	1	0.1	1	..
Sub-Total	1	0.1	2	0.1
Community Health				
Domiciliary	3	0.4	25	0.9
Occupational Health	1	0.1	3	0.1
Plunket	1	0.1	8	0.3
Public Health	8	1.2	14	0.5
Practice Nursing	5	0.7	75	2.6
Sub-Total	18	2.6	125	4.3
Other Nursing Employment				
Agency	6	0.9	58	2.0
Armed Forces	-	0.0	-	0.0
Other Nursing (non-hosp)	-	0.0	29	1.0
Sub-Total	6	0.9	87	3.0
Not in Nursing Employment				
Health related non-nursing	5	0.7	18	0.6
Tech./Laboratory	2	0.3	8	0.3
Full-Time Study	5	0.7	19	0.7
Non-health related	6	0.9	67	2.3
Not in paid employment	27	4.0	231	8.0
Sub-Total	45	6.6	343	11.8
TOTAL	680	100.0	2902	100.0

Source: The Nursing Workforce in New Zealand 1983. Wellington, Division of Nursing,

MASSEY UNIVERSITY
Department of Sociology

Memorandum to: Ms Judith Perry
[redacted]

Copies to : Dr John Codd (Education)
Mr A.R.P. Eustace

From : Professor G.S. Fraser
Chairman, Sub Committee on Ethics in Research Involving Humans

Re : M.A. Thesis: "Professional Socialization and Nursing Education"

Thank you for meeting with the sub-committee, 30 April 1984, to discuss ethical aspects of your proposed research.

The sub-committee is satisfied that there are no adverse ethical implications associated with the proposed research. In reaching this conclusion the sub-committee noted the following points:

i. It was impressed by the care and thought which you and your supervisor, Dr J. Codd, had put into the preparation of the research protocol. Such attention to important aspects of research design augers well for the success of the proposed research.

ii. The methods you intend using for gaining the voluntary participation of respondents (i.e. informed consent) are sound; as are the procedures for ensuring the strict confidentiality of all materials relating to individual respondents. The formalization of these matters in a contract with respondents is prudent.

iii. Hospital staff who will be associated with your research will be briefed by you on the nature of the project and of your relations to respondents during the field work.

iv. The 'reflexive' component of the research is a sensitive matter. However, the sub-committee was satisfied with the procedures you have adopted for working with each respondent, especially the step of allowing each respondent to review and confirm all field work material which relates to them.

The sub-committee appreciated your full cooperation and looks forward to being kept informed of progress with your research.

G.S. Fraser

Appendix 3.

Thank you for agreeing to assist with this research which is an attempt to identify those factors which enhance or detract from your ability to use the knowledge and skills you gained from your comprehensive nursing education.

Confidentiality

As a participant in this research you will remain anonymous and all case study material will be confidential. Any written documentation will be such that individuals, clinical areas, and events will not be identifiable.

You will be fully informed of the nature and consequences of this type of research and will be free to discontinue participation at any time. Your right to privacy will be respected so that you will be able to divulge as much or as little information as you yourself decide.

As this kind of research has the potential to change your normal practice, sufficient time will be provided for informal discussion. You will be free to withdraw from the study at any stage.

As part of this research you will be given written documentation of all case study material pertaining to you and all material will be available at the conclusion of this study.

Results

This research is part of an M.A. (Education) thesis which will be finished in mid 1985.

It is anticipated that the conclusions drawn from these case studies may be used to inform future curricula decisions in Nursing Education and that some parts of the material may be included in future papers or journal articles.

Date _____ Date _____

Signed _____ Signed _____

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