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.