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TEACHING AND LEARNING IN NURSING EDUCATION :
A CRITICAL APPROACH

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RGON MA

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ABSTRACT

This thesis investigates tutors' and students' experiences of teaching and learning nursing during the final year of one three year comprehensive (polytechnic) nursing course. The use of critical social science exposes for critique the ways in which sociopolitical forces constrain individual and professional action. The critical reflexive analysis of the perceptions of nine tutors and thirty eight students illustrate the ways in which dominant ideologies embedded in the social practices of nursing education and health care shape the consciousness of tutors and students towards conformity, compliance and passivity.

Although previous studies provide useful descriptions of socialisation and educational processes, they overlook the importance of the reflexivity of understanding and action, and of the structural constraints in nursing education and practice. By focussing on either individual agency and deficiencies, or on bureaucratic conditions of education and practice, previous studies directed attention away from generating the political knowledge which may have assisted nurses to overcome some of the contradictory and constraining conditions of their practice.

It is the political processes of teaching and learning and their practical effects which are revealed for critique and transformation using a critical reflexive methodology. It is claimed that this methodology motivates research participants themselves to become aware that their preconceptions are shaped by aspects of the prevailing social order such that they are prevented from achieving their nursing ideals and educational goals. Thus, through the processes involved in becoming socially critical, tutors and students would be able to transform those sociopolitical

constraints. Although collective political action is not fully demonstrated in the time frame of this study, it is suggested that engaging in this research has had ongoing liberating effects for the participants.

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PART ONE

THE CONTEXT

CHAPTER ONE

CHAPTER ONE

THE CONTEXT

In this chapter the historical context and educational concerns central to this thesis are introduced and the thesis outline is presented.

HISTORICAL AND EDUCATIONAL ISSUES

In New Zealand over the last several decades discussion, and sometimes heated debate, has taken place amongst nurses, other health professionals, and policy makers about the most appropriate way to train nurses for an environment that has been undergoing rapid and complex changes. Nursing education in New Zealand began with publicly funded hospital schools of nursing which trained nurses to provide the nursing and domestic services primarily for that hospital. Over the years this 'Nightingale' apprenticeship system of nursing training was increasingly criticised as being very narrow, very "medical", task orientated, not educationally sound, potentially dangerous for patients and so on (Burgess, 1984; Kinross, 1984).

With both the dissatisfaction and the attrition rate of these programs increasing in the 1960's, nurses began to lobby for changes in nursing education. Preparing nurses at the tertiary level in which they had full student status was deemed to have educational advantages not possible in the traditional apprenticeship system. However many nurses (and others) remained convinced that students could only learn to be competent nurses by "doing" - by undergoing the traditional hospital based nursing training and providing most of the nursing service within the hospital.

As a result of these discussions and debates the Government, in 1971, appointed a World Health Organisation nurse consultant, Dr. Helen Carpenter, to investigate and make recommendations about the most appropriate system of nursing education in this country. Recommendations from a local committee (Nursing Education in New Zealand, 1972) endorsed Dr. Carpenter's recommendations and suggested overall responsibility and funding for nursing education be transferred from the Department of Health (hospital schools) to the Department of Education (polytechnic schools). Furthermore, graduates from the polytechnic schools would be eligible to register as *comprehensive* nurses (medical, surgical, psychiatric, psychopaedic and obstetric) rather than register separately as general and obstetric nurses, or psychiatric nurses, or psychopaedic nurses as was the case from the hospital schools of nursing.

This was accepted by the Government and it was decided to phase in three year polytechnic comprehensive nursing courses leading to registration as a comprehensive nurse. Concurrently it was decided to decrease the number of hospital based programs, and to introduce post registration undergraduate nursing studies at two universities. In 1973 two pilot polytechnic comprehensive courses began in Christchurch and Wellington and by 1975 a further two commenced in Nelson and Auckland. By 1988 there were 3,878 students enrolled in comprehensive nursing courses in fifteen polytechnics throughout the country producing approximately 1200 registered nurses each year (Department of Health, 1989). (New Zealand has a population of about three million people and a national nursing workforce of approximately 30,000 registered nurses). The last hospital based school of nursing closed in 1988.

The overall aims of the transfer of nursing education were to meet the perceived educational needs of nurses who would work in a rapidly changing social, cultural

and political environment of health care and to meet the increasingly sophisticated health and illness needs of the patient, community and society. Theoretical teaching and clinical practice in a variety of settings would be coordinated to provide students with an educational background appropriate for a health service oriented towards "the prevention of illness and the promotion of health" (Carpenter, 1971:16). The emphasis on clinical experience within a hospital would change from a task orientation to patient centered care suitable for the student at a particular level of her experience, and supervised by a tutor.

This movement from service-based training within hospital schools of nursing, to departments of nursing studies within polytechnics, 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 the socio-historical dominance of other disciplines, such as medicine, over nursing as a profession, and over nursing education and practice would be decreased (Hyman, 1985). The focus of nursing could then be directed towards people and the maintenance of health rather than towards the traditional medical emphasis on hospitals, illness and curative practice. 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, and from a clear nursing orientation (Kinross, 1984).

From 1973, when nursing education began the move to tertiary educational institutions, the intention was that nursing curricula would integrate areas of knowledge, with the central relational concept being holistic health care. Nurse educators thought that this would enable students to learn to provide health care from a *nursing* perspective, thus developing the appropriate professional nursing knowledge, experience, attitudes and values (Bevis, 1973).

Evaluation of the outcomes however, demonstrates that such integration has occurred mainly at a superficial level and that there was much confusion about the meaning of integration in the curriculum (Holdsworth, 1969; Ketefian, 1974, Wu, 1979; Burgess, 1984). As well as some subject integration comprehensive courses have tended towards greater tutor-student participation, but have both explicit examination procedures and implicit evaluation criteria. The student must meet examination criteria set by the polytechnic and criteria set by an external examining body, the Nursing Council of New Zealand, for entry into practice, as well as exhibiting "professional behaviour" throughout the education period. There is no formal mechanism for the validation of polytechnic courses by an external authority.

Apart from the financial cost of such a major change in nursing education, the traditionalism and conservative attitudes amongst nurses and their professional colleagues ensured an uneasy beginning for the new courses. As Burgess (1984) points out:

In clinical situations resistance to change showed up in individual staff members, doctors and nurses, some of whom were anything from uncooperative to hostile towards (polytechnic) students, their students and the new courses. During the early years both students and tutors...weathered some painful experiences at the hands of their professional colleagues.

Burgess, 1984:68

One government initiated evaluative study of the comprehensive courses has been undertaken under the auspices of the Department of Education to fulfill the recommendation in the Carpenter report that there be an ongoing evaluation of the new courses. After a survey and interviews with students and new graduates from 1973 to 1978 from two of the four polytechnics offering comprehensive nursing courses, the final report was presented in 1981 (Taylor, Small, White, Hall, Fenwick, 1981).

The assumptions about tertiary education were centered on the expansion of knowledge for nursing practice so the content of polytechnic courses included natural, biological and social sciences as well as increased nursing knowledge. It was assumed that changes in nursing education would produce changes in nursing practice. However, while Taylor *et al.* (1981) highlighted positive aspects of the new courses - educational aims were met and graduates were able to work effectively in the health care system - it was noted that nursing practice in hospitals was far removed from the kind of nursing that these graduates had been taught.

The comprehensive courses emphasised caring for individual patients as "whole" people with biopsychosocial needs while hospital based nursing practice was task orientated and fragmented the delivery of nursing care to individuals. The comprehensive courses were seen as "the thin end of an innovative wedge in nursing practice in hospitals" (Taylor *et al.*, 1981:178).

Over the last sixteen years it has become increasingly obvious that changes in nursing education were introduced without considering corresponding changes in nursing practice or in the organisation of that practice. The socialisation processes and the organisational structures and constraints which underpin nursing thought

and action in education and practice were not taken into account. Nor were the effects on the autonomy of nurse educators or the educational needs of nursing students, of the rather conservative traditional modes of tertiary education in the polytechnics. For example organisational conditions such as specified class contact hours, marking class rolls and tutor-student ratios, and hierarchical systems constrained the educational and practice choices that tutors could make.

Nursing is now taught in the setting of two highly structured institutions - health and education. Teaching, learning and clinical practice 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).

A major problem for nursing education in this context is that the knowledge and skills required for clinical practice cannot be specified in accordance with some institutional requirements. 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 that 1500 hours be designated to each of theory and practice), ensure that distinct boundaries are maintained between tutors and students and between subject areas. This ensures that institutional structures control what is overtly transmitted to students, and create and maintain hierarchical relationships between tutors and students (Bernstein, 1975, Department of Health, 1986a).

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

polytechnics offering a comprehensive nursing course designs and develops its own curriculum but the Council sets guidelines for curricula, approves curricula and sets the national State examination for registration (tutors and students often refer to participating in the State examination as "sitting states").

Nursing education in New Zealand now takes place across a number of different sites including the polytechnic, the base hospital and associated agencies, and the local community. The tutors referred to in this study are registered nurses who have undergone twelve weeks tutor training and have completed some university courses, post registration. They teach students in both the polytechnic and in clinical nursing settings. Each tutor is usually associated with the polytechnic and one other site, whereas students experience their education across all sites.

FORMAL NURSING CURRICULA

Polytechnic schools of nursing appear to adhere to a broad definition of curriculum. Curriculum, in its broadest sense, is often taken as a neutral term embodying the content of an educational enterprise. Therefore, it 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 focuses attention on the overt content and the manifest context of learning.

All fifteen polytechnics offering comprehensive nursing courses in New Zealand are instructed to use an objectives or systems model of curriculum (Nursing Council of New Zealand, 1977) which exemplifies this view. Indeed in the "Standards for the Registration of Nurses from Technical Institutes: Assessment Guide" (Nursing

Council of New Zealand, 1986) criteria for evaluation of curricula closely follow this technical-rational model. Thus, in developing polytechnic nursing curricula, tutors are obliged to perceive the curriculum as having prespecified objectives and criteria (in terms of student behaviour) that can be measured through empirical investigation to show whether or not these have been attained (Tyler, 1949).

Nursing curricula in New Zealand are, therefore, based on a model where concern for input, process and outcome are expressed in terms of objectives, content and evaluation. This technical-rational approach to curriculum design (based on the Tyler (1949) model) provides a framework for action based on the philosophical beliefs and values set out in the first stage of its development. Tutors see the curriculum as offering solutions to problems through the processes of defining the philosophy, determining objectives, content, and evaluation procedures. Such solutions can then be judged as 'right' or 'appropriate' in terms of the stated philosophy and objectives. The curriculum can then be improved so that its stated objectives can be achieved (Codd, 1984).

Among the basic premises of the objectives model are a set of principles and technical-rational recommendations which seem appropriate for the practical task of achieving certain stated objectives. 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 until ends have been identified. However, the separation of means from ends prevents any critical examination of the justification for objectives (Wise, 1976). Once the latter have been decided, there is little inclination to question their basis. Effort is directed towards the means of achieving them.

As Pitts (1985:38) points out "the obscurity of meaning is evident when the professional student is educated in a technological structure that imposes predetermined objectives onto the learning process". Whatever the aim of the process might be the actual experience for the student is often one of control and coercion that is internalised and eventually reproduced in the professional relationships of graduate practice (Perry, 1985¹).

An 'objectives' model, Stenhouse (1975) argues, is spiral in nature since the intended learning outcome, or behavioural objective, becomes the basis on which the curriculum is designed. Student attainment is measured by how well objectives have been achieved leaving the appropriateness of the objectives unexamined. 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. The 'common sense' practices of selection of students and teaching and evaluation procedures based on these assumptions also act to maintain existing nursing culture.

For example, the only formal requirement for entry into a school of nursing is a recognised educational qualification (such as Sixth Form Certificate) yet it is also well known that nursing is a 'caring' profession - a humanistic discipline where qualities additional to academic achievement are essential. This formal entry qualification may deny Maori and Polynesian students, for example, access to nursing education when they may well have highly developed 'caring' attributes. Most polytechnics have 'affirmative action' policies or informal means by which such students can enter the course on a quota system. Such entry criteria may be

¹ now Clare, J. i.e. The author.

matters of subjective judgement by those selecting students and to date there is little support for these students during the course. Teaching methods and assessment procedures are generally monocultural.

Teaching and evaluation procedures within an objectives curriculum 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 relationships (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 knowledge development 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 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 (Apple, 1986:49). 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 is unquestioned, and the hierarchical relationship between teaching and learning is considered unproblematic.

Freire (1973:46) refers to this hierarchical relationship between teacher and taught as "anti-dialogue" and suggests **anti**-dialogic teaching is a relationship of authority

which implies "manipulation" on the part of the teacher. Thus, this kind of relationship prevents individual autonomy and responsibility for learning by 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". Evaluation of learning in the form of examinations and tests constitute withdrawal from the account.

It is not surprising that the development of nursing curricula has followed the model of traditional curriculum theorists. As Apple (1979) points out, the fundamental concern of those in curriculum development was that of social control - mainly for ideological reasons. The curriculum was seen not only as a means for maintaining an organised society but also as a means of preserving the characteristic lifestyles of dominant and subordinate groups. From this perspective schools may be seen as mechanisms used to teach a normative consensus and as institutions where individual experience could be based on economic functionalism and efficiency in social selection and control. Nursing education, like other kinds of formal education, may be used to inculcate in students the rules, norms, values and knowledge 'necessary' to maintain and perpetuate an existing social order - a system of health care.

GRADUATE EMPLOYMENT

Students who satisfactorily complete a three year comprehensive nursing course at any one of the fifteen technical institutes or polytechnics 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 area health boards throughout the country. The remainder are employed by the Health Department as public health nurses, and by other agencies. Of those employed by area health 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 (Department of Health, 1988). The hospital, then, is the professional setting in which most comprehensive nurses from polytechnic courses begin their professional practice. It is the clinical setting which most students perceive as being where "real" nursing takes place, and it is therefore the setting in which most students aspire to work when they graduate (Perry, 1987, 1988, 1989; Walton, 1989).

Thus the point of transition from comprehensive nursing education to hospital based nursing practice provides the context for the central research problems of this present study.

PROFESSIONAL SOCIALISATION

My previous research (Perry, 1985; 1987-9) and other studies utilising a critical social theory approach, indicate that there may be unacknowledged aspects of comprehensive nursing education which shape students' and beginning graduates' perceptions of themselves. Nursing students (and, later, graduates) may develop personal and professional dependency, a professional identity which allows 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.

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 to which she is exposed. These experiences could be expected to play a part in deciding which beliefs, attitudes and values become critical in forming the nurse's professional self. 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 (Perry, 1985).

It has always been accepted by nurses that professional socialization is an integral part of the declared aims of the formal curriculum for nursing education and practice. The emphasis on 'professional behaviour' in polytechnic courses; the Nursing Council requirement that the student be attested "fit and proper" for registration; and the strong expectation that students and new graduates conform with existing practices and beliefs of the nursing team within the clinical agency, are all manifestations of a concern by the nursing profession that nurses develop a strong commitment to traditional professional ideals. During this process of enculturation, then, 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 as they are expressed in nursing education.

These attitudes and values are reflected in curriculum aims but they may be contradicted by institutional experience in both the educational and practical contexts. Thus, nurses may encounter discrepancies between the formal overt messages and the informal 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 education 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, may begin her practice within the constraints of medical and technological ideologies and institutional regimen which may not recognize 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 (Perry, 1985; Pitt, 1985; Forbes, 1990)

There are already structured power relationships established within the hospital and the polytechnic and students and graduate nurses may be expected to quickly find their place within them. As Giroux (1983:63) suggests, while "(school) cultures may take complex and heterogeneous forms, the principle that remains constant is that

they are situated within a network of power relations from which they cannot escape".

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. As Allen (1985) points out, classroom and clinical practices actively encourage future nurses to adopt values and behaviours that minimize their ability to engage in critical reflection - a necessary pre-requisite for autonomy.

Increasingly, in New Zealand's current economic and political climate, both educational and health institutions have hierarchical structures and organisational practices which reflect a demand for cost-effectiveness and quantifiable goals (Wilkes and Shirley, 1984; Lauder, 1987; Malcolm, 1988; Davis, 1988). 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 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 produce self doubt and insecurity at the psychological level.

The contradictions between what is believed and what is experienced by students could arise from discrepancies 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 or covert 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; Bourdieu, 1977; Giroux, 1983). The appropriate response to this is not to focus on the formal content of nursing curricula as Horsborough (1987:263-4) suggests, or on individual learning styles as Bevis and Clayton (1987) suggest, or even on problem based learning which Higgins (1989) advocates. Rather, the covert message systems which are intimately involved in educational transmission and which constitute the hidden curriculum should be examined. Thus ideological tensions between theory and practice, teaching and learning may be made explicit.

THESIS OUTLINE

This thesis is presented in three parts. Part One (chapter one) has introduced the historical context and educational concerns central to the study. Part Two (chapters two, three and four) explores the theoretical and practical implications of previous studies in the field and sets out theoretical and methodological issues relevant to this study. Part Three (chapters five, six, seven and eight) provides an account and theoretical interpretation of the research, including its limitations and implications.

This study is a critical ethnography which utilises the central tenets of critical social science as they are applied to teaching and learning in nursing education. The critique of the critical theoretical framework which develops as the thesis unfolds demonstrates an increasing reflexivity and understanding of the complex practical and theoretical processes involved in engaging in research with an emancipatory agenda.

Thus, this study is an attempt to go beyond the description and explanatory analysis which many previous studies provide. It offers a critical reflexive analysis of the socio-political relationships which influence the actions of tutors and students, and of the consequences of those actions, within the context of comprehensive nursing education. It is an exploration of the ways in which the instrumental rationality of institutions shape the consciousness of tutors and students in comprehensive nursing courses.

In Part Two, the next chapter will show that research already carried out in New Zealand and elsewhere, has obscured the socio-political contexts of nursing education and practice. By concentrating mainly on the process of socialisation of students in hospital schools of nursing, or graduates in a hospital, from functionalist or interpretive perspectives, the experiences of nurses were placed in a given role structure. From this perspective individuals were defined as reacting to a pre-determined set of role relationships within the already established social structure of the school or hospital. Neither these role relationships, nor the tutors and student's relationship to the established power structure in the institution are seen as problematic. Reliance upon questionnaires and surveys has tended to objectify the day-to-day actions (and consequences of those actions) that tutors, students and beginning graduates take.

On these counts, then, these previous studies are limited by not providing a comprehensive view of the experiences of teaching and learning nursing. Theoretical perspectives which are grounded in data closely tied to the lived experience of students and tutors are not provided. While providing useful descriptions of socialisation and educational processes, past research has overlooked

the reflexivity of understanding and action as well as the structural constraints of day-to-day nursing education and practice.

Two more recent New Zealand studies (Perry, 1985; Hickson, 1988) and an Australian study (Street, 1989) have attempted to take account of the socio-political context of nursing education and practice. These studies examine the socially generated constraints on personal and professional action in the polytechnic or the hospital settings. Hickson (1989), for example, found that "practice expressing the participants' professional nursing knowledge and values was often denied in the face of shared understandings reflective of the institutional ideology".

These and other previous studies are discussed in the next chapter in relation to the underlying assumptions about the generation of what is deemed to be legitimate knowledge within different research approaches. The work of selected education theorists is used to provide a basis for discussion of the educational implications of this study as outlined in later chapters.

Chapter three provides a general outline of the theoretical stance taken in this study - critical social theory - and constructs such as culture, hegemony and ideology-critique are discussed and explicated. The application of critical theory approaches for the study of the educational experiences of tutors and students is explored. It is argued that exploring the experiences of teaching and learning nursing in the polytechnic and hospital setting requires a form of ideology-critique. This entails an examination of the actions that students and tutors take, and the subsequent consequences of those actions, as well as the social relationships they encounter and develop during their education and practice. The methods and procedures used in this research are discussed in Chapter four.

Part Three contains a theoretically informed and critical analysis of the power relationships embedded within the context of nursing education. Chapters five and six provide an account of the critical reflexive analysis of teaching and learning experiences, generated through interviews, journals and field notes from myself, tutors and students over an eight month period. In this way, tutors and students can be seen to experience, in part at least, a political process in which they come to terms with the organisational, ideological and hegemonic constraints which shape nursing education and practice. This account is a synopsis, guided by the interpretive framework outlined in Chapter three, of the data gathered during indepth interviews with tutors and students over an eight month period and from the journals they kept during that time.

In Chapter seven further theoretical interpretations of the account of the research is provided. Both the polytechnic and hospital experiences are viewed as contributing to a process of inducting students into a professional culture. Ways in which social structures shape the consciousness of students and tutors towards ideological consensus are discussed. The students' 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 tutors' perceptions of their work and of their practice as nurses are discussed and interpreted in relation to their prevailing ideological assumptions about nursing education and practice.

The study is revisited in Chapter eight.

PART TWO

—

THEORY AND METHOD

CHAPTERS TWO, THREE AND FOUR

CHAPTER TWO

In this chapter an overview of the theoretical and methodological positions of empirical-analytic and interpretive studies of the professional socialisation of student and graduate 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 nurses and nursing conducted within both empirical-analytic and interpretive epistemologies have been unable to address the issues which are central to this study.

Three more recent studies based in critical social science are discussed highlighting their potential for illuminating the ways in which social structures shape the consciousness of nurses - one of the central concerns of this study.

EMPIRICO-ANALYTIC AND INTERPRETIVE STUDIES

Most previous studies of student and graduate nurses in professional settings have been carried out by sociologists and psychologists seeking to explain the socialisation process that students and graduates must go through to become accepted members of the nursing profession. Some more recent research mainly carried out by nurses has set out to describe and explore nurses' professional actions in clinical practice. There has been little research which critically examines the actual experiences of tutors and students as they encounter the structures and processes of nursing education at a tertiary level.

Research studies of nursing education and practice can be placed in the context of the three main traditions of social science and educational research - analytic empiricism, interpretivism and critical social theory (Husen, 1988). Both epistemological and methodological arguments for and against each of these positions are well documented (Fay, 1975, 1987; Bernstein, 1976; Comstock, 1982; Bowles & Klein, 1983; Allen, Benner & Deikelman, 1986).

The underlying view of social science reflects the period when each of these studies was carried out and the choices available to the researcher for the generation of what would count as legitimate knowledge. Earlier studies, (e.g. King, 1968; Birch, 1975; Chick, 1975; Miller, 1978; Bates, 1979; Bezuidenhout, 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. Here 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 explanatory bases to their analyses are carried out within a causal 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 inducted. In one sense this is essentially a functionalist view where the actions of individuals are governed by functional laws that operate beyond the individual's personal understanding and control.

Empirical Analytic Studies

Empirical-analytic social science, (following the tradition of Durkheim, Parsons and Merton) belongs within the tradition called positivism which, in recent times has taken on pejorative connotations. The central tenet of this tradition is a conceptualisation of social action which can 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. This entails positivist assumptions about the normative basis of interactive behaviour.

Wilson (1971:21) for example, 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. Understanding socialisation from this model allows 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.

A second essential element is that explanations of patterns of action should follow the hypothetico-deductive model thought to be 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 taken to be 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 largely accepted as intellectually and academically respectable in determining criteria for legitimate knowledge.

Challenges to Analytic Empiricism

The epistemological and methodological tenets of empirico-analytical social science have been challenged by many writers, mainly because they do 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).

In *Knowledge and Human Interests* (1971) Jurgen Habermas contends that there are three categories of knowledge which are integral to human existence - technical, practical and emancipatory. These three categories are derived from knowledge - constitutive 'interests' expressed in a distinct methodological approach to the generation of knowledge. Such interests are knowledge - constitutive because they "shape and determine the categories relevant to what we take as knowledge as well

as the procedures for discovering and legitimising knowledge claims" (Bernstein 1976:192).

Habermas (1971) claims that science should be understood not merely as a formal abstract system but as a *product* of concrete social activity in that it presupposes human interaction and language. There are three knowledge-constitutive cognitive 'interests'. 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 incorporated in interpretive science; and the third cognitive interest is an 'emancipatory interest' grounded in the human capacity to act naturally and to reason self consciously and is incorporated in the critical sciences.

As Habermas (1971) emphasises, natural scientific knowledge contains knowledge about reality from the perspective of a particular knowledge-constitutive interest: technical and practical control. Therefore such knowledge cannot be 'value free' since it takes the form it does from the value attached to command 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).

Bourdieu (1981:93) points to the way in which analytic empiricism

"is so detemporalised that it tends to exclude even the idea of what it excludes: because science is possible only in relation to time which is opposed to that of practice, it tends to ignore time and, in doing so, to reify practices".

That is, practical action must be located within its historical antecedents, and its possibilities for the future, to overcome the positivist tendency to freeze action and its attendant socio-political conditions, both historically and contextually. Thus with interpretive methods of research the notion of time passing is reintroduced.

Focal Points of Studies in the Empirico-Analytic Tradition

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

Commonly hospitals, for instance, are seen as bureaucratic organisations (Simpson, 1970; King, 1978; Miller, 1978, Horsburgh, 1987) 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 student and graduate nurses 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.

...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 dissension, 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, implies that socialisation is merely a process of role adaptation:

it is not until they enter as graduate nurses that they are faced with the realities of the discrepancies between the idealised professional role they learned as students and their new role within the bureaucratic structure of health agencies...

(Miller, 1978:2)

Her assumptions seem to be that the graduate *must conform* to a predetermined set of role expectations and 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. While people do indeed act on the basis of shared understandings of appropriate values and beliefs there is no acknowledgement of the ways in which this 'shared' understanding may be shaped by the prevailing institutional ideology to become an integral part of the professional self.

Similarly, Horsburgh (1987) expects to find that students and new graduates experience "reality shock" (Kramer, 1974) as they enter the clinical practice area in a bureaucratic institution. Kramer (1974) builds on Corwin's (1961) notion of professional disillusionment to explain the phenomena of the attrition of nurses during their first year after graduation. The new graduate encounters "reality shock"

when she finds that caring for patients and assessing their needs are given lower priority than the repetitive tasks forced on her by the bureaucratic system.

Three different explanations for this have been offered in the literature. Some researchers and writers have focussed on personality and other psychological variables such as motivational conflicts which prevent students from becoming professional (Bailey & Klaus, 1969; Adams & Klein, 1970, Chick, 1975). Other researchers and writers have explained that sociological variables such as the conflicts between bureaucratic and professional ideologies cause intense personal and professional frustration and drive nurses out of the field (Menzies, 1960; Edwards, 1963; Bates, 1979; Buckenham & McGrath, 1983). Still others argued that the socialisation processes of education were ineffective - the student was not successful in internalising the values and norms of the professional group which were assumed to be compatible with occupational identity (Cohen & Gesner, 1972; Simms, 1977; Horsburgh, 1987).

These explanations ignore the tension between social structures and individual agency but focus attention either on the individual (deficiencies) or on the bureaucratic conditions of education and practice. In this way, these studies have directed attention away from generating knowledge which may have assisted nurses to overcome some of the contradictory conditions of their practice.

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. Although Olesen and Whittaker (1968), Chick (1975) and Horsburgh (1987) used qualitative

methods in an attempt to analyse the perceptions of their subjects, their findings have been interpreted within an explanatory framework which demonstrates the conceptual gap between theory and practice which this approach exemplifies.

For example, the notion of 'role' is used in all 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.

By focussing attention on the individual's adaptation to rule governed institutional cultures these studies have obscured the practical effects that institutional structures and ideology have on individual thought and action. In this way, such explanations have prevented nurses from fully understanding their experiences and the ways in which they might challenge and change those structures which constrain their practice.

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 empirico-analytical studies had tended to consider incapable of rational explanation.

THE INTERPRETIVE TRADITION

Studies of nurses undertaken in the late 1970's and 1980's have reflected the movement in social science and educational research towards the interpretive paradigm. 'Interpretive social science' is a generic term which includes a variety of positions, for example phenomenological, ethnographic, illuminative, and qualitative.

In general, one of the main steps in interpretive social science analysing social phenomena is that of 'rendering intelligible' the subjective basis on which it rests. Thus, the basic assumptions about people, society and socialisation in this paradigm, change the emphasis away from a conforming individual in a rule governed culture, to an individual actively interpreting social action within her own awareness of the social context. 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.

The central aim of interpretive 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. Rather, what the situation means to those involved, and by what frames of reference they make sense of their situation is examined. The kind of knowledge gained from this perspective contributes to the understanding of professional socialisation by providing an understanding of self, of action, and of the particular social setting of that action. Such tacit awareness is, in Wittgensteins' (1953) terms, knowledge of 'how to go on' in the contexts of practical day-to-day life - or "practical consciousness" (Giddens, 1982).

Habermas (1971) argues that interpretive social science offers another 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, undistorted communication within a particular social setting. For example, Buckenham and McGrath (1983) exemplify this position when they present the view that learning is simply a matter of 'reconstructing social perceptions':

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)

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.

Studies of Nurses in the Interpretive Tradition

Some of the interpretive studies (e.g. those reported by Kramer, 1974; Davis, Kramer and Strauss, 1975; Thomson, Kinross, Chick, 1977; Field, 1983; Benner, 1984; Bassett-Smith, 1989) have taken a phenomenological approach and deal with the individual perception of nurses in different practice areas. These studies, which focus on individual characteristics of the student or graduate nurse and her understanding of her situation, are necessarily bound by epistemological limits. The historical, and socio-political forces which shape that understanding may not be clarified or incorporated in the research (refer to p37).

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. Others have used grounded theory as a strategy for understanding individual perceptions of specific practice contexts (e.g. Paterson, 1989; Christensen, 1989).

Symbolic interactionism sees meanings as social products which are formed in and through the activities of people as they act towards each other (Blumer, 1967). As Buckenham and McGrath explain:

...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).

Four more recent New Zealand studies which explore more fully the ways in which nurses exercise personal and professional agency utilise grounded theory as a research strategy. Paterson (1988) Bassett-Smith (1988), Christenson (1988) and Walton (1989a), while not specifically focused on the education or socialisation of nurses, have generated substantial knowledge about the ways in which nurses understand and experience the personal-professional worlds of nursing practice. All four studies demonstrate that professional nursing decisions are made in the tacit understanding of the prevailing ideological constraints within the hospital where these nurses worked. Walton (1989:77) for example, found that the hospital environment, along with illness and treatment regimes, limited the nurses' range of possibilities for action.

This kind of knowledge however, cannot alert nurses 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. Interpretive researchers, then, are prevented

within their own epistemology from generating knowledge which will give participants in the research the opportunity to challenge and change constraining forces. Knowledge gained does not lead to a critique of the socio-political conditions of their situation. The problem situation remains but subjective interpretations of the situation leads to incremental knowledge of a personal-professional nature.

This kind of theoretical explanation, when applied in an educational context, leads to a focus on the individual, on individual learning styles and on the relationship between teaching and learning (Bevis, 1987; Bevis & Watson, 1989). While this focus may lead to questioning the assumptions on which traditional nursing curricula are based, it ignores the nature and form of power relationships within nursing education. An outcome of this kind of interpretive research is expected to be the "development of teaching strategies which will enable students to use clinical data for inferences and deciding on courses of action" (Tanner, 1987:29). It is assumed, for example, that once nurses know how inferences are made from clinical data then nursing action will follow. However, since the focus of the research is the development of subjective interpretations of nursing activity, teaching strategies which will alert nurses to the structural and political forces which constrain their day-to-day nursing practice are unlikely to be included.

Interpretive approaches fail to address the centrality of power relations both within nursing education and between nursing educational contexts and the larger social and political domain that influences and constrains them.

Challenges to Interpretivism

There are two main arguments against the interpretive model (Fay, 1975, 1987; Bernstein, 1976). The first has to do with the interpretive theory of social science and the second with how theory is related to practice.

Firstly, 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.

The interpretive model is also considered 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. 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 relations 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; Lather, 1986).

A second criticism of the interpretive model is that it inadequately relates theory to practice. An individual's identity as a person is tied to the particular world view of her group and the beliefs which are rooted in that world view. Therefore, competing interpretations of what that individual is doing may be seen by her 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 simply through the presentation of ideas is naive (Fay, 1975).

Furthermore, interpretivism cannot provide a means by which people are able to distinguish interpretations that are distorted by ideology from those that are not. Nor can it provide some view of how any distorted self understanding can be overcome (Carr & Kemmis, 1983:127). 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 individual's interpretations and actions, and external factors and circumstances (Fay, 1975; Bernstein, 1976; Thompson and Held, 1982).

CRITICAL SOCIAL SCIENCE

These two cognitive interests discussed above - technical (incorporated in analytic empiricism) and practical (incorporated in interpretivism) - are not sufficient to secure freedom from the material conditions which constrain social life. Habermas (1981:198) contends that the third cognitive interest - an "emancipatory interest" will secure this freedom. —

The emancipatory interest is incorporated in the critical sciences (sociology, political science, feminist theory) and in all systematic reflection (as in philosophy and psychology) and is grounded in the human capacity to act rationally, to self-consciously reason and to make decisions in the light of available knowledge, rules and needs. Bernstein (1976:193) suggests that this interest is grounded in power since it arises from self knowledge generated through self reflection. Self reflection includes both rational reconstruction - the ability to suspend everyday 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, 1980:328).

The emancipatory interest is an interest in reason, in the pursuit of knowledge for its intrinsic worth. This third interest is different therefore from the other two interests - the act of knowing is not immediately connected with the utilisation of knowledge but provides the impetus to achieve self understanding and autonomy of action.

Studies using a critical social science approach

Whereas conventional research naively aims to be apolitical, critical enquiry is explicitly normative. Both empirico- analytic and interpretive research tend towards reification and consequently a conservatism that is accepting of the status quo. In contrast the interest of critical enquiry holds the potential for being emancipatory and serve as a catalyst for change. As Combleth (1984:30) explains, critical enquiry can "reveal inherent contradictions in the social order and how repression or dissatisfaction can be alleviated by altering underlying structural conditions".

Critical theory has not been widely used in empirical research - it more often exists 'in the abstract'. There are, therefore, few studies using a critical approach available for critique and debate and even fewer related to nursing or nursing education.

Three recent studies (Perry, 1985; Hickson, 1988; Street, 1989) and commentators (Allen, 1985; Smyth, 1986b) have attempted to take account of the socio-political context of nursing education and practice and to examine the socially generated constraints on personal and professional action in the polytechnic and hospital settings.

Perry (1985), for example, in her examination of the induction of five graduate nurses into professional nursing culture, demonstrated that tensions between social structures and individual agency constrained the personal and professional choices of nurses in various ways. An ideology of individualism predominant in the polytechnic and the hospital masked the social conditions which produced feelings of personal inadequacy and self blame. An ideology of consent masked the social structures which produced contradictions between graduate education based upon

ideals and beliefs, and the exigencies arising from clinical experience and hospital practice. Thus the kinds of experiences that graduates had during their education prepared them to more readily accept the constraints they found on entry to hospital practice.

In her critical approach to the study of the ways in which knowledge is viewed, transmitted and crystalised in the practice world of four nurses, Hickson (1988) demonstrated the ways in which constraints on personal and professional agency were experienced by each of the four participants. Hickson contends that the way that nurses and other social actors came to "know" and to interpret their social worlds is dependent on the socio-political context in which that knowledge is produced.

The artificial boundaries imposed by time limits were a major limitation in these studies since the data did not demonstrate the participants' on going reflection-in-action (Smyth, 1986) to any extent and the meaning of emancipatory knowledge for each participant was not fully developed. The participants were able to reflect on their educational and clinical practice experiences during the course of the interviews but reflexivity (or praxis) was not clearly demonstrated although this could be expected within a socially critical approach.

Street (1989) in a critical ethnography of clinical nursing practices examined the relationships between power and knowledge in clinical practice and focussed on the hegemony by which oppressive practices were maintained, accommodated or resisted. Street (1989:186) claims that

"these analyses and critiques will enable nurses to recognise the politics which constrain and oppress their clinical practices and to understand

the mechanisms which maintain and legitimate oppressive structures for themselves and their patients".

How this personal recognition and understanding would be translated into political action to transform the social conditions of practice is less clear.

The Challenge to Critical Theorising

Although the studies mentioned above are pioneering in nature in that they set out to explore the world of nursing from a 'new' philosophical approach to the generation of knowledge, criticisms may be made. The first is mentioned briefly above and relates to the artificial boundaries imposed by academic study which delimits the researchers involvement in the development of transformative action. As the collaborative efforts between researcher and participants result in emancipatory knowledge, action and reflection, these boundaries may well impose premature 'closure' of this process. Thus the meaning and use of emancipatory knowledge for the individual, and its connection with practical action which has the ability to transform oppressive conditions, is left unexplored.

A further implication of these studies is the idiosyncratic and individualised focus of transformative action. If the goals of critical theorising are to be realised then the research process should enable nurses to work together to collectively transform some of those structures and practices which they presently find oppressive and inhibiting to professional nursing practice. The studies outlined above describe personal-professional changes at the level of personal ideology but do not demonstrate individual or collective political action. This point is elaborated in later chapters of this thesis.

As will be demonstrated in the research account presented in chapters five and six, these criticisms are also relevant for this present research. Indeed chapters seven and eight contain further critique which illustrates the complex nature of the practical and theoretical processes of critical research. These chapters are a useful illustration of the ways in which critical research must be reflexive (self-critical) of its own agenda and methodologies.

The central features of critical theory used in this present study are identified and discussed in the next chapter. This expository account, mainly derived from a range of critical theoretical literature, includes some critique of these central constructs in-so-far as they are explored in the research account presented in chapters five and six.

SUMMARY

This chapter has provided a brief critique of the theoretical and methodological orientations of some of the studies of nurses, and their educational and practice settings pertinent to this thesis. 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 nurses within an institution. Literature from a third philosophical position, 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, was briefly outlined.

In the following two chapters the central features of the theoretical and methodological frameworks underpinning and guiding this study are discussed.

CHAPTER THREE

CRITICAL SOCIAL THEORY

In the previous chapter critical social theory was introduced and some recent studies of nurses utilising this approach were discussed. This chapter begins with an expository account of the nature of critical social theory. Discussion then moves to the application of a critical theory approach for the study of the teaching and learning experiences of tutors and students in a comprehensive nursing course.

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 life. 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 static role structures but as dynamic systems built up out of the actions and interactions of individuals in a structural sense. 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. For example, a nursing student, in a clinical learning environment in a hospital, may wish to provide holistic nursing care for her clients as she had been taught. However, the low staffing level of the ward, or the time allocated to nursing tasks, or a lack of understanding of 'holistic nursing care' by registered nurses in the clinical area, may make holistic care impractical. The student's intentions are thus redefined so that she may concentrate on nursing tasks to be achieved in a predetermined time frame. The student's understanding of what constitutes nursing care in this clinical area has been shaped by external socio-political constraints.

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 complex 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 (Craib, 1984). Therefore critical social science can be recognised as a process which combines the elements of enlightenment, empowerment and emancipation (Fay, 1987).

Essentially, then, critical theory is not a body of explanatory theory in the traditional sense, but a form of consciousness in which social agents come to realise the conditions for their autonomy, enlightenment, and fulfillment 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'" (ibid). That is, critical theory presupposes interaction between theory and practice (action), agent and structure.

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 on their actions of the established structures of the institution or the particular profession. The central aim of critical theory is action at the socio-political level.

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 critical theorizing 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 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 study (Willis, 1977).

Quantitative analyses may be employed but they will always need to be complemented by an interpretive approach. However, as Jayaratne (1983) and Stevens (1989) suggest, it is not the mechanical application of any particular method that leads to critical insight but rather the use of methodology in a manner consistent with the philosophy of critical social theory that raises consciousness, liberates and transforms oppressive conditions. It is the combination of interpretive with empirical validity which gives critical theory its unique methodological features. Nevertheless, there are some limitations which have been identified in the literature.

CHALLENGES TO CRITICAL SOCIAL THEORY

The most common general criticism is that critical theory is utopian. It 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 claims 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. Some studies reveal the consciousness raising and enlightenment which results in individual or small group practical action (Tripp, 1987; Hickson, 1988; Street, 1989). However, the theoretical and practical links between enlightenment, action and structural change are less well developed as will be shown in this present study. Nevertheless other writers (e.g. McCarthy, 1978; Geuss, 1981) have argued that critical theory does have the potential to produce political action leading to structural change within particular social and institutional contexts.

Fay (1987:144-145) distinguishes "four different types of limits to the specific agenda of enlightenment, empowerment, and emancipatory action of critical social science. Epistemological limits prevent rational analysis from achieving consensus. Thus it is argued that there are constraints inherent in human reason which cast doubt on the viability of the notion of human autonomy. Therapeutic limits are those barriers which prevent rational reflection from altering ways of thinking and behaving in an educative manner. Ethical limits refer to the point where rational reconstruction may produce undesirable effects for the very people it was meant to benefit. Power limits are those constraints on human life which restrict the ability of humans to be autonomous". These points are discussed more fully in Chapter seven.

The issues discussed above involve complex philosophical arguments. However 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) 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 NURSING EDUCATION

The central claim of this thesis is that the consciousness of third year students and their tutors in a comprehensive nursing course is shaped in particular ways by the ideologies of an existing professional culture and by institutional structures. This can best be understood within a critical theory perspective which requires an examination of the judgments and actions of tutors and students and the subsequent consequences of these actions, as well as the social relationships they encounter and develop within institutions. Such an examination, within the context of a critical social theory, can be based on five separate but inter-related theoretical constructs: culture (manifest in a hidden curriculum), relations of power, emancipatory knowledge, hegemony, and ideology critique. Each of these constructs is discussed below in the context of nursing education.

Culture

Culture can be construed as a dynamic process which reflects human action, experience and material production and which is inevitably related to the dynamics of power. Giroux (1983:19) elaborates the Frankfurt Schools' notion of culture that assigned it a key place in the development of historical experience. In this view,

culture is intimately related to the structuring and mediating of social processes, and to the transforming action of language and resources in resisting and reconstituting those processes. Culture is seen as a human construction which is altered through people's progressive understanding of historically specific processes and structures - people change themselves by reconstituting collective social and historical meanings.

Within an identifiable culture, different groups represent different interests with differential access to status and power. Within each culture, as Street (1989:11) puts it, this is "reflected in hierarchical relationships between groups and classes in which power is used by a dominant group to consolidate their interests and to convince the subordinate groups to consent to the continuation of the existing order". This is the process that Gramsci called ideological hegemony (refer to pp70-5) to account for the way power plays an intimate part in the production and reproduction of culture.

Nursing education is concerned with the induction of neophytes into a professional culture and institutional practices within existing health care structures in order to prepare individuals to meet essential health care needs in a community. Preparation for nursing, then, entails more than just acquiring a theoretical and experiential knowledge base for nursing practice. Students are also exposed to a process of enculturation which comprises many elements - theories of knowledge and ways of knowing; symbolic forms of knowledge; rules and rituals governing the actions of individuals; as well as patterns of personal beliefs, values and attitudes and commitment to nursing.

It can be seen that the process of induction into the culture of the profession extends beyond the formal curriculum. The informal or hidden 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. 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 (Higgins, 1989; Gordon, 1988; Harris, 1988; Cornbleth, 1984).

Culture and the hidden curriculum in nursing education

In New Zealand, nursing education and practice are characterised by a lack of opportunities for tutors and students to critically examine the epistemological basis of educational transmissions, and the elements of culture central to nursing as a profession (Ramsay, 1978; Perry, 1985; Horsburgh, 1987; Forbes, 1990). 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 judgments 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 judgments 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 could focus on these cultural traditions, on the qualitative, lived experiences of students and graduates, so that the structures and constraints which shape nursing education and practice could be critically examined. In other words, the 'hidden curriculum' should be 'surfaced', made explicit, so that its practical

effects on the educational experiences of tutors and students are acknowledged. As Giroux (1983a:61) suggests, the hidden curriculum must be openly acknowledged as a "pedagogical concern" and that if the "notion of the hidden curriculum is to become meaningful it will have to be used to analyse not only the social relations of the classroom and school but also the structural 'silences' and ideological messages that shape the form and content of knowledge".

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).

Nursing tutors, like other teachers, act upon their intuitive and experiential knowledge and understanding of education, of their discipline and of educational theories, whether explicit or implicit. As well, behind every philosophy or statement of policy in nursing education, 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 unacknowledged or '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.

These unintended messages transmitted by the physical and social structures of learning environments and by the teaching processes themselves, may have undesirable effects on students, as well as others, involved in the teaching-learning process. For example, *personal* knowledge, for nurses in both education and practice, may be discredited since they must be "initiated" into what is deemed "worthwhile" knowledge for practice (Perry, 1985; Hickson, 1988). In this way tutors and students may learn not to trust their own judgments - they may also learn to internalize the conditions which prevent them from clarifying their actual educational, professional, and social situations.

Because teaching and learning are cultural activities the hidden curriculum is intimately linked with learning, and with the values and beliefs students come to hold within the contexts of nursing education and practice. For example, students are 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, may be internalised during the educational experience and thereby reproduced later within the professional conduct of graduates (Perry, 1985; Forbes, 1990).

Because the hidden curriculum is an "enacted cultural structure" there will always be a number of different features hiding, confusing and contradicting as well as supporting and reinforcing any particular values position (Tripp, 1987). There may be a discrepancy between what it is openly intended that students learn and what they do, in fact, learn. For example, it appears that with the change to tertiary

education in New Zealand, it was intended (i.e. part of the formal curriculum) that students learn to practice differently (holistically). But they also learn to conform quickly to the requirements of the clinical agency where task management and the pressure of time are paramount. Thus conformity to traditional practice (unintended consequence) could take precedence over different practice (intended learning state) and become the basis on which the student's professional self is built. What students and graduates *do* learn is as culturally formative as the messages that they receive about what they ought to be learning (Perry, 1985).

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)

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). As Giroux (1983:284) puts it "by mediating between society and the student's consciousness through the dispositions, structures and modes of knowledge, pedagogic relationships, and the informal culture that make up the school itself, settings for socialisation have become sites for controlling the definition of the student's reality".

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 not have intended. Thus, there is a certain paradox between the apparent educational aims of tutors and practice aims of nurses, and outcomes for students.

At the abstract level, tutors and senior nurses appear to expect students to develop emotions, purpose, integrity, and autonomy consistent with the professional attributes that are assumed to enhance teaching - learning - professional relationships. These ideals are a part of the formal doctrine of the nursing profession. At the practical level, and in the ethos of both the polytech and the hospital, the aim appears to be towards co-operation, conformity and acceptance of existing practices, beliefs, attitudes and values (Perry, 1985; Pitts, 1985).

Both the overt and the hidden curricula may 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. At present the understanding of what counts as legitimate knowledge for practice is shaped by forms of technical control which arise from the dominant ideologies already embedded in the education and health care structures. The "doctor-nurse game" (Stein, 1988) is a cogent example of the ways in which nurses often deny their own personal and professional knowledge and values while upholding those of doctors. Nurses themselves, therefore, "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 (refer to p75) through the ways in which knowledge is selected, distributed and evaluated (Bernstein, 1975). Thus curricula convey substantial ideological messages which are a critical part of cultural reproduction and are intimately linked to principles of social control. For example, in an objectives model of curriculum 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 processes of enculturation, the intended and unintended learning states of the curriculum, and the world view of the dominant ideology within the institutions of health and education, may all remain unchallenged.

Teachers and students, however, do not interpret and act on the curriculum-in-use only in a passive way - they often reject or circumvent the basic messages and practices of the overt and covert curricula. Thus there is a dialectical relationship between individual agency and the sociocultural realm where educational practices and content are both reproduced and contradicted by those who experience them (Bernstein, 1975; Bourdieu, 1977; Giroux, 1980).

On the assumption that knowledge is socially constructed, tutors and students are seen as producers as well as consumers of knowledge. Thus the production of personal and shared meanings by tutors and students is constituted by the dialectical relationship between knowledge and power, cultural production and reproduction.

The possibility of the development of a critical consciousness ("conscientization") depends 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 within 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 p66) which would provide the individual with a means to socially critique the ideological character of education and practice. Emancipatory knowledge could lead to transformative action under conditions where the curriculum effectively shapes the thoughts, values and feelings of students, or where the instrumental consciousness of those in nursing education and practice control the lives of others through the use of objective information. This is the point of 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 focused 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 rational discourse which may lead to increased dialogue and debate about the nature of knowledge required for professional practice.

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 shared 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.

Rather than conceptualising power as a commodity held by the ruling class and culture as in the Marxist tradition, Foucault argues that power is a strategy and depends for its existence on the presence of a "multiplicity of points of resistance" (Foucault, 1979:93). He asks the questions - how is power exercised, by what means, and to what effect? The answers to these questions demonstrate the centrality of uses of forms of power by dominant classes or cultures to shape, control or coerce those who are labelled deviant.

However, as Sheridan (1980:165) points out, Foucault emphasises that power is not always negative or repressive. It can also be positive "knowledge producing" in the sense that it "produces domains of objects and rituals of truth". Hence nurses, as individuals or groups subject to established dominant patterns of thought, values, discourse or behaviour within an institution may be both coerced into conformity (which is presented as a morally 'right', legitimate choice) and at the same time be aware of this coercion and its consequences. Awareness and understanding, however, does not necessarily lead to transformative action so that conformity may prevail as the only practical choice for action.

It is these more subtle uses and less direct effects of power to which Lukes (1974) draws attention. 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. Thus Lukes' account of a different conception of power is concerned not with 'power to' (a capacity or ability) but with 'power over' (a relationship).

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 or desires may be shaped and determined through the socialisation process they encounter in the hospital, so that their 'real interests' or needs may be suppressed (Perry, 1985; Street, 1989).

Geuss (1981) in his discussion of what might be meant by the claim that a group of agents is deceived or deluded about its needs or real interests, suggests that agents may have an 'interest' in the satisfaction of their wants or desires but may be mistaken about what these wants and desires will lead to.

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 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 (1977:203) suggests that this is the 'educative role' of social theory in that the research processes provide the means whereby the participants "can come to see themselves in ways radically different from their own self conceptions". Through the process of increasing conscientisation, the critical social scientist not only assists people to define their self perceptions differently, but also facilitates an awareness as

to which aspects of their social order are repressive. This process may provide the participants with sufficient knowledge and self understanding with which to identify and pursue their 'true' interests.

In the research account presented in Chapters five and six, tutors and students reflect on their experiences in both classroom and clinical settings. The interviewer, with their informed consent and through emancipatory reflexive dialogue encouraged each participant to focus on her situation as she perceived it and to examine her experiences in the light of both her education and her understanding of the organisational constraints she encountered. The intention was to not only increase self understanding, but to increase understanding of the social and political contexts of nursing education and practice with the expressed intention of engaging in transformative action.

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 (refer Chapter 2).

Critical theory is explicitly founded on an awareness of the ways in which conditions, such as hierarchical power relationships and other institutional regimes

and ideals which support dominant ideologies, can generate certain beliefs, ideas and self understandings. These may be illusions (or false consciousness) which are necessary to sustain a particular form of living - "the things people cling to because they provide direction and meaning in their lives" (Fay 1977:214). 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.

Although the actual practice of nurses has changed over recent years, as nurses start to value their own expertise and to act on their substantial clinical knowledge, those who administer educational courses and clinical agencies do not always act in ways that acknowledge these changes. The instrumental approach to the organisation of nursing services ensures that actions nurses take are constrained by organisational factors such as time limits, tasks and procedures, individual workloads, staffing levels, the dynamics of the relations of power between health professionals, and the over-riding demands of doctors. Constraints produced by hierarchical power relationships may be accepted as natural and therefore unchallengeable - part of the 'common sense' taken-for-granted order of the institution (Perry and Moss, 1989).

For example, graduate nurses in hospitals may be expected to 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 essence 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 proposed 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; Comstock, 1983). 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 and communicative competence

In chapter two, 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 an 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 everyday 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. Knowledge is seen as a product of and serving the purpose of human action.

Held (1980:256) contends that according to Habermas critical theory is "grounded in a normative standard that is not arbitrary but inherent in the very structure of social action and language". 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 (Habermas 1984:41). Talking is, then, a necessary precondition for emancipation. Everyday speech can lead to the ideal conditions in which practical rational discourse can take place.

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 and there are equal chances to select and employ speech acts. There must also be 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; and 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 preventing the attainment of a rational consensus which, in itself, implies autonomy and freedom from constraint.

This is Habermas' theory of communicative competence and 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. And Rasmussen (1990) concludes that at best Habermas's communicative thesis is grounded in a utopian assumption about the way society ought to be. However, the value of the theory of communicative competence may lie in its ability to explain the ways in which

communication becomes distorted and is systematically employed to support and magnify the effects of ideological hegemony.

The structure of language is central to understanding how beliefs and values are socially produced, as Mepham (1974) points out. He argues that the particular mode of production in any society gives rise to a particular form of social life and provides the conditions for specific forms of language. He demonstrates how real social relations become distorted through a complex set of language structures which contribute to 'false consciousness' and which perpetuate taken-for-granted labour and class divisions in society.

Individual consciousness may also be shaped by the insidiousness of particular forms of language and patterns of communication. For example, drawing on a range of marxist, feminist and linguistic theory Spender (1980) argues that there is growing body of evidence that the very substance of women's lives, including language and communication, is socially and ideologically constructed. Citing a range of research literature Spender (1980:43) concludes

...men deny equal status to women as conversational partners with respect to rights to full utilisation of their turns and support for the development of their topics. This is another example of male dominance, as men exercise control over the talk of women. Just as they have more rights to the formulation of the meaning in the language as a system, so it seems that men have more rights when it comes to using that system. Males have greater control over meaning and more control over talk.

(Spender, 1980:43)

To assume, therefore, that discourse between women and men can take place free from coercion indicates a degree of 'gender blindness' which ignores women's oppression and subjugation to male language, speech patterns and paradigm of discursive argument.

Habermas' (1984) accepted that few social conditions are likely to be characterised by ideal conditions and symmetrical power relations. His 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 where it is presupposed that certain validity claims have been met. It is through discourse, Habermas (1974:18) argues, that a rational consensus can be reached, given that "there is sufficient time to examine all aspects of the situation discursively".

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, intentionally or not, 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 dominated groups conform with existing beliefs and practices within the institution, occur where a consensus is established under conditions of hegemony.

Hegemony

Dominant groups are able to define and maintain social situations for the individual. This may be understood through the Gramscian concept of hegemony which describes 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 to 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 doctors, 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). Nursing education does not simply "process students" or

"process knowledge"; it helps create and legitimate forms of consciousness which reinforce existing hegemonic structures. As Apple (1979:82) points out "hegemony is created and recreated by the formal corpus of school knowledge as well as by the covert teaching that can and does go on".

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 an ideology of consent secures the participation of student and graduate nurses in 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.

Williams (1977) uses Gramsci's concept of hegemony to describe the process by which certain values and social relations maintain dominance within a culture. Hegemony refers to the entire social process in which lived identities and relationships are saturated by dominant meanings and values. A lived hegemony is "continually resisted, limited, altered, challenged by pressures not all its own" (Williams, 1970:112).

Hegemonic ideology, then, is not simply a static body of ideas to which members of a culture are obliged to conform. Rather, it is protean in nature (readily taking on various shapes or forms) in that dominant relations are preserved while their manifestations are highly flexible. Individual members of a culture must come to actively identify with and reformulate dominant ideals. It is this ideological work - renewing, recreating, defining, and modifying the hegemonic that is evident in

narrative accounts of the experiences of those teaching and learning in nursing education (refer to chapters five and six).

The hegemonic must continually evolve so as to "recuperate" from the challenges of alternative hegemonies. (Barrett (1970:111) uses "recuperation" to refer to the "ideological effort that goes into negating and defusing challenges to the historically dominant meaning of gender in particular periods".) Williams (1977) notes that truly alternative hegemonies can themselves become hegemonic; and where these impinge on significant areas of the dominant, there is strong pressure to defuse the challenge by incorporating it within dominant ideals, thus recuperating the hegemonic.

For example, nursing rhetoric has always included the ideal of "caring for the whole person, sick or well" (Nightingale, 1876, 1969:9) in contrast to the medical ideal of 'cure of disease'. However, caring for the whole person and the emphasis on wellness in nursing practice, has been such a challenge to the ability of doctors to maintain their ideological dominance, that these concepts are now incorporated into medical practice. The key to establishing hegemony, Apple (1986:26) suggests, usually rests with the group which can establish the parameters of the terms of the debate, and which can incorporate the competing claims of other groups under its own discourse.

In this context both human knowledge and institutional structures can be seen as the outcome of a dialectical interplay between objective constraints and subjective experience. For all social actors have "some degree of penetration of the social forms which oppress them" (Giddens 1979:72). Knowledge in this sense may lead to only a partial understanding, or misrecognition, of the power structures or forms

of domination that may underlie an organisation. Nevertheless this knowledge, partial or otherwise, produces conditions whereby nurses, for example, can act in a way that illustrates some understanding of their workplace and which allows self-reflection on hospitals as social institutions in which they may be oppressed. As Giddens (1981:54) explains:

all human action is carried on by knowledgeable agents who both construct the social world through their action, but yet whose action is also conditioned or constrained by the very world of their creation".

Hegemonic structures, therefore, 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

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 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. Therefore, the dominant ideology, in this thesis, is taken to be a system of beliefs, values and practices which are socially constructed but which shape the self consciousness of individuals in ways that distort their realities and protect existing power relationships in the polytechnic and clinical agencies.

Barrett (1980:97) argues that "ideology is a generic term for the processes by which meaning is produced, challenged, reproduced and transformed". Ideology is a complex phenomenon, a process through which cultural meanings and values are (re)produced. It 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 one of the central 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 may not be validated if subjected to rational discourse.

Geuss (1981:15) suggests that ideology is a form of consciousness 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) allow her to develop a particular understanding of her social world and a way of legitimizing social practices within that world.

A graduate nurse, for example, 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 the new 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 rational discourse with nurses and others in the health system, would be shown to be reflexively unacceptable to her (Hickson, 1988; Street, 1989). Professional socialisation could be said to be hegemonic because it produces a particular world view and a relatively rigid set of behaviours based on that world view. Ideology-critique is one means of exposing the hegemonic nature of professional socialisation and its practical effects on nursing practice in hospitals and nursing education in a polytechnic.

Ideology-critique is a process which shows that 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 person has. For example, the beliefs and attitudes that nursing students and graduates hold may be incoherent because they fail to account for their everyday experience. Ideology-critique is one means by which these discrepancies and contradictions between a nurse's 'form of consciousness' and the conditions of her social world, may be illuminated.

Ideology-critique may promote understanding of the tensions between personal beliefs and knowledge and socially constructed conditions of practice. This in turn may lead to the transformation of practices of decision making, communication and productive work. In chapters five, six and seven of this thesis, data and commentary present a critique of the dominant ideology revealed in relation to the ways in which student and tutors experience contradictions in their day to day practice. These contradictions, which are brought about through the pattern of power relations existing in institutions, emerge as issues at the individual level because they prevent the tutor or student from perceiving that it is external constraints which limit their options for teaching or learning.

SUMMARY

Critical social theory offers the researcher an opportunity to move beyond the level of description and explanation in order to develop critical reflexive analyses of the political nature of nursing education. 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 a legitimate partner in the processes of reflexivity and transformative action. The extent to which this position is problematic is frequently overlooked in previous research using critical approaches. In chapters seven and eight further interpretation of the research data reveals the ways in which the practical application of a critical approach fell short of its emancipatory intent.

In the following chapter the methods and procedures used in this study are discussed.

CHAPTER FOUR

THE RESEARCH PROCESS

This chapter introduces the methods and procedures which were used in this study to design and carry out the research and to work reflexively with individuals and groups. The strategies used to conduct interviews and to incorporate information from journals kept by the participants are described and discussed. Ethical considerations arising from the research process and the precautions taken to protect the participants are identified.

INTRODUCTION

This research describes and explores the educational experiences of thirty-eight third year comprehensive nursing students and nine tutors as they participated in this research. An attempt was made to identify those ideological forces which shaped the consciousness of tutors and students as they shared the educational process in two highly structured institutions - the polytechnic and the hospital.

THE SPECIFIC CONTEXT OF THIS STUDY

The Sites

This study was carried out in a Department of Nursing which was located in buildings typical of most polytechnics in New Zealand. The traditional style of classrooms with rows of desks facing the blackboard was common, occasionally modified by placing the desks in a less formal seating arrangement, or by

conducting classes in 'seminar' rooms with more informal seating arrangements. In addition there were two clinical practice rooms with equipment likely to be required for experience in delivering nursing care. These rooms were kept locked but students had access to them out of class hours by prior arrangement with a tutor.

The base hospital was a fully functional acute hospital serving an urban and rural population. Associated with it were obstetric services and district nursing services and the usual long-stay hospitals such as geriatric and psychiatric hospitals and services. Smaller mainly long-stay hospitals some distance away were used for student clinical experiences as were local rest homes for the elderly. Community agencies such as childcare and kindergarten centres, schools, 'sheltered' houses, public health nurse's practices and general practitioner's surgeries were also used for student experience.

The participants

One of the fifteen Polytechnic Schools of Nursing in New Zealand was selected because it was a small school with a relatively stable staff. Although I had little previous interaction with the tutors, I was familiar with the general organisation and procedures of the school as I had worked for some years in one polytechnic school of nursing and had been involved with curriculum development in a number of others. Moreover, the curriculum was about to be reviewed and, on initial enquiry, I was enthusiastically welcomed as it was thought that this research would assist with curriculum development.

I had previously decided to work with third year students and their tutors as I have a specific interest in the effects of particular curricula and in the induction into professional nursing culture. Moreover, I thought that third year students would

have had sufficient classroom and clinical experience to have developed a range of understandings of their situations and to have formed some theories-in-use (Schon, 1983). I hoped that, through the research process described below, not only would access be gained to this largely unarticulated practical knowledge but students would also be more aware of the grounds for, and value of such knowledge. In the event students were very enthusiastic as they saw me as an outsider who was keen to understand their situations and to work with them to overcome some of the constraints (as they saw them) to their practice. As one student put it:

The fact that you are impartial - I mean - you are within nursing but outside of the Polytech system - you can sort of stand back and take an overview and you could see the problems that are there and are willing to admit to them rather than cover them up...you are able to see that - you know the type of attitude.

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All tutors engaged in teaching these third year students took part in the study but most also had some input into other parts of the nursing course. The tutors were all very experienced nurses but their polytechnic teaching experience ranged from one to six years. Most had completed the required twelve weeks of tutor training. In all cases teams of three tutors worked together to provide specific classroom and clinical experience for forty two students over a period of 38 weeks.

The research approach described below required informed active participation and an understanding of the likely consequences of taking part in such a study. With this in mind eleven tutors and forty two students in a third year comprehensive nursing program at a New Zealand Polytechnic were approached to take part in the research. Preliminary informal discussions were held with the tutors and students who would, potentially, be involved in the study both in groups and individually. All tutors and thirty eight students agreed to participate in audiotaped individual and

group discussions and to keep a professional journal for a period of eight months. Subsequently two tutors withdrew from the study because they were no longer involved in teaching third year students. All tutor and student participants were pakeha (white) women.

The curriculum

The formal curriculum design at the time of this study was based on an adaptation of the Tyler model (refer Chapter 2) developed by a curriculum committee which included some of the tutors in this study. The curriculum is continually modified and must be approved by the Nursing Council of New Zealand. Each tutor worked within a team of two to four tutors and assisted in the development of a particular module linked to the overall curriculum. Each module was designed to provide sufficient theory, information and practice opportunities for a specific aspect of nursing such as psychiatric nursing, obstetric nursing, medical and surgical nursing and so on.

There was an emphasis on "self-directed" learning as an integral part of the curriculum design. Students received "learning packages" at the beginning of each module which contained learning objectives, references and workbook-style tasks to be achieved at points within the module. Each class was divided into groups and each group rotated through the three modules.

Students and tutors taking part in this study were involved in the last three modules of the three year course with each module extending over six to eight weeks. Tutors teach in both the classroom and clinical practice in their specialist areas (for example midwives teach obstetric nursing). At the conclusion of each module students must pass a two hour written examination, an assessment of their clinical

skills so that they can progress to the next module. On completion of these final three modules students have a six week elective period - usually in a clinical area of their choice - to consolidate their clinical practice skills. During this elective period students are not usually supervised by tutors but are responsible to the charge nurse of the clinical practice area.

The above is a pattern followed by all comprehensive courses in New Zealand. The arrangement of the modules and the order in which they are presented may differ across the country but the content, relation of theory to practice, teaching methods and clinical experience are similar for all courses. Students are expected to leave the course with sufficient knowledge, information and skills to practice as a registered nurse at a "beginning practitioner level" in any area of nursing practice. Following success in the final examination set by the polytechnic school of nursing, students are eligible for the two part state registering examination set by the Nursing Council of New Zealand (usually referred to by tutors and students as 'sitting states' or 'finals').

The fieldwork

Following interviews and informal discussion and after reading journal entries I made 'theoretical and methodological notes' (Schatzman & Strauss, 1973) to focus my attention on the research process. Field notes often took the form of memos to remind me of significant events to follow up or check out with other participants. Some notes recorded a significant change in my perception, understanding of the participants' world or a critique of my interviewing techniques (refer appendix 5).

For the conduct of the research I was given permission to visit the polytechnic on a regular three weekly basis for four days each time over a period of five months, then

less often for a further three months. It was agreed that during this time interviews would be conducted with each tutor and with those students available at the school thus minimizing disruption to their study and clinical experience. As well as interviews at the polytechnic, permission to interview tutors and students in the hospital setting was given both by the head of department, nursing studies and by the principal nurses of two hospitals where most of the participants were working over the research period.

This access to students and tutors in both school and hospital settings was significant for the conduct of the research for two reasons. Firstly, conducting interviews during or immediately after clinical experience yielded data rich in practical examples and gave an immediacy to the participants' reflections. Secondly, arranging interviews with participants at their place of work caused the least disruption to their usual routine.

Accordingly, before each visit to the polytechnic, I arranged an interview schedule by telephone and mail; and at the polytechnic an interview room was set aside away from the usual territory used by tutors and students. A list of clinical shift work duties and class times for each participating student was sent to me so that I could arrange a convenient time and place to conduct individual and group interviews. Thus dialogue with students often occurred during or immediately after clinical experience in the hospital setting. Occasionally tutors were also interviewed while 'on duty' giving immediate access to the nature of practical knowledge and some insight into the ways that tutors and student were able to shape and form that knowledge.

THE DISCOURSE

Reporting and interpreting tutor and student discourse in this study rests on reconstructing and reconceptualising the experiences of tutors and students as they write and talk about their personal and professional lives. In depth analysis of dialogue allows greater insights into *what* is being said through what tutors are saying, doing and being - at times quite unbeknown to them (Lévi-Strauss, 1979). Through systematically illuminating these experiences and the contexts in which they occur it was expected that all participants would come closer to achieving an interpretive understanding of the nature of the boundaries of their practice.

In the report of this research, I have also been mindful of the ways in which the written word transforms discourse. As Ricoeur (1981:91) points out, discourse becomes 'fixed' when it is written allowing the 'text' to become independent of the intentions of its original author. A transcription of dialogue is decontextualised to the extent that "it transcends its own psycho-sociological conditions of production and thereby opens itself to an unlimited series of readings". Discourse with tutors and students in this study transcends the research intention, (emancipatory dialogue leading to knowledge and transformative action) if not the academic intention (production of a thesis).

Moreover, the time-space fixation of discourse in its written version creates an autonomy for the text that has significant consequences. The potential audience is unknown but exposure to the 'talk' of nurses as it is presented here may allow the reader to achieve a particular kind of self-understanding. As Ricoeur (1981:94) puts it:

To understand is not to project oneself onto the text but to expose oneself to it; it is to receive a self enlarged by the appropriation of the

proposed worlds which interpretation unfolds. In sum it is the matter of the text which gives the reader (her) dimension of subjectivity".

Nurses and others reading the report of this research may gain insights into their own practice by thinking through the ideas presented and applying them to their own situation.

In previous chapters it was argued that critical theory places present social action and relationships within an historical context and focuses on the individual's present understandings and interpretive acts. It claims to investigate not just social institutions and practices but also the beliefs people have about their situations - the social and political knowledge which is part of their reality. According to critical theory, oppressive and frustrating conditions exist at least partly because people are systematically unaware of their needs and the nature of their relationships.

The critical theory approach to the research process used in this study focussed on personal accounts of experience, personal perspectives of culture and structural boundaries, and personal values. This approach allowed the researcher and participants to work reflexively together, sharing knowledge and understanding, with the intention of developing ideas that were of practical use in transforming the conditions of the participants' practice.

The presentation of the research in the following two chapters, therefore, differs from the conventional instrumentalist notion of a research report in two ways. Firstly, *themes* were identified in the narrative accounts (in the form of interviews and journals) that tutors and students gave of their understanding and experiences. Within each theme, extracts from these narratives have been used to highlight significant aspects that all tutors and all students discussed. The commentary linking

these extracts or protocols is partly my interpretive account of the participants views and partly my understanding as a 'participant' in this research. Secondly, since the account of the research was shared with the participants at a number of points (refer pp94-6) it may be seen as a *collaborative account* of the research process. Thus it meets the validity criteria for trustworthiness discussed below.

The interviews

Tape recorded in-depth interviews were used as one of the research tools in this study for two reasons. Firstly, a tape recorded interview not only captured the immediacy of the situation and vividness of speech, it also protected the participant against misinterpretation, and allowed her control over what was recorded. Since all tape recorded interviews could be transcribed and the transcriptions given to the participants to read and alter if necessary, some of the ethical problems associated with the interventionist nature of a critical approach to research could be resolved. Code names were used for all participants and actual names or other identifying characteristics did not appear on any transcript material nor will they be used in any publications or reports of the study.

Secondly, in-depth interviews were used (rather than types of observation) because they are more consistent with a critical theory approach. All parties to the interview are participants in that they are observers of themselves and others. A *critical dialogue* can provide the means of collectively generating theory through providing conditions which help the participants to reflexively understand observations and experience within the socio-historical context. Moreover the process of analysis can be shared and ongoing as all participants gain insights and increase their confidence in interpreting the knowledge generated (Lather, 1986).

In all, twenty eight audiotaped individual interviews lasting from one to two hours were conducted with eleven tutors, at three weekly intervals over a period of eight months, resulting in some 825 pages of transcript. Several hours of unrecorded informal discussion also took place. Three group discussions were not audiotaped. Fourteen audiotaped small group and six individual audiotaped interviews were conducted with students, lasting from one to three hours over a period of five months, resulting in 328 pages of transcript (Appendix 4). Field notes were made of several hours of informal discussion which were not audiotaped (Appendix 5).

Each interview was generally unstructured but focussed on issues of concern either of recent experiences or events or from journal entries. Each interview began with a general discussion to re-establish rapport. Then the discussion moved to significant events usually identified by the participant but occasionally identified by me from previous interviews I had taken part in that day, or had been written in my field notes or in one of the professional journals kept by tutors and students. The aim was to explore the experiences, perceptions and situations of all participants, including myself, in a way that would help to reveal some of the personal and professional decisions that influence and shape action.

As soon as possible after each interview with tutors, audiotapes were transcribed and given back to the participant for discussion, clarification and analysis at the next interview. I was as clear as possible about the theoretical orientation and interpretation I was developing in the course of analysing our discussion. This approach to interviewing allowed what Bogden & Bilken (1982), Mischler (1986) and others have called a 'shared construction of meaning' where, as feelings of trust and empathy are established, meaning is clarified and misinterpretation is corrected.

It was more difficult to give transcripts back to participating students as they were often off campus on duty in different clinical areas. To overcome this a final group session was held with all thirty eight participating students over a four hour period during their last week at the polytechnic after State examinations. During this time transcripts were available for discussion and clarification; the research process itself was discussed in relation to their experience of it; further insights into their educational experiences were revealed and discussed and future career aspirations were discussed.

I was aware of the difficulty in maintaining 'critical detachment' (Comstock, 1982:377) or of being "objectively subjective" (Reason & Rowan, 1981:xiii). It is not difficult for the researcher to become involved in the personal and professional lives of the participants. To prevent this I was careful to limit my participation at the polytechnic to the times when 'data collection' was scheduled or, if participants wanted to talk to me about something we had previously discussed, we would move to another room to maintain confidentiality and to keep the discussion within the boundaries of the 'research'.

The journals

As a second research method, each participant was asked to keep a professional journal for the duration of the study to carry on a dialogue about various dimensions of experience, recording events which were significant for them. I supplied them all with a hard covered notebook, and group discussions about the process of keeping a professional journal were held. All tutors participating in the study kept a professional journal and, on average, fifteen entries of four pages each were made. Journal entries were made by tutors on a regular basis whenever a significant event occurred or when there was an issue of concern.

In this way, the evidence or descriptive accounts of an instance of practice can be re-examined in the light of espoused theory and re-interpreted to pose further questions, so that similar instances can be approached from other perspectives (Benner, 1984). As Holly (1984:18) points out :

If we could freeze our perceptions **at the time of our action** we might be able to identify and understand better the underlying problems and contributing factors that are ordinarily only vaguely felt. And we could prevent many problems from recurring - we could learn from our mistakes. Keeping a personal-professional journal allows us to do just that - to take snapshots of our lives...

Beginning entries in the tutor's journals were mainly descriptive of events, feelings and issues. Part way through the study I asked the tutors to refocus their journal entries (refer Appendix 6) because it was clear that they were often simply recording events rather than actively using the journal as a basis for dialogue and for analysis and introspection (Holly, 1984). Later entries are more analytical as tutors developed the ability to 'argue with themselves' and to explore ideas which seemed more consistent with their personal educational philosophies than with their actual educational practices (refer to p110-120).

Most tutors used their journals in conjunction with the interviews, recording parts of the interview dialogue and then the events that occurred following the interview. This process was assisted by negotiation of the scheduling of interviews; by my own field notes written to ensure significant reported experiences were followed up; and by the preliminary analysis I made after each interview.

Twenty one students of the thirty eight participating in the study kept a personal/professional journal for the duration of the study. The number of journal entries ranged from three to fifteen with about three pages each entry. Students kept

their journals in a more haphazard manner than did tutors, with most students reporting that the journal was an imposition when they were doing their final preparations for State examinations. Nevertheless of those who used them, their journal entries revealed both to them and to me some significant insights into their perceptions of their educational experiences. These are discussed in the following chapters.

OBJECTIVITY AND SUBJECTIVITY IN RESEARCH

As argued in Chapter Two, most previous studies of student and graduate nurses have been based on the notions of neutral observation and objectivity in the empirico-analytic sense or in the interpretive sense.

Analytic empiricism attempts to separate objectivity from subjectivity, fact from value, logic from feelings, and theory from practice. Reason may be understood as the capacity to merely formulate empirically testable hypotheses (Habermas, 1971:161) rather than to develop an empirically grounded critique of prevailing ideological assumptions. Indeed as Rorty (1982), Grimshaw (1983) and others argue, there are no natural or neutral terms with which to formulate philosophical or other problems as all are bound up with historical and cultural traditions.

Research based on the above dichotomies, while making a claim for 'neutral observation', ignores the historical embeddedness of all thought that affects our conception of the nature of reality. Not only is the researcher separated from the subject (or object) of research but, to maintain objectivity and prevent bias, the researcher is distanced from the research process. In other words, research in both the analytical-empirical and interpretive traditions objectifies the experience of

research so that the researcher's knowledge and viewpoints are removed from consideration (Oakley, 1981).

Interpretive methods seek to separate researcher from subject by attempting to replicate the participant's world view and adopting her precise vantage point. In interpretivist research, then, it is taken-for-granted that the researcher and those she seeks to understand will have different perspectives but that the process of reflective interpretation will bring about a 'merging of horizons' (Salmond, 1982). Thus knowledge is gained by both the researcher and the participant about the subjective interpretation of the situation but there is no opportunity, within the bounds of the research methodology, for critique of the historical, social and political forces that gave rise to the situation in the first place. Research from this viewpoint then, objectifies both the researcher's and the participant's experience by removing it from its historical and cultural foundations.

In each of these accounts there are marked differences in the relative status between 'researcher' and 'subject'. Both empirico-analytic and interpretive approaches accept the separation of persons as researcher and subject, and the interpretive researcher's stance has been described as that of reflective spectator. Critical social theorists, however, see this distancing as alienating and describe a more appropriate researcher's stance as "reflexive spectator; that is, the spectator who reflexively engages the world to change it and is reflexively changed in the process" (Carr & Kemmis, 1983:168).

A critical approach to research explicitly links theory, research and practice through reflection, discourse and action. While critical theorists accept the broad approaches of the interpretive tradition, they move beyond them in that they attempt to provide

the conditions in which people can reflect on experience in a way that results in practical action.

For example, in this study the impetus for making and validating decisions for action developed through a critical reflexive dialogue. The participant (or co-researcher) and the researcher reflected on experience, and sought to make sense of it, in the light of the social and political context of that experience (Fay, 1977). Therefore, those most affected by the outcome of research (the participants) had the primary responsibility for deciding on courses of action which seemed likely to lead to change in their social and political situations.

Thus understanding and action could be intimately linked (Freire, 1970; Lather, 1986) and the research process could become a process of 'conscientisation'. As Bowles and Klein (1983:126) point out, the decisive characteristic of this approach is that "the study of an oppressive reality is not carried out by experts but by the objects of oppression. People who before were objects of research become subjects of their own research and action".

In this study emancipatory discourse between researcher and participants and among the participants themselves was used as the primary research method. An attempt was made to eliminate any status differential between researcher and participants by engaging in critically reflexive dialogue and working together to develop theories that might have allowed better understanding, and ultimately transformation of thought and practice (Freire, 1973; Fay, 1987).

This study, therefore, emphasised the importance of personal experience, of acknowledging the subjectivity of the participants and myself as researcher and of

sharing a critique of the social milieu in which the research was based. The intention was that practice would be placed in a critical framework of understanding by reconstructing present thought, feelings and actions in relation to their cultural, historical and political antecedents. Knowledge achieved in this way had the potential to inform practical judgement and transform practice through deliberate strategic action (Fay, 1977, 1987; Freire, 1973; Lather, 1986).

ETHICAL CONCERNS: CONFIDENTIALITY, NEGOTIATION AND RECIPROCITY

It was important for the protection of those involved in the research and its integrity, that all participants, but students in particular, were not coerced into taking part in the study. On the basis of my previous research (Perry, 1985; Perry, 1987-9) I was aware that students often feel relatively powerless and may be vulnerable to 'persuasion' by those they deem to hold power over them. I was concerned therefore, that students fully understood the nature of their participation in this research and that they had an opportunity to fully consider the implications for their education before they gave their consent to participate.

To assist in this process the nature of the study and all potential risks and benefits were fully and carefully explained to each tutor and student participant. All participants were required to give their written informed consent (Appendices 1 and 2) and they were expected to comprehend the nature of the study being undertaken. I explained to them that they could withdraw from the study at any time and that they could turn the tape recorder off at any stage. Students were reassured that all information that they shared with me would not be discussed with their tutors in detail and the right of all participants for confidentiality would be protected.

During the course of most interviews the tape recorder was turned off for varying periods both by me and by the participants. The need to protect others from potential harm, and not to adopt an exploitative attitude to interviewees as a source of data (Oakley, 1981:48), meant that I was particularly concerned not to record any dialogue while the tutor or student was distressed, or was recounting distressing or personally sensitive events. In each of these cases, if the tutor or student didn't request it, I would suggest that the tape recorder was turned off while we discussed the episode. Later I would ask permission to record the main issues relating to the episode as we discussed it again. In this way I felt that the interviewee had more control over what was being recorded through having had the opportunity to 'talk out' unrecorded what was personally sensitive or distressing to her.

Both the theoretical approach to this research and the interactive nature of the interviewing style meant that the research process was openly interventionist. Although all research is interventionist in some way, a critical approach gives the researcher the right to challenge the participants beliefs and ideas and to put a different point of view. I tried to minimise the negative effects of this through the recording process described above, and by giving each participant the transcripts from their own interviews to clarify or to withdraw information they were unhappy about being used in the written form. None of the original interview material was disallowed but clarification and updating of the issues raised in the transcripts took place.

All participants expressed their satisfaction with the opportunity to review and comment on previous discussion and analysis (refer to chapters five and six). In the same way, some of the tutors wrote comments beside entries in their journals to the

effect that part of the entry was for "my eyes only" and could be discussed at the next interview but was not to be used in the written report of the research.

These kinds of negotiations occurred at frequent intervals throughout the research process. As Tripp (1983:39) argues, negotiation of meaning and modification of views (not because statements are inaccurate but because of possible social effects) are essential if the participants are to actively 'own' the data. For the protection of the participants, it was important that no identifying speech or practice characteristics appeared in the written report.

In this study, negotiation with the participants occurred in three cycles. The first was associated with establishing the conduct of the research process and clarifying the nature and use of interviews and journals. The second cycle of negotiation occurred with the return of interview transcripts to the tutors in the study and the subsequent clarification and analysis of the data they contained. Associated with this was the clarification and analysis of journal entries which occurred during each interview. It was more difficult to return interview transcripts to students who were often in different clinical locations. However transcripts were made available as far as possible during the course of the study and were available during the final group interview with all students.

The third cycle of negotiation with tutors began with the presentation of a brief draft report so that they could see the contexts in which their written words would be used. This created an opportunity for further comment on the accuracy of interpretation and modification where necessary. On completion of the final draft of the thesis, chapters five six and seven were given to each tutor participant and a group discussion was held. The implications of the study for each tutor and for the

course were discussed and arrangements were made for the dissemination of the research report to a wider audience at a later date.

Student participants had been given my telephone number, address and approximate completion date during the final group interview so that they could obtain a draft report if they wished. Since most students were intending to leave the local area after graduation this seemed the most appropriate way to ensure their access to the written form of this research.

These opportunities for participant autonomy were particularly important because it could be expected that self-reflective inquiry would continue beyond the artificial boundaries of this study. Previously unrecognised socio-political constraints may continue to be surfaced and further possibilities for action may continue to be seen. Indeed, at the final group discussion mentioned above, tutors discussed personal and structural changes they had made or were intending to make as a result of participating in this research.

I was also aware that the interaction I had with the participants was changing and shaping my own perceptions and interpretations of the nature of teaching and learning in the nursing course. I was aware too that I seemed at times to be imposing a theoretical interpretation during the course of our discussion which was unwelcome at the time to some participants. I took care therefore to ensure that participants would be able to express and maintain a different interpretation.

However there is a point where the researcher must take responsibility to decide on and justify the use of particular data and its interpretation because, as Tripp (1983) points out, it is the researcher who has an 'outsider's' view and access to all the

participants' statements. I was well aware that I had read widely in the area and had over the years developed a particular theoretical orientation to the issues and concerns that the participants were sharing with me. I also took seriously my responsibility to translate the 'study' into a 'report' which fairly represents and interprets the participants context-dependent views.

All the processes described above, went some way to deal with ethical concerns but they also acted to further establish the mutual sharing of information and experiences. This is the 'intimacy' Oakley (1981:49) identifies as being essential in longitudinal in-depth interviewing.

Since this was a deliberate attempt to involve the research participants in the interpretation and analysis of their own data it meets some of the criteria Fay (1977:218) identifies as essential for the development of emancipatory knowledge through the processes of reciprocal reflexivity and critique. Such reciprocity, or mutual negotiation of meaning and power in research design, creates conditions for rich data. More significantly for this study, it allows the researcher to consciously use the research process "to help participants understand and change their situation...for the purpose of empowering the researched" (Lather, 1986:266).

VALIDITY CONCERNS

Although the findings in the written report of this study cannot be generalised to all tutors and students or to all polytechnics they can satisfy the criteria for scientific rigour. As Comstock (1985:387) points out, the aim of critical approaches is to "stimulate a self sustaining process of critical analysis and enlightened action". It is this dialectic of theory and practice validated in the self understandings and

transformative actions of the participants which distinguishes critical research methods from traditional research methods. This is the educative effect of a critical approach (Fay, 1975).

Lincoln and Guba (1985:296), Sandelowski (1986:29), Lather (1986: 268) and other writers suggest that '*trustworthiness*', *transferability* and *confirmability* are more appropriate terms for praxis oriented research than the traditional notions of validity and reliability. To achieve '*trustworthiness*' data must be credible to those from whom it was obtained; applicable to other situations in similar settings when detailed '*thick description*' of the context of the study is provided; and confirmable through examining the characteristics of the data by utilising a number of research methods and by establishing a sound evidentiary base.

'Transferability', the term used to describe the likelihood of another researcher following the '*decision trail*' of this research and arriving at similar conclusions, has been attempted by describing in detail the processes and procedures followed for data collection.

However, as Lather (1986:272) suggests, these strategies do not go far enough to establish credibility in praxis-oriented research. She notes that the issues of false consciousness and resistance (refer to p61) which would prevent emancipatory discourse may have been disregarded. Lather (citing Reason & Rowan, 1981) proposes that another criterion '*catalytic validity*' should be used which:

"represents the degree to which the research process reorients, focuses, and energises participants toward knowing reality in order to transform it, a process Freire (1973) terms conscientization"

(Lather, 1986:272)

Catalytic validity recognises the reality-altering impact of critical research processes. However, because of the artificial boundaries of this study this criterion was not fully demonstrated. Participants did discuss and reflect upon their situations and experiences of education and practice, and in many cases demonstrated reflexivity. Some transformative action was reported. However a longer time period would be required to show evidence of some of the ongoing personal and structural changes the participants might have made either individually or collectively.

In this study, data and methodological triangulation - criteria Lather (1986) sees as essential to establish validity - was achieved through the data sources and research methods described above (i.e. interactive interviewing, ongoing analysis of transcripts; journalling and ongoing analysis of journal entries; and researcher field notes). Ultimately it is for the participants and the reader to judge the trustworthiness of the data obtained through the methods presented here (Lincoln & Guba, 1985:298). To assist with this process the research report in the subsequent chapters offers description, explanation and analysis based on the theoretical discussion in previous chapters, and there are substantial records of transcripts and journal entries.

SUMMARY

This chapter has provided description and rationale for the methods and procedures used in this study. Interviews, journals and field notes were used together to provide a rich source of data for both the participants and the researcher to use as a basis for a reflexive critique of the current situation and to identify areas for transformative action.

The conditions for research established with the participants encouraged the exploration of the meanings that actions and events had for the them. Dialogue and journalling created the opportunities for emancipatory discourse. These research methods were also used to explore 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 without violating the larger store of data from which it is drawn.

The following chapters provide multiple examples of tutors and students speaking and writing about their experiences of teaching and learning in the third year of comprehensive nursing education at a New Zealand polytechnic.

PART THREE

THE RESEARCH ACCOUNT

CHAPTERS FIVE, SIX, SEVEN AND EIGHT

INTRODUCTION TO CHAPTERS FIVE AND SIX

The following two chapters provide an account of the ways in which tutors and students made sense of their experiences as they reflected on their engagement in teaching and learning practices both in the classroom and in clinical practice. Extracts from both interviews and journals are used to allow the participants to 'speak for themselves'. Discussion and interpretation of the data are guided by the theoretical and methodological positions supporting this research and outlined in Part Two.

Because New Zealand is a small country with only fifteen polytechnic schools of nursing (each with an individual course) and a relatively small, mobile tutor population, indepth description would enable tutor identification. Middleton (1987:19) identified this as a methodological and ethical problem in a country with a population as small as that of New Zealand. Anonymity was guaranteed at the time of initial negotiation with the participants. Therefore only sufficient description of the context and the participants as will allow the reader to make sense of the data has been included here.

As described in chapter four the third year course was divided into six to eight week modules with specific clinical placements relating to each module. There were alternate classroom and clinical periods of two to three weeks each.

The principle of student-centred learning which permeated the curriculum design was translated into practice similarly in each module. Students were given "packages" of workbook-like material to complete usually by the end of the module

although sometimes these were to be completed before the student went out to the clinical placement. In addition some of the classroom sessions were voluntary.

As discussed in previous chapters, there were social and structural constraints, to which both tutors and students referred and which prevented them from fully realising their educational and practice ideals. These constraints, which were both material and conceptual, arose in part from the educational context of the polytechnic and the practice context of clinical agencies, and in part from the school of nursing's organisation of curriculum, pedagogy and evaluation in the third year course.

As will be shown in the research account which follows, tutors and students were constrained by the curriculum (which was organised in modules with designated subject, classroom and clinical hours within the modules), the order in which students moved through the modules, tutor access to clinical areas and so on. The tutor - student relationship was similarly constrained by practices and procedures existing in the polytechnic and the clinical agencies. These constraints related mainly to hierarchical relationships and the emphasis on specific knowledge and competency acquisition. Evaluation of the student's progress largely rested on previously established criteria to meet the requirements of the polytechnic and the Nursing Council of New Zealand. The requirements to use specific written forms of evaluation, and to keep written personal files for each student, for example, were constraints referred to by both tutors and students. In the clinical agencies constraints mainly related to organisational factors such as time limits, tasks and procedures, individual workloads, staffing levels, the dynamics of the relations of power between health professionals, and the over-riding demands of doctors (refer also p64).

As will be shown in chapter five, throughout the period of this research tutors became increasingly reflexive as they explored the inconsistencies between their intentions and their actions through critical dialogue and journalling. Although they were unable to fully penetrate (Willis, 1977) the ideological and hegemonic basis of their day-to-day practice and engage in transformative action during this study, in many instances tutors increased their ability to engage in ideology-critique and to reflect on areas for change.

Tutors experienced a disjunction between the social structures of teaching and professional practice. The principles, practices and procedures of the polytechnic often prevented tutors from maintaining their nursing focus and skills. And those of the clinical setting often prevented them from providing students with the kind of educational experience they thought necessary. Moreover, manifest in the protocols presented in the next two chapters, are tutors' understanding of the attitudes, values and beliefs about nursing education held by their peers in the clinical setting. Tutors generally experienced these as being contradictory to, or conflicting with, the attitudes values and beliefs held by those in the education setting. In this way, the data demonstrates that tutors "worked in two worlds" and moved between two professional cultures.

Chapter six provides evidence of the ways in which students were able to distance themselves from their educational experiences through the research processes of critical discourse and journalling. They spoke about those aspects of their education which were personally and professionally frustrating to them in the safe environments of group interviews and personal journals.

Unlike tutors, students experienced a continuity of social structures between education and practice. They discussed and reported ways in which they learned to act in accordance with what they perceived was expected of them. And students complied with those practices, principles and beliefs which they perceived to be desired by those in education and practice who had the power to determine their future. Where these expectations were incompatible, students generally reported complying with the requirements of the clinical agency because it was here that they had to demonstrate their competence as a student nurse. The value placed on 'practice' as superior to 'theory' in the clinical agencies reinforced their understanding of what it meant to be a student nurse. In this way, their education can be construed as inculcating them into a professional culture.

Both tutors and students experienced similar tensions between social structures and individual agency and were engaged in producing and reproducing professional nursing culture. Their individual consciousness of themselves as professional nurses can be seen to be socially constructed within institutional contexts where structured power relationships are well established.

Tutor protocols are labelled with the tutor pseudonym and the interview number (for example, Ann Int1) or the tutor pseudonym and journal entry date (for example, Ann 2/5). Student interview protocols are identified by class (for example, STU 3B1) and journal entries are identified by student number and date (for example, Stu24 2/5). The interviewer's comments are typed in bold print and different speakers during group interviews are identified by brackets such as { or [.

CHAPTER FIVE

TUTOR DISCOURSE

This chapter is primarily to do with tutors' experiences, but some extracts from students' interviews and journals have been included to present a more complete picture. Excerpts from interviews and journals, unless specified otherwise, are representative of themes which emerged from the data rather than individual tutors' views. Each extract is representative of many extracts which could have been chosen to illustrate the particular point being made. There is no attempt to create an indepth profile of individual tutors but rather the intent is to identify themes which emerged from the examination of all interviews and journal entries of these tutors teaching in the third year of a three year comprehensive nursing course. These themes are: *the experience of reflexivity; reproducing cultural knowledge; and classroom and clinical experience.*

Tutor discourse reveals the extent to which their thoughts, intentions and actions were embedded in dual cultures - a teaching, 'polytechnic' culture and a nursing culture experienced both in the school of nursing and in the clinical agencies. There appeared to be similar structural constraints in the polytechnic as there were in the clinical agencies (e.g. refer p16; p189) so, for the most part, this duality was managed smoothly, obscuring the processes of reproduction of professional culture. However, when tutors experienced a disjunction between knowledge, beliefs and values in the education setting and those in the clinical setting, they were more willing to engage in ideology critique.

THE EXPERIENCE OF REFLEXIVITY

This theme highlights the ways in which tutors used the research process to ground their current experiences in the past and to talk about the future. All tutors referred to their own nursing education experiences as having influenced the ways they think about and approach their work as tutors. Their reflections on current experiences and what they expected to be able to do in the future were developed as the research progressed.

The past

In the following dialogue this tutor reflects on her own educational experience and contrasts it with what she thinks should happen with the students she teaches:

Like, not being nasty - I don't think that I do anything that the tutors did with me - you see, because I always felt talked down to...I always felt a bit patronised and I became very quiet - I was very quiet in class - probably like some of our students here. And I just did my own thing in the end. I did what I thought they wanted.

And you have described that as negative experiences?

Yes.

Are they really positive though? Because you've learnt from them. And you do different things because of them? It might have affected the way that you interacted with other people, and that you wouldn't want to do to other people what had been done to you.

Yeah. But I use my psych tutors as role models, because there were very positive things like - there were lots of role plays and things. Yeah, I suppose when you look at it they are - they are very positive. But I ... think that if I hadn't come tutoring I wouldn't have thought they were positive. I think if I had responded to my clients like these tutors responded to us I would have been at fault... honestly.

Lyn Int 2

Lyn was able to reflect on the conditions of domination she experienced as a student and expressed her intention to avoid perpetuating them as a tutor. However, at the time of this research tutors engaged in socio-political actions which did perpetuate

the social structures and conditions of domination, even though they knew that these same structures limited both their teaching and nursing practices and constrained students' choices. They were well aware of this contradiction and its practical effects on their practice and on students' experiences but could see little alternative to it. In this interview the tutor explains her own attempts to "use the system" as a student and her inability to act now that she is a tutor.

...(students) do pick out different traits in how a tutor will handle things. Yeah, and they use the system a little bit which is good, you know, that shows some knowledge, some insight.

Did you do the same as a student?

Oh yes. Very true - in the end you know - you knuckle down. You fight the system and then you make the decision to knuckle down, when it's only you know, half way there, you knuckle down and you finish and you just get there. Just did what was expected and kept a low profile and hated it. Hated being really put down. I was always very conscious of it, I don't think you say in front of the client - and that happened to me a couple of times and I hated that. I would feel so ashamed (if I did that), because if I'm not happy about what a student's doing, I will wait until they've come out of the room, and out of the area.

Are tutors still doing that to students?

Oh I think they probably are.

Are you able to say anything?

Oh, you know, maybe I'm not strong enough in myself or confident enough in myself in what I'm doing yet to be able to do that. And the people who are like that are very strong people.

What is it in the system that allows them to be strong?

I think that in some way it is good, you have this individual authority and power. But it is too much. We are not assessed. Like if the students do evaluate us - we don't act on it, or they don't see us acting on it - so they don't see any change, so after a while they get to think, you know "Why bother"? And I don't think we are judged enough by our peers.

Lyn Int3

Later in this interview the personal (rather than structural) explanations the tutor gave for her inability to act were explored. The tutor explains here that in common

with all tutors she is "trying to survive and feel secure" in rapidly changing education and health care institutions.

It interests me that people have a personal explanation for not being able to act. Yeah. Like you said "Oh well I'm not strong enough", there's something wrong with me and I can't confront this person, or I can't mention it.

Yeah I think there ought to be a way, that's right. You know there's something wrong, and you've got to change it... You've got to be careful sometimes, people are very territorial and I think people are starting to feel a bit threatened in the system at the moment about - you know, all the changes that are happening, and I'm busy trying to survive and feel secure -

It is fairly political I think.

Lyn Int3

Thus personal explanations ('not strong enough; not confident enough') were given for what were essentially socially produced constraints in their day to day practice. This prevented tutors from realising how such constraints could be overcome.

The present

Through dialogue and journalling, tutors began to further uncover some of the understandings they had about the socio-politico-historical dynamics of the contexts of their practice. This process of critical self reflection through emancipatory discourse enabled some tutors to see themselves as active (or at least potentially active) participants in challenging and changing the constraining conditions that were a part of their day-to-day lives.

Although they had previously realised that there was a structural basis to the disease they felt with the ways in which they were "forced" to teach, they now realised that this was something they could act upon. As Carol explains:

The opportunities for teaching nursing practice in the clinical areas abound and at the moment I feel as if I'm only just tapping into them. I

would choose to concentrate my energies here...once back at the polytech...after extremely busy weeks in the clinical area I find it hard to motivate myself when there are no immediate goals to achieve...

Carol 22/10

In the following journal entry Robin explains that she had been unaware of individual student's backgrounds and the relationship of their individual learning needs to the content and processes in the module. There was little in the overall organisation of the course which would have encouraged her to take this individualistic stance in her work. Robin saw this information in terms of "problems" alerting her to the knowledge and skills that individual students might bring with them to the module. This extract also demonstrates one of the ways in which the interview and journal were used to facilitate posing new problems rather than hunting for solutions to unexamined and taken-for-granted questions. The tutor engages in what Freire (1973) calls "the pedagogy of the question" rather than the "pedagogy of the answer", and is willing to critically examine assumptions she holds about her teaching.

Judith discussed my journal with me yesterday and provoked me to think more about where our students are at personally and professionally at the beginning of the module. This prompted me to read the student files and I picked up what could be two serious problems in student behaviour...I would like to discuss these student's experiences and expectations of the module with them and stimulate them to think of some personal goals for themselves... Judith wondered what it is that we want them to be at the end of the module and whether this is reflected in the curriculum and objectives for the module...

When we discussed these things we wondered about students attitudes and professionalism and what these imponderables actually were that we judged students by. I'll think about these for my next talk with Judith... and also how things flow from theory to practice, and whether the things I've discovered about students in their files have made any difference to my interactions with them.

Robin 25/5

In a subsequent interview, Robin explains the changes she would make in her teaching practice:

Now with this class I am going to gear what I say quite a bit lower. There is actually a language problem as well - with some of the students - and cultural difficulties.

Yes so - I suppose there is a bit of a balance though because there must be people in that class who are functioning at a reasonably high level.

Yes I think there may be. You can tell that when you are in the class. But it has made me a lot more aware of the specific problems of two or three members of the class.

It's not very easy but I think it is good to know about them so perhaps you can give them more individual attention and make sure that they understand at each area of the lesson - of the critical area actually - I was saying that before...And I thought also - this is something I haven't done before - but to ask the students their expectations of the module.

Robin Int3

Many tutors stated that they had never looked at the overall curriculum but relied on the course outlines for their particular modules. In this way each 'team' of tutors was relatively isolated in their modules from other tutors, and from the content and processes of other modules.

As the following excerpts indicate, tutors appreciated organised time together to discuss those issues outlined above. Previously meetings dealt with administrative matters or "students causing concern" but the "research" meetings gave them organised time together to discuss more "philosophical issues", and, as one tutor explained, "our team talking to you helped with our relationships together" (Ann 1/6). The "philosophical issues" tutors identified were their attempts to critique and to transform some of the practices that they found incongruous in their day-to-day work.

Well I felt that after your last visit, we had talked about how we felt talking to you and that opened up more communication than maybe we have had in the past.

I think the students too - one of the students said something to me very interesting a couple of days ago - I don't know if she is actually a part

of the study. She said to me "It must be very difficult to be a tutor". And I said "Why do you say that?" And she said "Well there must be times when you get really impatient with us - when you really want to do things yourself and"

She was talking about other things - this was quite incidental - and so we were able to talk about the study and what we had learnt..

Ann Int3

Tutors in general expressed their appreciation of the opportunities afforded by this study to step outside their usual frames of reference and examine their taken-for-granted practices. As Karen explains:

Well as I think I said in one of my summaries in the journal - that I would like to really use what an individual has to offer, you know, and not to try and put them into a mould - I think that would be really good - because I consider that really on certain times when I have done that it's been good for both of us. I have used that idea quite a bit actually when I come to think of it. In the clinical area, I think I am much more - more brave... about - the students advocate I am more brave about the hospital staff - Yes, I am... (laughs). Because of course these things take time - ... but I can see little changes.

I was getting so brittle myself I think - I thought... sort of come to terms with this great oppression. Well I think you can - I have found myself - if I am in a situation where I am continually being put down then I can pass it on to the students and that's what so dangerous, and I think I've come to - made sure that I have been a bit more meticulous about that - you know.

I think that you have got to appreciate that they (the students) are under enormous stress ... they have got so much value out of talking to you.... to enable them to try again...

Karen Int4

Dialogue with other tutors in their 'team' and with tutors in other modules, led to a critique of the structural bases of the values, meanings and motives that they held personally and collectively. The ways in which their particular module was organised, how it related to other modules and the institutional practices underpinning the course, the nature of knowledge, and teaching and learning in nursing, were explored. As Comstock (1982:381) points out, such meanings, values and motives were not reducible to individual psychological attributes but could be

seen as socio-historical constructs linked to the social processes and structures that created and maintained them.

For example, all tutors expressed their dissatisfaction with written student assessment forms which were intended to assist the student to critique her own practice. However the form was often used by tutors to comment on student performance, and although the student could write a comment in reply, such comments were limited to either agreeing or disagreeing with the tutor. Thus the intention of tutors was contradicted by their actions distorting the meaning of the assessment for both tutor and student.

Following a team meeting where this was explored, Jane explains how her team examined and changed the basis of their "accountability" to students:

Well we have talked about it and we're altering our format. Well I feel really pleased about that because this has been an argument of mine that our form wasn't accountable enough, and I think that is really important for the students. So we had this single form, I don't know if you have seen it, it just goes zero to ten -

Oh yes.

It talks about privacy, knowledge, you know - interaction and all that. And I felt it should be more accountable - like we should have clear guidelines - what the students should be marked on and what the expectations were - so we have done that and changed the format of the form. And that will remain the assessment that we do and then they have got the form that they have when they go away which seems to work all right and we haven't had any complaints from the students about it. The first couple of times, with the students ... we got them to evaluate the forms.

Jane Int3

An understanding of the historical dialectic (by which social processes and intersubjective meanings have developed) led to an awareness of the ways in which their personal understanding of teaching and learning differed from the dominant ideology in both the polytechnic and the clinical agencies.

In the following extract, Carol reflects on the beliefs about students and their relative position in the relations of power in the clinical agencies. The student was considered to be ignorant - without 'official' knowledge - and therefore unable to participate in the decision making processes to do with client care.

...the doctor went on to explain that he felt the student did not have the experience to back such value judgements - and what constituted value judgements etc. If such a report had been signed by a charge nurse or a tutor it would have been taken seriously but not a report from a student. I tried to explain that students come from a wide range of backgrounds and they may in fact be very accurate judges of behaviour! However the important thing I think was that the students had reported the "patient's" behaviour very accurately and this eventually led to the client receiving the medical and nursing attention she needed.

...I think it's important to ...be kept in check by the real needs of the consumer (oh but it's painful) but I think it's one of the greatest challenges facing us.

Carol 19/7

Most tutors already understood the contradictions between the technical, objective mode of practice the clinical agencies favoured and the more subjective, observational nursing practice they were trying to teach students. However, understanding the socio-historical origins of these contradictions demonstrated to them ways in which their self understandings were mediated and distorted by ideological and hegemonic processes in both institutions.

In the following example this tutor explains that some clinical areas were still dominated by medical interests and that "when nurses have a lot of status" that can change. One way of achieving this is to change the emphasis of nursing education.

What do you think the overriding thing is that students should learn from this whole programme?

(pause) - See it would be good if they could have a nursing model instead of a medical one I think. And I think that we could do that in our module.

Can you change that?

Yes I'm sure we can change that emphasis. But I think that is a big thing about this sickness, medical emphasis... but I think other areas - like in the psychiatric area, and the geriatric area, they have done much better than the obstetric area in promoting nursing.

A nursing emphasis.

That's right. Mind you, I think also they are probably two areas that perhaps aren't so medically dominated - nurses have a lot of status and maybe that's why nurses have been able to get in on those areas.

Carol Int2

The institutional context, with its procedures and practices that shaped the nature of the tutors day-to-day work, was a site of constant struggle. Constraints, such as the need to record contact hours, and access to polytechnic vehicles to travel to clinical placements, shaped the nature of the tutors' work and the students' access to tutors' time. The polytechnic required tutors to comply with the regulations governing their employment as tutors. Yet those same regulations prevented tutors from carrying out their work as they would want to, or as the school of nursing required them to. In the following excerpt the tutor explains how she dealt with this kind of constraint:

And you see it sounds - it's very simple when it's just a tutor in front of a class, but when you actually get into things like community health - now you can say "Well OK, she should claim 30 contact hours because she is responsible for those students", and we can rationalise it that way - but what actually happens in practical purposes, the tutor's got the students out there and she's not really required with them, um - she will pick up some link courses or something else, but she can't claim double contact - she can fill up her contact hours to 32, but she may have officially done 50 - which she can't claim - so we actually do some fast -um fiddles of course, as everybody does.

Emma Int1

This is an example of 'getting round the system' rather than perceiving the situation as a structural constraint which, if dealt with directly, had the potential to change. It was a common-sense response by tutors in this study brought about by their apparent powerlessness to challenge and change the taken-for-granted nature of technical-rational forms of control in the polytechnic.

For example, in the next interview the same tutor is unable to penetrate the ideological basis for her unease that such constraints will become less tolerable in the future.

And we just look terribly dumb that we can't even get our contact hours right, but in fact you know, there is a tremendous amount of emotional energy, time, PR, um - trips out to see people that goes into that sort of thing - and it is absolutely essential because we are going to need - if anything the contact hour thing is going to get funnier and funnier because we are going to need to do more and more of going out to where the clients are as opposed to imagining them sitting there in hospital.

And especially as people are de-institutionalised and so on - the community contact is going to be greater.

Yes, of course it is. They are being - and yet - on one level it's all happening out there in the community, but on another level it's different, you train them to work in the Med Surg area and that's all we're doing.

Emma Int2

The future

Throughout the period of the study, some attempt was made by all tutors to examine the ways in which their socio-political conditions had changed in the recent past and the ways in which those conditions could change in the foreseeable future, given their increased understanding and self awareness. Some strategies were developed which would maintain their critical awareness long after the formal completion of this research.

In the next example, Lyn explains that students need one particular tutor to relate to and so does she - she needs a "peer tutor" with whom she could try out ideas:

Do you see yourself acting as a student advocate?

Well I'd like to in the future. I tried. I felt like I was banging my head against a brick wall a few times. I got really annoyed. It annoyed me - several student problems had really annoyed me that we couldn't do enough.... I think what should have happened is - I think they needed

one particular tutor to relate to ...and I think the peer tutor is a good idea. And then I'll go away and think... I'll write a note about that. Because maybe that tutor could have helped -

Lyn Int3

In the journal entry below, Carol reflects on the need to take account of the student's reaction to course objectives.

This student appeared to have a more mature attitude and to take more responsibility for her own learning. She was very anxious to 'have a go' at different procedures... Other students seem to think that if they have performed a nursing skill once then that is sufficient to meet the course objectives. Maybe we have to look more critically at the objectives when students adopt that 'been there done that' attitude.

Carol 11/8

Thus through increased dialogue in each 'team' (module) the tutors who worked closely together began to 'problematised' previous assumptions and to rediscover the contradictory demands created and maintained by the structures in which they worked. In this way previously taken-for-granted situations, or those situations where it had been decided that 'nothing could be done', were more likely to be seen as problematic.

Tutors, in general, were not reflexive in the sense of understanding what must change to transform inhibiting conditions and then acting on that understanding. However, through critical dialogue, their subsequent actions were more socially conscious and reflective and the potential for transformative action was apparently increased.

...I have found it valuable to be a part of this study. Initially, at times I found it a little threatening...It has made me think about what I do on a different level ... more broadly I think. Next year I would like to concentrate on what the students as individuals have to offer rather than fitting them into a mould. What you mentioned about tapping into their creative energy is important I think. I have to leave a little more "space" in my relationships with the students.

Carol 22/10

I know I'm very busy - far too much work - so at times I've just got no energy left to do the journal. But what has interested me is that I have found it difficult to reflect on classroom teaching situations and whole weeks go by with nothing emerging. Yet it's not like this in the one to one teaching situation in the hospital.

Karen 1/6

In the following extract, Lyn demonstrates increasing enlightenment and a starting point for action:

Was there anything in the transcripts that you were surprised about when you went back to read them? Could you remember talking about those things?

Yeah, most of it, yeah. I didn't really... I wondered if - what would happen in another year's time - you know if you asked me the same questions, it did make me feel that.

You think you have moved on from where you were then?

Yeah, I think I probably have, yeah. I think, well I wrote it down, I think it is part of being able to reflect, because you actually do it, and we always talk about doing it, but we don't get round to it. And probably this has been good ... myself and another tutor we talk a lot about things, and I think that is probably really good. So it has been good from that point of view.

You helped give me the push to put the ideas forward. I felt that like it was going to be a more difficult time for change now actually, with the way economics are, and you can really see it sort of creeping into the department. People starting to get very frightened, very clingy, and very territorial, and very sort of worried.

Clinging to what they have in case it is taken away? Or to prove that they...

They have to prove themselves in what they have always done. So I think from now on is going to be a very difficult time to change. More than it has been in the past. I mean everybody says that we should change with this new economic climate, but I see the reverse happening when you are sitting there at meetings.

People getting more ...?

Yeah I think so, more rigid, more frightened. And it comes out like "You know you are lucky to have jobs and all that - you are doing all right!"

(laughs) Instead of 'they are privileged to have us work here'!

Yeah, yeah, it has changed, changing very quickly. I find that quite frightening.

Lyn Int 4

In the following extract developing critical consciousness is revealed by Ann's stated intention to engage in emancipatory action in a hospital culture which was committed to technical action. In this clinical area the charge nurse gathered information from her own observations and from the nurses on duty then wrote a 'report' for each patient. The accumulated reports were then read to the nurses on the next shift to bring them up to date with the nursing requirements for each patient. Ann, however, in common with other tutors working in this clinical area, would prefer that the client was fully informed and involved in decisions about her own nursing care. Here she explores what it would mean to practice in this way even though it would be contrary to established ward practice:

...and actually saying to the client - introducing the next oncoming nurse to her and just saying what the problems had been as defined from the morning and what they were focussing on and what was necessary to be done... and I have always wanted to try it so we will just see if it comes to anything. If it doesn't then the idea has been put and maybe it will come up later.

Could you do that anyway though - with your own students? I mean does it have to be a ward wide thing or..?

Oh right - in other wards?

Mm.

There is no reason why we can't is there? I hadn't thought of that. I have always sort of thought that the charge nurse decides on - it's her role to decide on how she wants report given. That's how I have always felt it, but really probably there is no need to think that way - yeah, that's an insight. Mm. I don't know that we have ever done that or if any of the other tutors do that?

It sounds really exciting - sharing knowledge with the patient - the patient sharing her expert knowledge about herself?

Mm. I think it is wonderful, and just having confidence to know that the oncoming nurse knows exactly what is going on. I think it would give the patient much more self responsibility too.

Ann Int3

By the conclusion of this study most of the tutors were engaged in exploring the possibilities for practising in ways that could challenge the prevailing doctrines in the organisation of nursing care. In this way too, tutors were reflecting on their actions in clinical practice and the practical effects that those actions had on student's learning experiences.

REPRODUCING CULTURAL KNOWLEDGE

Having knowledge, 'getting' knowledge and 'knowing what to do' were central and overwhelming concerns of tutors and students in this study. The student's ability to develop 'personal knowledge', which would assist her to gain the professional knowledge on which clinical judgements rest, was seen as developing slowly in a sequential, linear fashion over the three years of her nursing education. The student was 'given' this knowledge by tutors, through the texts and student centred learning packages, and in clinical practice. It was a legitimate target for both formal and informal assessment.

The distinction between 'knowing that' (propositional knowledge) and 'knowing how' (practical or habitual knowledge) explains this separation of thought and action in tutor discourse (Ryle, 1949; Polanyi, 1958; Pring, 1976). Propositional knowledge as "given" to students by tutors and practising nurses, constituted the principal way of knowing, and was legitimated through formal testing procedures and the emphasis on learning "content" throughout the course. Practical or habitual knowledge was gained in the clinical area where students were supervised and expected to apply the theory they had been given in class (refer to p128). The students' practical knowledge and skills were subject to formal tests but the nature of this experiential learning opened up more aspects of the student for assessment.

Observations about personal characteristics of the students and subjective comments about their work were written on their personal files. Such assessment practices serve to intensify the forms of surveillance that typify institutions such as schools and hospitals (Foucault, 1977).

The intention of all tutors was to provide opportunities for students to be self directed so a number of teaching methods were used to achieve this. Informing students, questioning them and discussing theories and issues were all ways in which knowledge could be transmitted to students.

Knowledge as information

Propositional knowledge, which tutors and students referred to as "textbook or classroom" knowledge, was necessary to "expose" students to "essential" information. In this way the student was "given" a range of theories or ideas about a subject, person or object without having direct experience or contact. Once this information (knowledge) had been transferred from tutors and texts to students they were considered to be safe to engage in practice and could gain practical knowledge.

As tutors explained, this 'banking' view of education (refer to p11) assisted students to have sufficient knowledge to be safe in the clinical area and to motivate them to learn more.

Well - how do they learn to make clinical judgements? I think they have a broad knowledge base to start with. That's one of the main things that we try to get - we give them that knowledge base before they go into the clinical area.

Is that building on to previous knowledge?

Yes it is - from the first year. And actually in that student centred learning package they have a revision quiz which we use to allow them to bring their formal knowledge to where they are at. So their

knowledge should be OK. We have a test at the end of that fortnight on the theory work so it should - I know that it motivates them to try and learn that material.

Ann Int2

Here the intention was that tutors would communicate their knowledge to the student so that the student could make sense of the clinical area. Students were aware of the testing procedures and would be motivated to increase and draw on their bank of information to pass the test.

Student centred learning

The aim of student centred learning was to "make the students responsible for their own learning" (Ann Int1) and was consistent with the overt curriculum design. Tutors prepared and revised material (referred to as "packages") which began with a set of learning objectives specific to their module, usually written in behavioural terms, and containing up to twenty or more pages of work.

The following extract illustrates further this technical-rational approach to education which emphasises not only content but having the 'right' kind of content (that is, to make students safe and later employable in the practice setting). Tutors, in general, believed that package work made students find their own answers and learn the information independently but many still felt obligated to check that this was happening. This extract also demonstrates the common concern of the tutors in this study that perhaps student nurses were different from other students. Many tutors expressed this concern but most wondered whether the course encouraged students to develop compliant behaviour.

I discovered that there are quite a few people (tutors) get their (completed) packages in and look at them. ... there's the fear that somehow or other (students) mightn't be learning and it's kindness - its out of kindness that somehow or other they mightn't be learning and

you might only discover it at the last minute when they've failed the exam or something - and it's too late to - I was going to say "rescue them" - I hope it's not that, but it's too late. Maybe they've got to pass on to the next module or something.

I do have some thoughts about this student-centred learning in that I wonder if developmentally the average seventeen year old is able to - the only thing is - I have some conflict there - is that at University - there's still the same seventeen year olds - or are they? - are they somehow or other a different group that comes in here, but I'll assume they are not - ...What I'm wondering is that if the group of students who enter a nursing studies course aren't more - a little more dependent - a little more potentially compliant.

Karen Int2

Thus it is assumed that the difficulties encountered in getting students through the student centred learning material were attributed to the personal deficits of the students. Here the assumption of personal deficit masked the processes in the course which encouraged or demanded conforming behaviour. Karen is unable to relate the compliant responses of her students to institutional or contextual influences but she is also hesitant in describing them as predisposed to compliance.

One of those processes was the practice of "marking" student centred learning packages - which could be instrumentally justified as this tutor explains:

...but the students, because such a big deal was made of the packages in the beginning, the students I think feel a certain security with the packages. And they believe, if they've got a package, that's it. You know, fill in the blanks and away we go. We've actually had quite a few this year, who wanted leave for various reasons, and they say "But it will be all right, so long as you give me the packages, I can do the packages". And the packages are becoming very dangerous and we actually are trying to eliminate some of them.

Yeah. Quite a few of the students haven't done them ...

Yeah. Right. Because some of them of course are not... I had two or three in my areas but I used to make the students hand them in and I actually gave them a mark for their package work because I feel that if it's worth doing, it's worth getting a mark for. Now lots of people disagree entirely with that, and they are entitled to it. Because they say "you are breeding a mentality that says - if I don't get marks then I won't do it". But you see... much as I love my job, I probably wouldn't

keep coming here if I didn't get a pay packet every week. And I feel this is how we pay the student, we pay them in grades, and if we ask them to do something, and that's not counted in - um - then I think we can't really expect them to do it.

Emma Int3

In this way, what was intended as a process to enhance the student's self directedness became a tutor directed teaching method where students were 'paid in kind'. Although not all tutors ascribed to this the expectation was that tutors had the responsibility to ensure that the work was done.

Although the intention was that students become actively engaged in their own learning, learning packages and testing procedures encouraged students to be passive recipients of 'essential' knowledge. The following journal entries illustrate tutors' concern with this:

Today... answered a few queries on their package work. Its not my section - which meant that I had to read the section through and I had difficulty sorting out what was being asked of them. We ask for too much - expect too much detail - this work must be reduced.

Kay 15/4

Students were asking what will be in the test - their anxiety levels are way up. My reply was that it is a nursing oriented test - not conditions - but the module is still condition oriented. I feel strongly that we expect too much of these students - my colleagues seem to want to impart ALL their years of knowledge

Kay 19/4

Today was aware that I was asking students knowledge of the clients and their care - at times it was too much for them. Let them know that I didn't expect answers to everything - but I hoped that I was showing them what they should be considering. Told them I wished I had been made to/allowed to think as a student.

Kay 20/4

Later in the process of reflecting on her unease about a test this tutor located this contradiction in the 'expectations' of tutors.

It is really making us look at the questions we are asking. And we've just been - one question a lot of them have failed and it was their

response to a patient saying something and you know, a lot of them were failing. But when we went back - a lot of the tutors had failed them - but when we went back and aired it as a group, perhaps some of the tutors were failing students because they didn't come up how *they* would have answered it. And I know (in one module) we kept saying we can't expect the students to write down what we would say. And as long as they show in their answer that they are listening to that person and say something appropriate, but we can't expect that they write down exactly what we would say. Because we've had years of experience - how to handle that question that the patient made.

How was that received?

I think that changed a few answers actually. I felt quite good (laughs).
Kay Int3

These extracts illustrate the tension between structure and agency and the unobtrusive exercise of power within the hierarchy of the institution to produce conformity. Tutors required students to answer test questions in a particular way to "demonstrate their learning" and to ensure that they were able to pass the state examinations at the end of the course. At the same time they expressed the belief that students should be autonomous learners. Thus their insidious use of power was not necessarily a conscious act - they were also constrained by the institutional ideology which they knowingly or otherwise sought to perpetuate.

This tension was also evident when "good" students did not meet the course requirements either in clinical practice or in formal tests. For example, as the following journal entry indicates, tutors were often puzzled as to what to do about those students who "displayed their knowledge" in the clinical setting yet could not write it down at exam time. The tutor here reflects on the "tenuous link between academic and practical competence".

I was sad to see the end of the class (module). I felt that most students became competent in theory once it was linked to their clinical practice. The problems that came up in their end of term exam were related to difficulty in written expression rather than a knowledge deficit. One mature student had seemed to be totally organised, in control and

competent in (the) ward but on her test paper she didn't have enough information. On the other hand a student who had great difficulty organising her (clinical) work, her clients and her report giving, wrote model answers in the exam - this illustrates again the tenuous link between academic and practical competence.

Robin 11/8

All the tutors taking part in the study, were aware that tutors defined all phases of the teaching-learning transaction. Tutors knew what had to be learnt and designed the modules to transmit this information (knowledge). As Karen explains:

... - because we design - we set the objectives - we set the learning objectives - I mean that always follows after I've decided what the content is going to be - but anyway - some objectives end up there and I say to them "Look these aren't just words, they are to try and aid you". If you feel "Where am I going?" - look back and see those objectives and see if you could meet them, and it might give you some support if you feel you have lost your way through a whole package - but I mean - I know that we - the only thing that we are not setting is the amount of time they are going to give to something, whereas when I was a student - if you worked for 32 hours - and we weren't able to control that, that only left us with a few hours in which to develop something further, or work if you wanted to, and that was in our own time. So - you know, we were fairly spoon fed. These students aren't as spoon fed, aren't quite as spoon fed, that's my view - but I'm still setting the objectives, I'm still deciding.

Karen Int2

All tutors became increasingly aware and uneasy with what they now saw as their power to prescribe what and how the student learned. It was decided that one way of changing the balance of power between tutor and student was to ask students to write their own learning objectives. This idea was explored by all the tutors in the study and eventually implemented in different ways. In the following dialogue Karen reflects on the practical effects of such a change and her need to continue to prescribe objectives herself.

I know (another tutor) talked with you the other day about students setting their own objectives. Yes that's right. How did you feel about that?

Well I think it's a really good idea. And actually it's terribly safe, I don't think anything could go wrong. I mean, - clinically it's really

sound. I still feel that necessity to say this is a learning objective - that you might need it if you are going to have a reasonable education as a nurse.

Karen Int2

Karen's concern was for the student who might miss something if she was not told what she should be learning. It was the tutor's responsibility to ensure that students had the knowledge they would need for clinical practice.

Knowledge through enquiry

Seeking answers to questions and encouraging students to ask questions were techniques used to shape student discourse about their practice. The tutors intended to provide opportunities for students to explore their understanding of the phenomena they encountered in the clinical area. However, it could be said that tutors asked students questions to which there were prespecified answers in the mind of the tutor. Students' responses were then evaluated in relation to this prespecified knowledge and tutors provided appropriate feedback to the students. Thus the tutors' intentions were contradicted by their actions.

As this tutor explains, classroom knowledge was extended in the clinical area through tutorials where students were encouraged to translate theory into practice. In this way students could unintentionally demonstrate that they were "learning".

They ask you a lot of questions. They say "Oh is this what we learnt in class?" - when we are talking about a condition and that sort of thing. We have a lot of tutorials in the clinical area and they take their client, and you might do nursing care and you might talk about the disorder, and you might talk about it to someone else who's - none of them are looking after this, but they have a contact with it in the ward - Mm. And they disagree about, you know, what's happening or they can't understand. ... you know we talk about it - and they'll come up with things, in keeping with the class situation, and that's good because you realise that they are learning.

Lyn Int2

Thus learning was manifested through their practice. Other tutors explained that in clinical practice students "began to see the point" of the theory they had had in the classroom. For example, Lyn explains:

There is a different feeling you get after they've been out in clinical for a while, and they can relate the theory back to the class situation. And they see how it all fits in. That seems to be an important part of the learning in this module.

Lyn Int2

Although this meant repetition of class work for both tutors and students it was considered essential to introduce the content necessary for the clinical area in the classroom first, mainly to ensure safety to practice. Then tutors would "draw the information out" when students were in the clinical area. This was a traditional 'tried and true' way to learn as Lyn explains:

Well I think they need some preparation and some concepts and some time to sort of think about some issues and think about how they feel about going into the area, and um - you know we look a lot at safety during the class time and that's a big fear. So I think it probably is better, because otherwise that means that they just go in and they are just new, so they don't think about it or anything. And too, probably we have to cover so much theory because they all go to such different areas. So yes, I think it is, it is good preparation for them.

They relate a lot of things back to each other too. I guess that is one of the big things about learning, that's how I learned as a student, people you've nursed and that - you relate it back.

Lyn Int2

Furthermore structural constraints precluded "classroom" teaching in the clinical area - theory belonged in the classroom.

So, could you just have a couple of days in class as an orientation and then put them straight into clinical and do all your theory/practice together?

I think that could work, but our problem with that working would be the clinical placements - like so many of them go off (elsewhere) - we haven't got enough places to place them.

Lyn Int2

As Pip explains, the difficulty that students had in applying theory to practice lay in their inability to understand the "different approaches of different disciplines".

I found that the students have a lot of difficulty applying the theory to the practical and get terribly confused because lots of - there are lots of other sort of ways of looking at a problem or even looking at a diagnosis may be quite different to how they have learnt it in theory and they get into the clinical area and they hear all these different approaches from different disciplines. It is very confusing for them. But so - I try to keep it really simple, the basic ideas...

Pip Int2

The implication here was that students should use the theory they had been given in the classroom rather than theorising from their practice.

The instrumental assumptions inherent in confusing expertise with 'knowing a lot of information about a clinical phenomenon' were not always left unexamined. As tutors developed greater reflexivity these assumptions were a source of frustration as they recognised the inconsistencies and tenuous links between classroom and practical knowledge in the uncertain world of clinical practice.

Knowledge Through Dialogue

The development of experiential knowledge was dependent on individual students making connections between classroom knowledge and clinical knowledge and developing dialogic relationships with significant others (eg charge nurses). This kind of knowledge was difficult to communicate to others and therefore difficult "to test" but was seen as essential for competence in the practice settings.

How do you know for each particular student - how do you assess their knowledge base...?

Just with talking probably. And that testing as I said, and on an individual basis in each clinical area. But we are not there when they are making their on-the-spot judgements and when patients change or something happens - so they have to have enough knowledge and enough confidence to be able to change that plan.

How do they get that?

I think they get that from normal practice in the area they are working in - they get it from previous experience in their second year of nursing. I think by the third year they are getting better at that because of their previous experience. I wouldn't expect them to do that in the first year. It's changed by the time they come to me. Yes. Those two factors. And they've been guided by the staff and having a good relationship with the charge nurse or with whoever else they've worked.

Ann Int2

Many tutors described ways in which they and clinical staff talked to students to "draw out the theory" and help the student make connections between classroom and clinical knowledge.

Personal or habitual knowledge was gathered by students in a haphazard way through clinical experience and 'learning on the job'. This was more difficult to evaluate than classroom knowledge as it was context bound or 'local knowledge' (Benner, 1984). It was also a target for assessment:

Although I did say today - I did reassure them today for example that their knowledge deepens as they go through the clinical area, because we use a lot of informal tutorials in each clinical area... And they have - when they are allocated clients at the beginning of each day then we go around the unit or a tutor goes to each student and say "OK, tell me about your client". And then we see whether they've assessed - or what they have assessed on the clients and quite often we will - the tutor will look at the client's notes if we're not sure what is going on - and we will formulate our own priorities if you like for that nursing area, and we will ask the student just what the (nursing) objectives for that person are. That's most of the time and that's particularly at the beginning of the module and particularly at the beginning of the clinical area. So hopefully having that knowledge it will help them planning care (for the patient).

Pip Int3

However, after considerable reflection on her own practice one of the tutors began to explore the meaning that a dialogic relationship might have for her practice. Freire and Shor (1987:98) suggest that dialogue is a challenge to existing domination. Through mutual inquiry the teacher and the taught engage together "to

know" the object of study. Thus the teacher relearns through studying with the student, dialogue illuminates the material to be studied and the learning process itself challenges the authoritarian position of the teacher.

In the following extract Kay's excitement about this different kind of relationship between teacher and learner emerges:

I felt different when I went into this group this time. And I think probably from our talking too, I went in feeling a lot more confident in myself.

Did you?

Yes. Nothing to do with subject matter. Just feeling I think, better within me. But I went in - and I suppose letting them set the objectives helped as well because I had let them know that this was new - let them know that I was starting to put objectives together and they could too. I got them involved and I said "I want to know too what you want out of these two weeks, and I want to know at different stages throughout these two weeks. I was very aware that throughout the two weeks that I was involved with them, I was saying to them - you know "Is this what you want? - Can we negotiate it?" - And I had never done that before you see. But I felt comfortable doing it this time.

Kay Int3

However, in this instance, dialogue between tutors and students could be seen as a technique for "drawing out" prescribed information and received knowledge. In this way, although the intention was to assist students to find their own answers, dialogue here was a manipulative teaching technique which ensured that "the inherited, official shape of knowledge was confirmed" (Freire & Shor, 1987:98).

CLASSROOM AND CLINICAL EXPERIENCE: WORKING IN TWO WORLDS

This section provides an overview of the ways in which tutors made sense of the contradictions inherent in teaching in institutions dominated by technical-rational models of management and education while endeavouring to practice from a different frame. From both the polytechnic and the hospital perspectives nursing education was premised on the instrumental notion that ‘real’ learning took place in the classroom (where ‘teaching’ took place) and was consolidated by practice in clinical settings (where ‘nursing’ occurred). This notion was constantly reinforced by the structural arrangements (institutionalised practices and procedures laid down over many years) within which the course operated.

One tutor described this experience as follows:

For those of us where our background is largely community - we get brought in here because of our skills, but in fact when you get in here, you lose your clinical skills fairly quickly because you are not actually out doing any tutoring (in the community). Because of the huge load of clinical teaching and supervision that is required in the hospital areas, you end up when the first years are going (into the hospital) for the first time - pulling in every tutor... and it often means that community based people are having to go into hospital wards where they feel (ridiculous) - they maybe haven't showered somebody, given an injection, given a bedpan for some time because we don't do that sort of thing on public health, so they end up inadvertently doing quite a bit of their clinical in the hospital but doing very little clinical in the community.

Emma Int 1

This situation, and others like it, created a major dilemma for all tutors. They were employed by the polytechnic as tutors and must therefore be ‘teachers’ - the assessment and promotion system was based on the premise that they were first and foremost classroom teachers. But almost half their work time was spent in one or more clinical area where they not only worked with and supervised students but, of

necessity, had to demonstrate their clinical competence to their peers to maintain their credibility as a nurse. As Emma explains, tutors "worked in two worlds":

And I think it is one of the problems of working in a Polytech that you've not only - OK the students' clinical experience is very important so you are working within - you know the hospital system, public health and whatever, but you've also got that set of rules that we have to - you know be seen to obey with good grace because we've got a function there, and then you've got another set of rules that are in the education system that you've got to work to - and so the tutors are often - they are working in two worlds - and it is very easy only to see the problems....

Do you think of tutors as being nurses or teachers then?

Ohhh - yes quite definitely ... I think of their primary responsibility as being teachers, but I think they function that way because I think a lot of them are good teachers - but they are good nurses too and they really believe in what they are doing as a nurse and they want to kind of get that through to the students. So I find it hard to separate the two.

Emma Int3

This was not just a matter of dual responsibility or even role diffusion. Rather this dilemma demonstrates the way in which the individual's consciousness of self 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. As Pip and Carol explain:

As I said to you the other day I have a lot of difficulty trying to reidentify - yeah, reidentify myself. And after sort of accepting that I'm a tutor and seeing myself in that way, I then found out that it was still OK to say - you know - that you are a nurse, and so now I feel quite comfortable in marrying the terms - saying I am a nursing tutor.

Pip Int2

I sort of - have still got that bind - am I tutoring or am I nursing? - Do you know what I mean - but I can see the time I would sort it out, and it's made me think I really like tutoring.

Carol Int3

For most of the time I felt I did function in the 'tutoring' role but there were times when I felt very much a staff nurse

Carol 26/11

Thus consciousness of self was not constitutive but could be seen as being constituted by the general social and structural arrangements in the polytechnic and clinical agencies. In this way, tutors (like students) were as much engaged in learning those elements of a professional culture which imposed a preconception of a professional self as they were in reproducing them. Tutors were caught between two cultures both of which demanded clinical and teaching competence. But, as Ann explains, the conditions of their work prevented tutors from maintaining their clinical skills except through the students with whom they worked:

Yes you do (lose clinical skills). I think tutors do - because you are not given the opportunity to demonstrate it. You do it with students but you don't do it with patients.

So do you have a sort of um - case load through students instead of...

Well you are acting with the patients that the students are looking after - you are doing that all the time - you go and meet them talk to them, and assess whether the students have given them the information that they wanted to hear - that sort of thing. And thank them for having students sometimes - just see how they feel about having students...

Ann Int3

Students too were aware of this dilemma and its practical effects on their educational experiences. In general students appreciated the assistance they received from "good tutors":

I think the best tutors that I've had are the ones that have just come in from actual nursing themselves and have had more nursing knowledge. The ones that have been in for ages - they are just out of it... To me it seems as though they can't identify with students"

StuOb2

And another student commented:

We did find that with the tutors that had been tutors for a long time... they are just so desperate for - not wanting to be horrible - but they just seem to be so desperate for client contact that ...(they take over)

StuOb1

Students resented working with tutors who "fluff around" and didn't have the local knowledge necessary for credibility in the clinical area. As one student summed it up:

Their fluffing and fussing rubs off on us. The ward staff just think that if the tutor is like that the students must be hopeless too. I'm sure that's why we get such a hard time in (the ward) - the tutor is out of touch with what they do there but she's never around long enough to get up to date.

Stu16 7/7

In a subsequent group interview students suggested that tutors needed regular refresher leave in order to:

...learn - how to work in with others again - you know in the team so that when they go out there, they are taking their students around and trying to teach them how to work in they at least know - how to manage it - a heavy nursing workload - and teaching somebody else to manage that - without doing all these wonderful things there's never time for....

STUOB2

In spite of this, tutors were often used as a resource for clinical staff and they gave assistance to the clinical staff in times of crisis or short staffing. Since many of the tutors had recently worked in a particular clinical area, often in senior positions, that was the area they went back to as a tutor. Tutors were often concerned about the contradictions this situation created. As the following journal entry indicates their responsibility was to create a conducive learning environment for students but they also had a responsibility to maintain standards of patient care.

And I think I'd think much more about the patients now, in relation to the students, and I can sort of see when care is fragmented and how frustrating it must be - I think I am more aware of things like that. But it's made me think too, more about tiredness and pressure on students and how your performance does drop - and that coping skills - these are important things to learn I think. And I think we are asking them to work 8 hour shifts, - where you do have ups and downs and little lulls in your (own) work, - that you do expect students to always perform.

Carol Int2

And last night I got home, I thought "I really don't feel very good about this at all". I felt better this morning after a good night's sleep. But not about the whole ward thing - I was quite happy about that - but just about my personal feelings - what happened last night - fragmented care of patients and things like that.

So that was the nurse talking?

Yes. It was very much so.

Carol Int2

And as Ann explains, the conditions of her work were such that little reflection or change could occur.

Oh it always seems to be hectic in the clinical area - as a tutor, even when there is not many patients there - you are sort of on edge and preparing for the next thing that might happen. And trying to keep up public relations with the staff that belong there and that sort of thing. And thinking of what you should be going over with the students.

Ann Int1

Tutors, however, did not always expect that there would be a dialectical relationship between 'classroom' and 'clinical' learning. The following examples illustrate this point:

I don't think I've taught them heaps but they learn a lot from the clients themselves and on each different duty there is something new.

Does it matter that you are not actually teaching them as you see it?

Oh I think they are learning by other ways - just by being there they absorb a lot and they learn just from looking at us and hearing our conversations with the clients.

Ann Int1

I think they need some preparation and some concepts and some time to sort of think about some issues and think about how they feel about going into the area, and we look a lot at safety during the class time and that's a big fear. And too, probably we have to cover so much theory because they all go to such different areas.

Lyn Int2

Other tutors commented that they enjoyed student's "seeing the light" when theory and practice came together in clinical experiences but they were unwilling to

explore other ways of achieving this (refer to p128). As Lyn and Ann explain:

There is a different feeling you get after they've been out in clinical for a while, and they can relate the theory back to the class situation. And they see how it all fits in. That seems to be an important part of the learning in this module.

Lyn INT2

...You know you commented that one person said that she could see the point of all the theory now?

Yes! (laughs) Well that was a relief really because they had been really hammering us about giving them so much stuff in class and how they couldn't see the relevance. I think what I've got to learn to do is see them where they are at when they come with this information, because it's easy to feel threatened by that and think "Well maybe I'm teaching them too much theory, or maybe they are right and I shouldn't be doing this, that and the other. But when they come and say that and when the light dawns later then you realise that it is all right, what you have been doing is OK. You seem to need their reassurances - most of us - I do anyway - that it is OK.

It is pity that there isn't some mechanism to get them over that barrier a bit faster so that you don't actually have to wait for the two weeks in class and then out into clinical?

Mm. I tell them in class that - you know when they are getting really bogged down - I always say to them "It will all be revealed" (laughs). They look at me and say "Oh yes?" - But it is. And it just unfolds this process of learning ... but it doesn't really happen until they get down there and they see it.

Ann Int3

Moreover, tutors believed and students agreed that classroom teaching and learning *ought* to lay the foundation for learning in clinical practice. The more clinical experience the student had, the more she could see the connections between what she learnt in the classroom and the people she nursed.

In the following extract a tutor explains changes she might make to her teaching areas to bring this about.

...the content might be OK, but the emphasis might need to change perhaps. I felt what they have in their packages and what they have in lectures is very much what they do in the ward - you don't want a narrow focus either - it might be important to have a broad idea about it.

So does that mean that you can actually cut down your class time, and do a lot more clinical time?

At the moment, they have two weeks and then six weeks clinical, Friday mornings also been taken up for class work - I think in our evaluations we've taken from the students, they found they needed the time to do their package work - I suppose we could teach more of it clinically but - we are already using the clinical room as class time. But it would be I think more of the emphasis that I would want to change rather than the content - because you have to have a basic line - be safe - I think that is important to build on.

Carol Int2

That students did not always agree with this last interpretation is not surprising since it was dependent on the individual student's experience. The willingness of clinical staff to provide the "right" experiences, the skills of the tutor and the climate in the often complex context of clinical practice were crucial. On the one hand students could not always "use" their classroom knowledge in the clinical area, and on the other hand they waited until they were in the clinical area to learn particular kinds of classroom knowledge.

(Learning objectives) are very idealistic, because often when you get into the wards, there isn't the right kind of patients in there to get the experience or you are not put in the position where you can meet them really. Sometimes you are buddied with another nurse and so you haven't sort of got the autonomy to go ahead and do some of the things that the objectives point towards.

CCStu

Ideas - that's fine, you can still keep the ideas and principles, but that doesn't always say that you have to write a long description of the care that you give. Because that is basically what we are talking about at Polytech... "A nurse does this!" We know what nurses do!"

StuOp1

Student discourse indicates that they expected theory to be demonstrated in practice (refer chapter seven). They had been led to believe by tutors and others that this exchange would occur if they 'worked', that is, completed their packages and passed the tests.

They understood that they would consolidate their classroom knowledge through practical experience in nursing particular patients within the structure of the ward environment. Both tutors and students believed that both tutors and ward staff would contribute positively to the ease with which the student could integrate and put into practice new knowledge. As this student explained:

I really feel part of the team now which is really great. I get to do heaps of different things now and meet lots of different people...No matter what area you are in the staff have a big influence on how your experience goes.

Stu30 11/10

However in spite of the expressed belief that tutors and ward staff would 'help' students, there was a largely unspoken agreement that this was entirely dependent on the people involved. There were many students who said that the value of their clinical experience could be almost entirely negated by the attitudes and beliefs of the nursing staff in the clinical area. Thus distorted communication produced passive resistance in students and the need to conform with existing practices (refer also to chapter seven). For example, these students who had worked in different clinical areas, explain:

Thank goodness the (clinical placement) has come to an end. I think the last week has been the worst - I absolutely hated it - or should I say the staff there. I have never come across a group of workers that have bitched so much about each other before. As a student I felt as if some staff held the opinion that we were lower than the low. End of subject.

Stu15 15/7

...they didn't really try - I didn't find in the ward that I was in - they just sat around and smoked all day and they hardly even talked to their patients - just sort of get them up, and I didn't find that very good at all, and I just - I don't know -

I didn't find it very good at all - they were all new to the area, but they just - they get the patients up - then they just sat - the staff were a bit like the patients. I wouldn't work there. I would rather be on the dole than work there. I never felt satisfied when I came away. I couldn't work there. No.

STUOP 3

Furthermore, the confusion as to whom they were accountable to for their clinical practice contributed to the discomfort students experienced during their clinical placements. They explained that they could not always rely on a tutor to help them.

It is very difficult to know who is in charge because you check something out with the charge nurse and it is OK with her but often with the tutor it is a highly different procedure - and you are left thinking.... And the patient gets embarrassed...

Does that happen very often?

Too often to be comfortable.

St3B1

This kind of distorted communication produced discomfort at the psychological level and prevented any opportunity for rational dialogue between the student and the tutor or the charge nurse.

Students generally explained that there were two kinds of tutors - there was much to be gained from a tutor who "keeps her distance and lets you relate to the ward staff" (StuOp1) and there were those who "hover - it makes me extremely nervous and liable to stuff something well and truly up!" (Stu28 22/7).

In the following group discussion four students explain that their experiences indicate that they were "better off" without tutors in the clinical areas. (The symbol { indicates a new speaker)

I think you've got to sort of be aware that some of the tutors can take over too. Well I found that with one particular tutor. I felt - she came in and introduced me to the client, and then she proceeded to talk to the client. And I went to go and talk to him and we just had nothing to talk about because she had nicked off with all the -

{ good stuff.

-good stuff. So I never had a good nurse-client relationship. We saw each other as a pain in the neck.

So his relationship was really with the tutor who disappeared.

Yeah. We did find that with the tutors that had been tutors for a long time. They are just so desperate for - not wanting to be horrible - but they just seem to be so desperate for client contact that ...

{I mean they just seem to think to themselves that everything's to be like in the text book, but you can't do it like that all the time. It just gets a bit frustrating at times.

{And then you would be wondering - is she going to pick up on some small thing that -

{... in that module that's not really important - but - you know, your confidence just goes down when that happens]

Mm. I think you tend to learn more if they are not there. I mean it is good if they are there as a reference - if you get stuck.

StuOb1

These comments were typical of the experiences students reported in many clinical areas. Students felt unable to be in control of their own practice and unable to discuss this kind of situation with the tutor. Tutors were able to define the limits or boundaries for practice in the clinical setting. These situations illustrate the ways in which the unequal relations of power in the clinical context limited students' choices for autonomy and responsibility.

The common sense ideology of the student's "personal deficit" maintained and recreated a belief in the benefit of hierarchical relationships. Students were tolerated as learners - ignorant in relation to practising nurses, and tutors could be labeled as clinically incompetent since they too could be seen as 'outside' the clinical agency's culture. Tutors often did not have access to the local cultural knowledge necessary to be credible as nurses. Nor did their conditions of work allow them to maintain their clinical skills to the level that was acceptable to many of their peers in the clinical area. They were as much caught up in the differential relations of power in the clinical agencies as the students were.

The contradictions between classroom knowledge and the students clinical experience were often quite clear to everyone involved but went largely unacknowledged between tutors and students. Tutors, however, were well aware of the difficulties students faced in some clinical areas but felt "helpless" to do anything about it unless they felt it was "unsafe" to have students there. They were dependent on finding sufficient clinical placements for students in a shrinking health service and were unwilling to jeopardise traditional placements.

In this way "common sense" reinforced the structural arrangements which contributed to the contradictions students experienced between their classroom and clinical learning experiences. One tutor in particular was well aware of the contradictions between what she taught in the classroom and what the students saw and experienced in their clinical placement. During this interview Jane explained the difficulty of placing students in clinical areas with few registered nurses even though tutors generally explained that "the (student's) clinical judgement is based on knowledge that's role modelled" (Ann Int1).

But the staff they have there mostly are enrolled nurses and hospital aides. In an attempt to introduce the nursing process, they allocated their staff to patients. But the staff they allocated were hospital aids and enrolled nurses!...

But you know, when you see what's happening out there and in other places they want pairs of hands, and whoever is there is going to have to do the work that is there, regardless. They are not going to get enrolled or registered nurses. Because the hospitals haven't got money for them. So that is sort of the structure out there at the moment.

Jane Int2

Students too were aware of these contradictions and felt it unjust that they should train for three years to do what aides with little training did in this particular hospital. They believed in a "fair exchange" - they would work an eight hour shift in a clinical area as a student without pay in exchange for learning experiences

which would lead to increased knowledge to assist them to pass their examinations. They felt "let down" when this exchange did not occur. They were also aware that the tutor could do little to change the situation.

So what - at the hospital itself, what did you learn that you didn't already know?

(All laughed)! -

Nothing. I might of- um - I didn't learn anything - the only thing I did was probably improve a few skills that I hadn't done much of.

[I think the basic feeling of the group of us that were out there was that we were just ... you know ... we were waiting until we got back into the real world.

St3B1 Int2

Basically, they (tutors) really don't want to rock the boat because - a lot, we've been told a lot of times - if we go along and we do something to annoy the staff, they can quite easily decide you know, well we don't want your students in the hospital anyway, and that wouldn't just be our course.

St3B1 Int2

Tutors (and students - refer chapter six) explained that clinical placements were often a matter of expedience and that they had a responsibility to ensure that students did not "upset" the clinical staff. Patient care was the primary function of the clinical area and nursing education subordinate to that. On the other hand students, and occasionally tutors, were used (unofficially) as unpaid labour by the clinical agencies at times of staff shortages. Tutors were reluctant to withdraw students at these times as it would be considered to be poor public relations and it was thought to be a good learning experience for the student.

Close observation of the student's practice and assessment of her knowledge in the clinical area was a responsibility taken seriously by all tutors. The quality of patient care that students gave was paramount and students must be "safe to practice" for the patient's sake as well as for their own.

As Ann and Carol explain:

We try to build in the safety factor by seeing each student, letting them tell us what they've assessed in the client. And if there's any particular concerns we'll go and see the client.

We instituted (practical exams) about two or three years ago because we felt that we didn't really have any way of assessing formally their clinical safety. So we tightened the structure up and we had what we called a clinical objective. When they go into their clinical area, they have an objective - a page of objectives for each area, and we go over each of those objectives with them for every area, and if they are not able to meet the objectives - say by the middle of the week or whatever - then we will try to arrange for them to meet them. So that's tightly structured.

Ann Int2

I think what the things that we are assessing are the basis, the basic sort of things - to do with safety really. Although, I think we do assess, communications and attitudes and things like that, but perhaps it is more at the conscious level. I mean it is - it does really interfere with a patient's safety I think if the nurse doesn't listen.

Carol Int1

However, the 'safety to practice' dogma was often used as a controlling mechanism - a bottom line for clinical practice. In this way prespecified clinical objectives and authoritarian relationships could be instrumentally justified and used to reinforce dominant ideologies. As Allen (1990:313) points out "the responsibilities for life and health create a sometimes morally overwhelming burden for (nursing) educators ...it creates an anxiety that transfers to our attitudes towards students ... if they make serious mistakes in clinical their failure reflects on us". Thus ethical questions may be reduced to matters of safety - that is one of the ways in which practical rationality gives way to technical rationality.

SUMMARY

The data presented in this chapter provide a clear picture of the ways in which tutors at this polytechnic talked about and understood their practice. Uncovering their understanding was facilitated by the research processes of critical discourse and reflexivity as discussed in chapter four. From the data the ways in which contemporary practices reinforced and maintained the legitimacy of established values, beliefs and practices become very apparent.

Tutors, through the processes of self reflection and dialogue, developed a greater awareness of the ideological basis for their current actions and the fundamental contradictions between their intentions and their actions. They did not however proceed to transforming the conditions which they found constraining nor were they able to penetrate and transform those beliefs and practices that constrained their own work as well as students' educational experiences.

The socially constructed and legitimated authority of tutors and practising nurses over students in the comprehensive nursing course was clear. Although the tutors' expressed intention was that students should become autonomous learners, the actions of tutors and clinical staff largely prevented this. The student centred learning packages and strategies such as informing, questioning and discussing gave the illusion of student empowerment while leaving the authoritarian nature of the tutor/student relationship intact. This aspect of the research is discussed more fully in relation to student discourse in the next chapter.

In the next chapter, data from student interviews and journals is presented as students speak and write about their experiences of comprehensive nursing

education. In particular it will be demonstrated that students experienced a continuity of professional culture as they attempted to satisfy the requirements of both tutors and practising nurses. But they experienced a disjunction between their personal beliefs and knowledge developed in the education setting and those they found in the practice setting.

CHAPTER SIX

STUDENT DISCOURSE

This chapter provides a descriptive and interpretive analysis of student discourse gathered during interviews and from their journals. In all, thirty eight students took part in the study with twenty eight keeping a journal to record significant events (refer to chapter four). Student discourse in this chapter reveals the ways in which students negotiated the 'common sense' realities of their experiences in the comprehensive nursing course. The purpose of the chapter, then, is to draw together the theoretical issues discussed in chapters three and four and students' reflections of their experiences of teaching and learning in the classroom and in clinical practice.

Themes emerged from both interviews and journal entries which seemed to be significant from a critical perspective. These have been identified as representing students' views as individual members of a group experiencing the comprehensive nursing course. Each extract from interviews and journals represents similar comments made by all students and constitutes a main theme occurring in student discourse.

The chapter is organised around these four main themes - *student centred versus tutor directed learning; reproducing nursing culture in classroom and clinical settings; tutor-student relationships; and post graduate employment.*

STUDENT CENTRED VERSUS TUTOR DIRECTED LEARNING

The aim of student centred learning was to "make the students responsible for their own learning" (Ann Int1) and was consistent with the overt curriculum design. Tutors prepared and revised packages which began with a set of learning objectives specific to their module and usually written in behavioural terms.

Students, however, experienced this work as tutor directed rather than student centred. All the students involved in this study commented on their packages as being of overwhelming concern in their attempts to make sense of the requirements and content of the modules. The following journal extracts are typical:

The module has started - and left me floundering. A tidal wave of information to take in is too much plus the package is vague and not set out in a clear and constructive manner making learning difficult and frustrating. The verbal information given to us about all the bits and pieces has left me confused... I will have to go back to the tutors for more specifics.

Stu15 23/5

We got off to a racy start - four packages! Mind you that doesn't come as a shock any more... Anyway I was stunned and amazed that the tutor had put a text and page number references in the packages. After endless hours looking through endless pages of endless books trying to find answers - if I'd wanted to be a reference librarian I wouldn't be nursing.

Stu33 28/5

We have just begun another week which involves two more packages on top of the three we got last week. I spent an hour tonight getting very frustrated looking up texts where we have been given references only to find I have to read thirty pages (when we have been given two) only to find the information I want isn't there and if it was I'd have to read it several times to understand it.

Stu 36 30/5

Well, first day of the module is over and I definitely know I'm suffering from sensory overload. We got four packages thrown at us, plus we've got more to come. I can't wait.

Stu3 23/5

Students understood that they should complete the package to "get" the knowledge they needed to function in the clinical arena.

I'm sure this information is important for our learning but sometimes I waste so much time trying to find it. ... I find I'm rushing through the packages to get the written work completed and not really absorbing the information "it will all come together in practical work" (tutors say) - if we get the opportunity to see the conditions we have studied.

Stu36 30/5

Students were led to believe that they were relatively ignorant and needed all the "theory" they could get to pass the modules and the course. Evaluation of the student's progress was mainly by structured tests to decide whether or not the student had "collected" the knowledge the tutor was trying to transmit. While tutors were constrained by the overt curriculum (the modular system and student centred learning), students were constrained by the discrepancies between the overt and the hidden curriculum. It will be shown later in this chapter that these discrepancies and contradictions distorted the communication between tutors and students.

The students also understood that if they were going to complete the packages it was simply a matter of "getting on with it" and seeking assistance from tutors where necessary even if they did not get all the assistance they wanted.

...then we got all four packages today and the usual confusing info... even worse when you find out that they're only for this week. However once you actually sit down and start it doesn't seem so bad.

Stu38 23/5

Once the initial shock of lack of informative textbooks and the amount of work to be done was over things seem to sort themselves out. The tutors once approached for more specific information... were more definite about what they wanted although I feel they guard how much information they give you. I suppose it's so that you do your own thinking on the subject and not use theirs.

Stu15 5/6

The tutors - just generally speaking - the tutors that are just fresh in from the field and have had their hands in, they are usually the most

interesting because they are up with the play and ... you get all the information out of them, whereas the other ones - you just get it in dribs and drabs.

StuOb1

In this way students felt that tutors "guarded" their knowledge, thereby mystifying and controlling the students' educational experience. Students generally said that they felt "let down" when they tried to fulfill their part of the bargain but the tutors work in the packages was out of date or inaccurate. It sometimes became a "guessing game or a lucky dip where we can't win" (StuOb1).

And then you go and find things that are photocopied straight out of a book, and you sort of think "Well they tell us not to do that - and look here they are doing it themselves". So those sort of things get a bit annoying.

Do you mention those things to the tutor?

Oh it's not worth it. Not worth mentioning. You just sort of go "Hehehe! I know where they've got that from".

StuOb1

{But often in our packages they'll say you know, "Refer back to your year one package - such and such for year two".}

[But the packages haven't been updated for a while because the book references are a bit out of date.]

They were referring to this book and they were giving the first edition as a reference and most of us have either got the second - some of us have got the first, some have got the second, and if you go to use the third edition, numbering just went crazy... So we had to tell them.

StuOb1

If you have a package to do then it should correspond with the text you had to buy right? No the text used is available from the library but only three copies. The one we have is rarely helpful as it centres more on medical aspects than nursing. Words fail me.

Stu15 25/5

Although most tutors did not check that students had completed their packages, the students believed that they risked missing important information for tests or for clinical practice if they did not do so. This belief was found to be untenable during

a group interview when several students said that they "had not completed packages for previous modules yet still passed the exams and did well in clinical" (Stu3B1). However in this and subsequent dialogue students said that the third year modules were different because "you need all the knowledge you can get to pass States" (StuCC).

- The learning objectives were devised by tutors and related to the content of the packages and to the subsequent clinical work. Some students commented that these were helpful but in general students said they "just use the objectives at exams and that, I've got some guideline if I want to study" (StuOb2). The following dialogue from group interviews is typical of these views.

We have learning objectives.

And are they meaningful for you?

They are very idealistic, because often when you get into the wards, there isn't the right kind of patients in there to get the experience or you are not put in the position where you can really meet them really. Sometimes you are buddied with another nurse and so you haven't sort of got the autonomy to go ahead and do some of the things that the objectives point towards.

StuCC

You've got some objectives that the tutors set in the packages haven't you?

[You stop reading those after a while.

{I haven't even looked at them. I'm not too sure what the objectives are in theory. I stopped reading them in the second year.}

So they don't mean much?

[Not to me they don't.

St3B1

Following these interviews, discussion with tutors about setting objectives revealed that they had not questioned this process or the relevance of the objectives to the

student's individual learning needs. After discussion with several of the tutors it was decided that they would ask students to set some objectives for themselves. As one tutor explained:

... because we design - we set the objectives - we set the learning objectives - I mean that always follows after I've decided what the content is going to be - but anyway - some objectives end up there and I say to them "Look these aren't just words, they are to try and aid you". If you feel "Where am I going?" - look back and see those objectives and see if you could meet them, and it might give you some support if you feel you have lost your way through a whole package - I know that we - the only thing that we are not setting is the amount of time they are going to give to something...

Karen Int2

Thus it could be seen that the learning objective was a teaching mechanism expressed in student attainment rather than a means through which students could become autonomous learners. In this way the ideological functions of the curriculum (transfer of norms, values and "essential" knowledge) could be maintained and recreated.

The initial attempt at "giving the students some control" did not impress these students however:

Do you get a chance to set your own objectives?

{ Oh definitely. }

[Yeah]

Yeah.

Have you done that?

Well we had to for five minutes in the class, we weren't allowed out until we did it. (laughs)

Well was that useful? I mean, if they are your objectives shouldn't you have the choice? Or do you think it is useful to be made to?

Well we didn't.

{I didn't put much thought into it. I thought - objectives - I just wrote down anything to get out of the class. (laughs) Just finish.}

StuOb1

However tutors in one module decided that they would continue to give back to students some control over their own learning including setting their own objectives.

Well we started using the things we talked about like the students writing their own objectives and we will carry on and expand that further. And probably I think I will try to take it into the classroom too.

Lyn Int 4

However, in general, students found it tedious and time consuming to have to complete the "student centred learning packages". The following excerpt is typical (refer also chapter seven).

Its good to be back in class doing intensive classwork...more efficient than student centred learning (packages). Sometimes I feel SCL is a waste of time. It often ends up that you spend more time looking for information than learning it. I really get up tight about this - it takes more time to learn it on your own after you've wasted the time finding it. Perhaps it's not the problem of SCL but that we're not used to it and I feel some tutors need to improve their methods. Sometimes I feel you don't even need the polytech.

I sometimes think now why did I come here today? To watch a video then go away and learn from scratch a subject we have not even been introduced to.

Stu16 22/6

Through the use of student centred learning packages in this way, knowledge was separated from practice, fragmented and objectified, and alienated from the subjective learning of students. They encountered discrepancies between the formal, overt messages (the student is self motivated and self disciplined; theory and practice will come together in clinical settings) and the informal covert messages (tutors determine what to learn, in what order and where the information will come from). Thus contradictions between what was believed and what was experienced

played a part in deciding which beliefs, attitudes and values became critical in constituting the student's professional self.

In this sense, students experienced this aspect of their education as a denial of their lived experience in both the educational and clinical contexts. They learned to negotiate among the differing explanations and meanings they encountered and to act in ways that were personally and professionally safe. Peer culture allowed students to be highly reflective and articulate in the ways in which they made sense of contradictory knowledge and experiences but there was no formal opportunity to share this with tutors or practising nurses. Thus the dominant ideology and professional culture shaped their developing professional consciousness and endorsed their embodiment of conformity and passivity.

REPRODUCING NURSING CULTURE

Another major theme to emerge from interviews and journals was the nature of the experiences that students described in the classroom and in clinical placements. All students made similar comments about, on the one hand, the "good learning experiences" and on the other, the "negative things".

Students described difficulties with concentration in the classroom, "getting through the day after being very active in clinical", and difficulties with particular tutors or teaching styles. The following examples are typical.

Two weeks of class just completed - it was all very interesting but very long. Full day sessions in class after ward work for a long time is quite difficult to cope with. It was very necessary as there isn't a lot of this work you can get from books. We did tend to get off the theme occasionally - a few topics we could have done without.

Theory today was quite interesting and didn't drag on, finished early afternoon. I think it's just about impossible to sit in class all day and learn everything that's being said.

Stu38 11/7

Students did not always see the direct relationship between the clinical objective and the clinical experience.

What are you learning?

Well that's what I worry about. I sort of look at my clinical objectives and think "Am I learning anything here?" But I think even if I am not learning any good techniques, I am learning about what not to do - how not to do things.

Stuopt1

Students expected that tutors would "give them what they were meant to know" either for the state examination or for competence in clinical practice. They expected to collect "parcels" of knowledge (Bernstein, 1975), deemed "worthwhile" for nursing practice by those who knew, both in the classroom and from their packages. Tutors, then, were able to define and legitimise this way of knowing over another, this kind of knowledge over another, and so on.

Students had been led to believe that tutors "knew" and they did not. When this exchange did not occur students felt powerless to do anything to change the situation even though they understood that there were procedures to follow.

Just finished a class week - what can I say? Boring for the first three days - I learnt nothing I didn't already know and felt I could have used my time more effectively.

Stu28 8/9

This week of theory was enough to drive anyone bats - disorganised tutors and repetitive lectures and I still don't know what I'm meant to know. It's also hard when you can't ask questions or disagree for fear of sarcasm from the tutor.

I was being silly and laughing a lot. It's either that or you'd go crazy. I thought of going to the HOD but I know you should go to the tutor first.

It's such a hard situation though because you can't say to someone "we find you really sarcastic and rude". So we've left it - perhaps the next class will do something (passing on the problem!)

Stu13 17/8

Don't think a lot has sunk in. The tutors use so many overheads - I don't mind copying but their spelling is worse than mine. Also they talk while you're writing which makes it difficult to remember anything because you're trying to decipher their writing.

Stu6 2/6

These examples demonstrate that students were unable to directly express their dissatisfaction to their tutors. The socially sanctioned power of the tutor created a climate in which students 'understood' that a protest would be interpreted as a challenge to that power. Therefore, in this instance, the relations of power between tutors and students masked any recognition that students could be knowledgeable or thinking, autonomous learners, or could act to change their classroom experience.

Examinations

Not surprisingly all the students in this study were concerned about the state examinations at the end of their modules. They felt that they had been working towards this goal for three years but the last few months had become a concerted effort by students and tutors alike to "get us through states". Many students wrote comments like "the tutors were just brilliant - they spent ages teaching us exam techniques - and giving us a mock exam paper which we marked and then discussed with them" (Stu18 15/10).

The students who were eligible to "sit states" had already passed the end of course examination and the clinical competency tests set by the polytechnic. Although the state examination is for registration to practice as a nurse, tutors and students in this study saw it as a culmination of their work - a test of the tutors' competence as teachers and a test of the student's knowledge deemed necessary to practice as a

registered nurse. Although these students realised that the state examination was for registration, their whole three years were shaped towards seeing it as their final test (it was often referred to as "finals").

However, in general, students were well aware that the state examination bore little relationship to the breadth of knowledge and skills they had gained over three years of classroom and clinical practice. The following journal extracts are typical of this view:

How can a three hour exam prove our competency?
 Something that gave me a lot of satisfaction was the fact that I (we) do have an incredible broad knowledge base. It's impossible to learn three years work for states - two three hour exams - ...

Stu22 11/10

Well we had our multi guess exam for State examinations. 150 questions and three hours later and I feel not too bad about it... It's so hard to believe our whole three years work hinges on two three hour exams. It doesn't seem fair at all.

Stu30 15/11

Thus students were aware of the contradictions inherent in the ideology and structures of a system of education that has a large practice component yet bases its final competency to practice criteria on national external written examinations. They accepted this contradiction because it was part of the 'natural order' - and because they, as individuals, were vulnerable at this stage of their careers and could not contemplate challenging an apparently accepted practice at this level.

CLINICAL EXPERIENCE

Clinical placements brought students face to face with their position in the established hierarchy of professional relationships and routinised practices. It was here too that they faced the contradictions between what they had been "given" in

the classroom and what they saw and experienced in practice. They found that they must use pragmatic rather than theoretical (classroom) solutions to clinical problems and dilemmas.

During their education students were 'persuaded' in various ways to take on the beliefs, values, attitudes and practices that formed part of the professional nursing culture in both the polytechnic and hospital, and were legitimated by those with more power. This persuasion occurred not because of individual agency necessarily, but because of the structures in which students experienced their education. For example, in the clinical areas, routine practices and procedures, and the attitudes and values of those to whom they must demonstrate their competence, often appeared to be inconsistent with the attitudes and values that students had developed about themselves and nursing practice from the classroom situation. As this student explains:

Oh, most places you've got to conform in some way to the way they do things - if you are doing a dressing or something, you know, they'll tell you not to fluff round the way we've been taught to. They say "Oh, it's not like that... do it this way", and you think "Oh, crikey". But they are sort of looking over your shoulder at you and you don't know what to do for the best. You know, we've had quite a few nasty incidents with staff over that.

Stu 3C

Well everyone's got to be washed and up and dressed and fed and everything by 8.30 and away to OT and then, when you are working with them, you know with the other staff member, you've got to do that as well otherwise they sort of frown on you.

Stu3B1

As argued in chapter three, the individual or group subject to established patterns of thought, discourse or behaviour within an institution may be both coerced into conformity (which is presented as a morally 'right', legitimate choice) and at the same time be aware of this coercion and its consequences. Such conformity was legitimated by those with the power to shape the experience of others.

In the following extract the student explains a situation where she had no choice but to conform with the existing power relations. She was aware of her conformity as a legitimate choice even though it was personally distressing to her. (During this interview the tape recorder was turned off while the student was distressed and her permission was given for recording her description of the event later).

... that little girl... she came in with head injury - second time, and they were quite - you know - judgmental - and the charge nurse didn't want the mother coming in. And she told the mother that she couldn't come and see the child and the little girl, she was just sleeping around the corner, and the mother was there, and the charge nurse was standing in the office yelling and screaming about how the mother wasn't to come... and this staff nurse...she thought she was marvelous.

Oh.

I was standing there cringing - I felt "Oh that poor mother - I mean, she can't make the big decision whether the mother did it or not - you know. It could have been anyone. But if she's right, the mother would need help - ... shocking, really.

What about the rest of the staff. Did they support the charge nurse?

Well they sort of - well I think the mother has been - because I think the social worker said that you just couldn't stop (her coming in) - when it's her child... and they are all really judgmental about everybody like - the solo mothers, and girls shouldn't be getting the DPB, and ...

Well you can't tell professional people that they need more sense - can't carry on like that. I just stood there, my mouth open - I couldn't believe what I was hearing from someone that was in that sort of position.

Would you be able to challenge her?

I don't know. (laughs) It's so hard to know what you would say. I mean you know what you think - but..As a student you know, I feel so powerless basically. All those things. The passive role!

It would take more than one person to...

Yeah that's right. Probably two people with the same ideas would sort of stand out. I just couldn't help thinking of that poor lady. I thought "Even if she has (hurt the child) ...she needs help, not to be shouted at".

StuOp2

Here the student recognised the discrepancies between her own knowledge, beliefs and values (gained from her life and educational experiences) and those of the

clinical staff from whom she was supposed to be learning. Her position in the relations of power left her feeling helpless and distressed not just for the mother in the situation but for herself as a student. She had decided not to talk to the tutors about the situation in the ward - "afterall what could they do - it would just get me into trouble".

In the above instance the student could be seen as an object of knowledge and as a target for the exercise of power. Foucault suggests that the "body" is a central component in the operation of power relations. To be located in a "political field, invested with power relations render (the body) docile and productive and thus politically and economically useful" (Smart, 1985:75). The embodiment of habitual activities and taken-for-granted hierarchical power relations often had the effect of regulating and controlling the students' (and others) sociopolitical action.

Power and conformity

Students received many direct and indirect messages from tutors and staff about their skills, efficiency, 'reality' and how they and their work were seen. These ideas and attitudes were not just construed cognitively but were also part of the indirect somatic knowledge which students understood would make them a 'proper' nurse. In general students felt constantly under pressure to conform to the largely unstated, and often contradictory, expectations of both tutors and clinical staff and to "perform" at peak levels at all times. The following excerpts are typical:

I sort of felt "Right I am going to show you!" So I got it all done, and she said to me at the end of the day, she said "Oh well I thought we were going to be much busier today, she said "I thought I was going to help you a lot more than I did". And that was a really cruel thing to say I felt. You know. She didn't say "You did it really well to get it all done".

Because you are dealing with people - a lot of people who - they see you as being a health specialist - but you aren't quite that as yet, and they are more ready to pick holes in you because you are a student, because, especially in a place like here - there's still the conservative attitude toward comprehensive students - so you are going to get that from the tutors and the patients and from the other staff that they are watching you - so you always have to perform.

StuOp4

Some students explained that the conflicting demands from clinical staff and tutors were personally "confusing":

But I'm still finding out that I haven't had enough practice of actually writing sort of specific nursing care problems by myself without a tutor. Just to get used to finding your own ability and that's what we found in second year was each tutor had their own way of liking objectives written.

Oh I see.

[Because you write for one, what you've been taught for her. You get "No, no - that's not right" from another - It just got a bit confusing at times.

Stu3b1

In this way an ideology of individualism masked the social conditions which produced feelings of personal inadequacy. Students tended to take personal responsibility for what were often external constraints produced by the social relations within the polytechnic and the clinical agency.

In each of the extracts cited above the disparity of power and distorted communication (contradictory messages from those who ought to 'know') between the students and other agents enabled the 'persuasion' towards ideological consensus to be effective. Students were constrained to believe that what they understood and experienced in the clinical agency, even though it was contradictory at times, was the approved and proper way. Because these beliefs were constantly reinforced by experience in different areas of practice, they prevented any serious

challenge to the structured relations of power and can be construed as a form of social control.

Students explained the misunderstandings between others and themselves, the inequality of the act of communication, and their perceived lack of power as contributing to the realisation that they must conform, or at least acquiesce to complete the course and to be seen to be clinically competent. The conditions of self blame, routine and ritual, and feelings of personal inadequacy, mask any recognition of the ideological hegemony they were experiencing. There was simply no possibility for other explanations or for challenges to the established order.

Students discovered that the exercise of power often had little to do with the knowledge and skills of those above them in the hierarchy. As this student explains, writing nursing care plans in the ward was very different to the way she had been taught in the classroom and led her to believe what should happen in clinical practice. She expressed amazement with the charge nurses lack of knowledge:

And the charge nurse asked me whether we were taught to do it and I said "Well we were taught to evaluate the objective on the evaluation side". And I mean - the next day they decided that was a stupid idea so they scribbled out the - I think they scribbled out the evaluation bit and put instructions on that side and put the objective under the instructions and just - you know. And I thought, what's the point of having that objective if you are not going to evaluate it? What is the point of writing the instruction? (laughs) You are not going to do the rest of it anyway. What a total waste of time.

Just filling in a form.

Yeah. I mean it is not going to be used. You know, why write it down if you are not going to use it.

StuOp2

and another student felt unable to comment to the staff nurse:

It was really strange the other day - we were doing a drug calculation - and the nurse did it in a hurry and I saw her afterwards and she said to me "Would you do it?" ... and we didn't have the same answer, like she had done it in such a hurry and it was really hard that - like when she did it again, I had the right answer and she didn't.

What did you say?

Oh nothing - I didn't say anything.

StuOp2

Although in this instance the student was 'expected to know', she was not meant to 'know better' than the staff nurse. Thus students' knowledge could be discounted since they were 'learners' and could not be expected 'to know' as much as practising nurses.

Congruence in classroom and clinical experience

All students, without exception, in interviews and journals, identified their experiences during the psychiatric module as being the turning point in their nursing education. For example, students said that they had "had it drummed into us from year one that we had to develop rapport - to have a good nurse-patient relationship - but they didn't tell us how. Or show us" (Stu3B2). The content and processes in the psychiatric module seemed to give them this kind of knowledge which they could use in other clinical areas. Many students gave examples of using interviewing and assessment skills in orthopaedic, obstetric, medical, surgical and community areas which, they claimed, they gained from their psychiatric nursing experience. The following extract from a group interview is typical:

I think part of Psych is that you become more aware of yourself as well and then a heightened awareness of yourself makes you more sensitive to other people's needs as well.

Can you just tell me a little bit more about that? What do you mean "awareness of yourself"?

I really felt that after I had done Psych that I was changed as a person. I don't think probably my personality has changed much but just my

whole views and attitudes and to go and learn about things that were quite different.

{More tolerance do you think?}

Mm. And interaction with people - changed. I'm sort of I think more receptive to their feelings and a bit more sensitive. Instead of seeing another person as a body with two legs and two arms and a head.

{A crabby person in bed, you know, which is often the case in the wards -

Yes.

[You tend to ...

Yeah, analyse them a bit more I think why they might be sad and depressed and not communicating... There's a lot more holistic I think in my approach to patients. A lot more considerate probably to their needs.

{Yeah - the psychological needs, the feeling needs, than rather just their body needs, their washing needs.

Do you think that it has changed your idea of communication too?

Definitely.

{Yeah I think so.}

[I think stress is a lot more importance now in communication]

{And body language and things like that}

[Mm. Realising how much more important it is to communicate well with the patient when the patient's feeling -... I suppose, I don't know what the word is but - um, feel happier about being in hospital because a lot of them don't want to be there, but if you can help them work out some of the stresses and problems that they feel they are having.they might accept the fact that they are in hospital and that - that's helpful....

CCStu

What about relationships with other health professionals, like doctors, house surgeons, and other people?

... I found that most of the doctors other than Psych have always looked down and just ignored you. Whereas you go over to the Psych area and they actually ask and they say "hello" to you and you just about die of shock. And they will ask you "How is so and so".

StuOb1

Many tutors too recognised the difference that psychiatric experience made to the "maturity" of the students. The tutor here explains that the learning environment in psychiatric settings was conducive to student learning.

... Because that's part of the process isn't it. Sitting in and observing. And really challenging people. And the Ward team welcome it. They respond very positively to students who do that sort of thing. ...they mightn't necessarily agree with the student's views. And they'll help those students get lots of extra opportunities and things -

It sounds as though it's a really good learning environment.

Yeah, yeah. So and I think it is good for us if they are assertive too. Because it's better than just passively accepting things.

Lyn Int 3

Field notes written following a long group discussion with seven students at one of their psychiatric clinical placements reveal their excitement about what they had learnt from this clinical experience. These students discussed the nature of the nurse-patient relationship and the meaning of communication. (This dialogue was not tape recorded.)

9/7 Met with seven students for three hours during their clinical placement today. We sat in the visitor's room at the entrance to the ward and as the clinical areas were very quiet the students had asked if they could have time out to talk with me. The session started off with the usual questions about their day and the patients they were responsible for - and there were the by now usual comments about never wanting to work in this kind of area when they graduate.

After about half an hour I asked "what are you learning here" and they said "nothing" and laughed. Then as a group they started to discuss what they meant by communication skills since that seemed to be the basis of their clinical practice there.

Communication to them meant "awareness" in the sense of being aware of 'self' in a specific context or environment; aware of listening with all the senses; aware of choosing words that conveyed specific meanings to often distressed or disoriented people; aware of space or distance between self and client; aware of using knowledge and skills to discover or explore the clients feeling state. They decided that they got this knowledge through finding a "good" nurse and working with her, from the "good" tutors and from reading about different conditions.

All students participated in this discussion - I said very little - there was no opportunity. They went on to discuss the difficulty of keeping their own personal feelings out of the professional relationship and agreed that it could not be done - it is not possible to separate the personal and professional worlds.

It seemed that some of their experiences in the psychiatric module allowed students to engage in reflective practice where they could bring classroom and clinical knowledge closer together. The knowledge, beliefs and values tutors expounded in the classroom were congruent with those espoused in this clinical area. Thus in one clinical area nursing culture was supported by structural procedures and processes conducive to trying out ideas and the creation of new knowledge.

Separation of theory from practice

Both students and tutors were aware that there were contradictions between what was expected of students in the classroom (theory) and what was experienced in the clinical agencies (practice). The dominant ideology of the polytechnic forced these students to think of theory and practice as distinct. They accepted as "common sense" explanations given by those who had the power to determine their future progress in the course. In this way theory could be seen as "idealistic" and practice as "reality" thus producing a distorted separation of theory from practice. However, some students were engaged in praxis as this example indicates:

...and some of them said oh well they didn't bother doing it (the package) until they actually got in and it related to the patients and then they started. They did the basic stuff, but some of the nursing problems and interventions and things like that they waited until they got out into clinical.

Stu 3c

Although the students in this study were able to recognise the artificial separation between theory and practice, they were unable to suggest ways to change this situation as it was not "appropriate" for students to do so. Nor did they expect tutors

to demonstrate how this could be done. They explained that tutors did not "want to rock the boat" because students were considered to be "guests" in the clinical agency (refer also chapter five).

Are tutors student advocates? - If you get into a situation in the ward where you need someone to back you up or support you or to change whatever is happening in the ward. Do tutors act in that role?

Basically, they really don't want to rock the boat because - a lot, we've been told a lot of times - if they go along and we do something to annoy the staff, they can quite easily decide you know, well we don't want your students in the hospital anyway, and that wouldn't just be our course.

Would they decide that - is that real?

Well I don't really think so, because they'd have no nurses coming up, but -

St3B2

We are not treated like guests - like you would expect guests to be treated.

LAUGHTER -

[We do seem to be treated as something different, like you've got your staff there, and you've got your students way over here with their tutor hovering over them] -

Well it's quite difficult really, because you are only there for two weeks.

[It isn't an appropriate time as a student to try and make changes - maybe you just learn the skills of giving good care and of being assertive, but not aggressive in the way you approach other staff, so that when you get on a par with them, that you can make some changes - or even -

StOb2

However the possibility for change by personal example was legitimated by tutors and accepted by students. As this tutor explains:

So - but yeah, I think we need to - I think we have very valuable roles to play and if we show the students that change can't occur then um - it won't happen. They won't feel motivated to go out and change it. Or they might still think that we're good role models, but we gave up on changing - got out.

Lyn Int3

And as students explained:

Like the tutor said ..., she said that if you are a good role model, if you are a student, people will be watching you, and if they see you doing something, and they've been doing it wrong, then they may think "Oh, well this might be the better way to do it" and if they try it and find that this is much better than their way, then they will probably change themselves.

StOb2

I still sort of have a bit of faith in the fact that if you hang in there and stick to your principles, that somewhere, somewhere along the line you are going to change somebody, even if it is only a little bit. But it's worth hanging in there for it type of thing.

StOp4

I suppose if I did work in a place like this I would have to set out to make changes. But how do you fight the whole system? How do you change people who aren't really trained in the first place - most of them are aides who've had a twelve week or less course and do everything except give injections and have worked there for years.

Stu37 16/7

Thus students accepted personal responsibility to change what were essentially external constraints produced by the sociopolitical relations within the institution. The belief that personal example was a realistic way to effect change in these settings was produced by an ideology of individualism.

Students, in general, realised that the tutors were as much affected by the tensions produced by unequal relations of power in the clinical agencies as they were (refer also chapter five). Furthermore their experiences in evaluating their clinical placements had led them to believe that nothing would or could be done.

Have you watched tutors change things in clinical or challenge the status quo?

Well we don't actually go back - you see, we write our evaluations, and what we didn't like about it and what we did like about it and we just carry on in our courses.

{ - And then another class writes it up - so we don't really know what happens about change -

[- unless it is something really really drastic which I haven't heard anything of]

ST3B2

However, as the following extract demonstrates, students believed that they should act (diplomatically) if the patient's interest was in jeopardy.

I think if you firmly believe that something has been done that's wrong, and that it really does need change for the patient's sake, or even their comfort, then I think that you should do something about it even if you are a new graduate -

{ Or even a student }

Yeah, I think that you can still query, but you've got to be very diplomatic in the way that you do it.

St3B1

Developing professional competence

For most students there were many instances of satisfying clinical placements where their confidence increased and their professional self image improved. These clinical learning experiences were discussed in terms of acceptance and trust on the part of the clinical staff and increasing the student's clinical skills. In the following journal extract the student explains that she was expected to ask questions and any difficulty in this clinical placement lay with her classmates.

The ward was really great the staff were excellent. I felt this was a great learning/preparing ward; anything I didn't know was carefully explained to me and I was supervised as I felt necessary. We also had an evaluation with the tutor concerned with this module - a lot of the other students complained about areas being boring and the staff being blase about the whole experience of having students around. In defence of some - not all - of those staff the attitudes of my fellow classmates to certain areas could do with improving. In some areas its hard for staff to delegate a lot for us to do.

Stu28 22/7

It's my last day on the ward. The entire staff have treated me as if I was a "graduate" nurse - it's increased my confidence greatly - I feel that I could cope with most nursing situations. I've learnt a lot.

Stu5 23/9

Tonight we finished our three weeks on the ward. Looking back I can see that I've developed confidence in being able to perceive and handle the clients. Also developed a knowledge of the illness/conditions. I have really enjoyed the three weeks.

Stu38 7/7

Many students felt impatient at this stage of their education - they were ready, they felt, to graduate as the following journal entry indicates.

...the staff are really good to me here. I'm learning - not much I didn't already know, but getting faster and more confident, and more disillusioned with nursing than ever. I'm being rather negative about this but this is how I feel. I think I'm 'trained' enough to be a staff nurse and the best way to improve is to be one.

Stu33 13/9

In general the students were curious about their likely graduate experience and reported many instances where they had tried to find out from clinical staff "what it was really like out there". The replies were often sobering but mostly what they expected. For example, this student could see a link between the lack of autonomy and low staff morale:

But I've sort of made it a point just to say to people - "Do you enjoy working?" - not saying why, but just sort of saying "How do you feel about working here?" etc. etc. "How do you get on in the wards?" And nobody has said a positive word about it. It has all been negative things - like "You've got to watch yourself with charge nurse - you know she's a real ... so-and-so."

And so they don't really feel that they are using their skills?

No and they feel that there's no way they can - that they aren't allowed to have any input to the care of their client really because they are told what to do - they are not allowed to use their initiative - you are not allowed to use your own head basically which I see as the lack of some people being able to delegate and they can't bring themselves to trust other people. And therefore, because the staff aren't getting responsibility, not only is it making them frustrated, but it is taking away what self confidence they do have in themselves, because if you are continually being run down, you know, looking over your shoulder, you begin to think. "I've got no value, I am of no worth, I don't know anything!"... And I can see how people might go ... no wonder morale is so bad (laughs).

StuOp1

This student's option experience (six weeks at another hospital without access to tutors) made her think carefully about working as a registered nurse after graduation. Many students reported similar experiences and gave personal explanations for their unacceptability to the clinical staff.

I got bad vibes from one nurse that she didn't like students. Just her attitude to me when questions were asked - the way she ignored students etc. This made me quite angry as she was young and must have remembered her own student days. Anyway our questions were answered by others.

Stu28 22/7

I don't find the staff very forthcoming. The charge nurse is brilliant and doesn't mind explaining things but the rest of the staff are very cliquey and just love to exclude you. I thought it may have been just me but I asked another student who is on the opposite shift to me and she has been there for two weeks and they still virtually ignore her. So I don't feel so bad.

Stu30 12/9

These students shared with their peers and their tutors the understanding that they were there to learn rather than to contribute to the collective knowledge and skills in the clinical area. After a discussion with students on this point a student recorded the following:

Needed the visit from you yesterday as it encouraged me...the session was very good but there were one or two things I disagreed on but didn't say so at the time...

I have just realised that for the whole three years we are never really encouraged to educate other staff. We focus education on client and family...I feel it is important to pass on your knowledge to other staff. Now that I have written all this down I have become more aware of things.

Stu31 15/6

In this way students became more aware of the ways in which the conditions of their educational experience shaped their understanding of that experience. The processes of reflection and dialogue during this research heightened their awareness of the affective influences which shaped their compliance to established patterns

within both institutions. Such compliance was accepted as "something you have to do" even though it could not be validated when subjected to rational discourse. Thus there was a dialectical relationship between individual agency and sociocultural conditions where educational practices were both reproduced and contradicted by those who experienced them.

TUTOR-STUDENT RELATIONSHIPS

Taking part in this study was seen by students as a unique opportunity to discuss their experiences. They appreciated the structured opportunity to distance themselves from the cultural traditions of the hospital and polytechnic and to critically reflect on their experiences of those traditions. They understood that tutors were unable to help them with this aspect of their education as the extract from the following group interview suggests:

...actually I think we are really lucky because when we talk about these things to you it makes us aware of all - you know, it makes you more aware of just how you are going to end up.

Could you talk to your tutors in the same way?

{It's that you're impartial.

[You are not our tutor, you are not involved with this polytech or this hospital. A lot of them have ties of loyalty to the hospital because they've worked there, and you're a third party altogether you see.]

{you can reflect our problems back and give us ideas on how to cope with them - so we feel we are getting value - it's like having our own counselor (laughs).

St3B Int2

Another student explained that they received mixed messages from tutors:

The fact that you are impartial - I mean - you are within nursing but outside of the polytech system - you can sort of stand back and take an overview and you could see the problems that are there and are willing

to admit to them rather than justifying... you are able to see that impartially - you know the type of attitude. Also the fact that tutors have got ways of coping with problems that you come across not changing them. But they reinforce that you've got to be agents of change as well. You know, I always feel like - somebody needs to be appointed to teach tech outside - well you know - that their primary role is almost like a counselor to the students - because it's really quite a stressful course.

StuOp3

These processes of distorted communication between tutors and students masked any possibility of a reasoned examination of the discrepancies and distortions in the students' educational and practical experiences.

Many students referred to taking part in this emancipatory dialogue as "having our own counselor" and thought that this would be one way to overcome some of the more confusing contradictions they experienced. The following excerpt was typical:

... How do you mean a counselor?

Well just the fact that you can talk to somebody - get rid of all your feelings, I mean that's counselling isn't it?

Yeah, I suppose so.

That's what we were doing... even if the counselor is silent - taking it in - it's therapy, and it's really good -

You found that useful last time to get rid of that stuff?

Yeah, it is actually, because you can throw it at each other, but it's like throwing a brick at a wall, it just bounces back and it doesn't go anywhere, but we feel like we are getting rid of some of the obstructions talking to you.

Can you not do that with the tutors?

Um... to a certain degree, but obviously it is better with a neutral person. You know with someone neutral. Well you've been through the system, and you know what nursing is all about, but you don't have to defend the area -

And the tutor does?

To a certain degree, in fact in this last module, the tutor we had was really exceptionally good, and we had quite a few gripe sessions at the

end of the day. Oh there's always positive things, but you tend to centre on the negative but -

yeah, it's just that we tend to feel that we are griping all the time. We should shut up and get on with it, but as we tell the tutors - over the last three years almost - they taught us ideals to aim for and we see them not being met in the clinical area, it only shows us that we are internalising what we've been taught. But if we gripe about it then it's not happening. So probably it is a positive thing. It's just that it feels like we are always being negative...

ST3B2

—
Engaging in the processes of this research appeared to influence their consciousness of themselves as student nurses but they had difficulty in translating this into practical action.

In addition to the feeling of "always being negative" and the feeling that nothing could be changed when they talked about their experiences in clinical practice these students felt that tutors could not be trusted with other information:

But do tutors act as student advocates?

Oh... no... we tend to sort it out amongst ourselves than go to tutors, because some of them we don't trust. You just don't know if you go and say something to a tutor where it is going to go ... Oh I'll start again - say if you've got something to tell a tutor and you don't want it to go any further than that tutor, you don't know if you can trust them or not - whether it is going to go further or not.

Is that because you don't know them well enough or because you had experience of them not being trustworthy.

{ Yes you hear stories, and you get to know which ones you can go and talk to. And also the ones that you work with you get to know which one. "I can trust you - I can't trust you!" And it's not very good, because you get awfully suspicious.

StuOb2

Many students commented on the lack of control they had over the information that went into their personal files during the course. Although they were aware that they could see their files at any time they felt unable to do so. The following group interview excerpt is typical:

I think you are a bit scared of it getting put down on your records, because you don't know what they actually ... because you can go and have a look at your records and that - and I know that I had a look one time, and I had this thing written and I thought "Good grief!" - that was back in my first year. And I didn't even know about the incident and yet this tutor had gone and written this great big screed of writing -

{ You should have moaned about that }

Yeah.

Do you think they should write them in conjunction with you?

No this was just an individual one put in and - you know it was really more subjective than objective, and it just sort of destroys a lot of the trust.

Have the rest of you seen your records?

No (many voices)

I think it would be helpful if they discussed them with us.

{ It's hard sort of going in there (the office) though. }

[You feel guilty going in to look at your own record]

STUOB2

These examples of latent conflict in the relations of power between tutors and students illustrate the ways in which those exercising power undermine the real interest of those they exclude. Many times during this research tutors expressed the hope that students would become assertive advocates for their patients yet in almost every way tutors acted to ensure the students' compliance and conformity with existing practices and rules. Thus tutors intentions were contradicted by their actions. Student's accepted their position as defined by those with more power because in many instances they could not see any alternative. When students could see alternatives they chose not to act because "we want to finish the course" (Stu16 18/9).

POST GRADUATE EMPLOYMENT

The final major theme to emerge from student discourse was post graduate employment. At the time of this research the New Zealand health service was still in the process of being restructured and all Area Health Boards were facing large budget cuts. Consequently nursing workforce numbers were declining and few nurses were being employed. The students in this study had understood that they were not guaranteed employment when they started the course but they had been led to believe that if they completed the course they would be employable as registered nurses.

The whole hospital is in an uproar as big staff cuts and expenditure cuts are ordered or else!... It makes me wonder where the health service is heading to. We know we don't have any nursing positions here and the situation is just as bleak elsewhere. I feel very cheated training three years and not knowing if I will have a job at the end of it.

Stu30 9/9

The local area health board chose to inform these students of the job situation one week before they sat the state examination for registration as a comprehensive nurse (referred to as "states").

...we all got a nice letter basically telling us that there were no jobs at all. I felt it was another kick in the teeth. We all knew the job situation but what we didn't appreciate was being notified a week before states to go and get stuffed - that they don't want us. I feel very angry about their attitude and insensitivity at when to send their reject letters.

Stu30 15/11

A number of students used their journals to express their feelings of anger and frustration. For example:

Rumours or truth, I don't know but the job situation for the graduates for the end of the year looks hopeless. Not much of a reward after a three year dedicated, stressful, chaotic, draining, confidence blowing, self esteem shattering, staff hammering, financial SLOG. Well that's a load off my chest. Perhaps I'll get a good night's sleep for once. One

thing they don't teach you on this course is how to really relax and unwind, forget our studying worries and the shit we get from everyone around us. Excuse my language but I'm feeling down and my anger is pouring on to the paper.

Stu17 10/10

Some students expressed concerns about their 'employability' - that perhaps they were personally inadequate now or in the future, particularly if they were without a job for any length of time. The messages that students received, in common with other members of the wider society, were that employment was an individual responsibility and unemployment was due to individual inadequacy. These ideas are central to the ideological reproduction of labour in a capitalist economy. This notion, however, was contradicted by the belief that students had fulfilled their part of the bargain - they had 'trained' for three years with no monetary reward and deserved to be employed now that they had completed the course. These journal extracts are typical of these views:

At the moment morale is pretty low, what with exams over and the job prospects pretty poor, everyone is on a major downer. Jobs overseas are an exciting idea but major worries take over with doubts about my abilities...

Stu37 7/11

Have been applying all over for jobs, so far have applied to seven hospitals. The one I wanted said no, I was devastated but hope somewhere takes me.

It's looking gloomy and as I recall Day one Year one we were told by our Head of Department - "you're the best you girls, the cream of the crop, and will make excellent nurses". That may be true but they can't even offer us a bloody job. Australia beckons.

Stu22 18/10

Full understanding of this situation requires knowledge of wider economic and political conditions. This would need to involve a collective process, rather than individual self reflection, which was not possible in the context of the research process with these students.

On the other hand students were quite clear that there were areas where they would not work if they had been offered a job there. These clinical areas were well known to the students as they had all spent some time there on clinical placement. In the following journal extract this student explains that working in some clinical areas would compromise their education based principles too much. Even though she was used to that as a student she should not have to work in those conditions as a graduate.

I've been asked a number of times this week, whether any of the comprehensive nurses are going to go out there and work next year, and because the enrolled nurse programme is going to be stopped, they feel that a lot of us are going to be channeled into geriatric hospitals whether we sort of want to or not, you know if we can't get a job (at the base hospital). And I said "Oh, I'd rather go on the dole, than work there because it's so structured and rigid - I mean you've got really old nurses doing it their way and I said well it compromised the way I've been taught, and they sort of wanted to know what that meant - because I disagree with a lot of the things they do and the way they do it - I wouldn't be able to work - I wouldn't be able to go there and do it the way they do... so I hope that - just to hope, get out and work - I'm not going to change the way I've learnt things just to fit in with everybody else. But that's really difficult because we are doing it all the time just as students...

StuOp4

Other students explained that they had particular preferences for the kind of nursing they wanted to do. The 'comprehensive' nature of the course ought to have provided them with the knowledge and skills to work in any area of clinical practice.

{Well... for example, I wouldn't work here, but not because the staff might not accept me, it's because I'm not interested in that area, and I know I wouldn't do a very good job - so I would be better off if I go and get some other job.}

Mm.

[I wouldn't be a good nurse out there. Because I'm not interested in that area. So I don't think it's - it's not fair to the patients, not fair to myself or the staff.

Where do you want to go?

{I'd quite like to - originally I liked Public Health - but of course I will have to do time in the hospital ...in medical - surgical areas.

Why do you have to do that?

[Well apparently you can't get into Public Health without going into hospital surgical or medical experience first.]

Mm.

Be a comprehensive nurse ...that's a laugh!

Stu 3C

Some students did find employment. Of the forty eight students in the course four were notified that they were to be employed as registered nurses. Others said:

I'm working as a housemaid/waitress in (an hotel) after exams.

Stu33 25/10

SUMMARY

In this report of student discourse it has been demonstrated that dialogue - the sharing of speech and recognition of the other's meanings - took place not between tutor and student but primarily among students. Student discourse which included tutors contained only that which was 'safe' to share with tutors. Students however were not 'silent' in the sense implied by critical pedagogy - they were highly reflective. They chose what they said to those in authority as a result of conscious and unconscious assessments of the power relations and safety (personal and professional) of the situation.

Students were already aware of the ways in which they were conforming to traditional institutional practices and expectations. They were also aware of the distorted communication that surrounded these practices and which shaped their understanding of their education. The research processes allowed that awareness to surface and become available for examination. However students perceived that there were external constraints which prevented them from acting on their shared

knowledge. They were reflexive but seemed unable to engage in strategic action - they could see little advantage in challenging those constraints they were able to identify. In general, because of their relative position in the relations of power in the institutions, they felt vulnerable and unable to make their concerns visible.

The next chapter provides further theoretical interpretation and critique of the issues raised in the account of this research.

CHAPTER SEVEN

FURTHER INTERPRETATION AND DISCUSSION

This chapter provides further theoretical interpretation of the discourse presented in chapters five and six.

A socially critical approach to the central research problems in this study held a promise of both uncovering the hegemonic ideology which produces contradictory conditions and constrains the practice of nurses, and of offering some means for the research participants themselves to challenge and change institutional structures.

The critical literature in education suggests that tutors who had engaged in self reflection, would devise various theoretical and practical means of giving power to students so that they would be more in control of their own learning. Both tutors and students could then choose to act cooperatively in ways that could challenge the taken-for-granted assumptions of the established order in nursing education. The rhetoric of critical social science suggests that emancipation and empowerment of tutors and students would follow their enlightenment (Giroux, 1986; Smyth, 1986; Freire & Shor, 1987; Higgins, 1989).

The empirical evidence from this study demonstrates that tutors and students were highly reflective. From a critical theory perspective, interpretation of dialogue and journal entries demonstrates that they understood, at least partially, their positions in the established relations of power. For the most part, they also understood that there were ways in which they could challenge and possibly change the situations which

frustrated and constrained them. They were less willing and seemed unable to challenge the oppressive structures which gave rise to these situations. Both tutors and students, whose experience of the course must be seen to be complementary, were able to engage in political analyses of their situations and to give personal and/or professional reasons for their inability or unwillingness to act to relieve the oppression they felt. They recognised and responded to the more subtle, covert messages they received about their personal, professional and academic acceptability, and made choices about suitable courses of action. Tutors and students did their best at the time, given their personal resources and the conditions of practice in the polytechnic and the hospital.

The central objective of critical social science is action at the sociopolitical level (refer to p47). In this study the reflexive research process gave both tutors and students a therapeutic and educative opportunity to alleviate at the psychological level some of the personal distress they described. Student discourse in particular, demonstrates that students used the processes of research to unburden themselves of some of the feelings they had about practices they encountered and found frustrating in the classroom and clinical areas. Through sharing their feelings and experiences in a constructive way, they were able to reduce their feelings of isolation and to perceive their individual situations as part of a more general pattern.

This therapeutic function of critical research assisted tutors and students, through rational reflection, to reconsider the ways in which sociopolitical forces shape their preconceptions and understanding of their current situation (Fay, 1987:145). Subsequent action however, where it occurred, fell short of transforming those situations because there were features which were impervious to rational reconstruction. There were simply too many personal and professional hazards

associated with making apparent their opposition to the ideological assumptions and myths inherent in their educational experiences. As Fay (1987:145) indicates, these "barriers to rational reflection" are a limiting feature of critical social science. Such limitations would prevent tutors and students from altering the material conditions in a manner likely to enable them to realise their autonomy

This study has revealed that tutors were disposed to working collaboratively together rather than engaging in *collective transformative action*. In the closeknit community of the school tutors' interaction with and acceptability to their colleagues and to students, depended to some extent on a personal reputation for collaborative behaviour. Tutors were aware of the ways in which those who expressed and acted on different beliefs and values were eventually persuaded to comply with the dominant ethos. They did not want to jeopardise their professional reputations, or chances for promotion, nor did they want to be out of favour with their immediate colleagues. This should not be seen as serving self interests only. Tutors were well aware of the effect such actions might have on their ability to organise their work and to teach students in the personal, relatively autonomous ways that they had already developed. Their collaborative behaviour masked the social conditions which constrained them and it acted therefore to support hegemonic structures.

Although they worked collaboratively and supported the status quo, tutors made personal and idiosyncratic challenges and changes to the conditions of their practice. These changes did not adversely affect the collaborative relationships that they had within their team (module). However tutors, like students, were unable or unwilling to translate this personal struggle into collective action to change "the system".

Ideology acts to systematically distort communication and therefore to prevent collective action. Tutors often resisted attempts to uncover the historical processes through which their self understandings had become systematically distorted (for example, refer to p123-124). The dominant ideology, expressed through tutors' interpretation of curriculum design and course outlines, timetabling and official teaching practices, espoused individual student responsibility and empowerment. However the actual experiences of both tutors and students contradicted this.

For example, although tutors required demonstration of 'classroom' knowledge, students wanted to satisfy the requirements of clinical nurses to whom they must demonstrate their competence. And tutors wanted students to fit in with little disruption to the clinical setting while at the same time demonstrating their different education-based ideals. Thus the official discourse of the curriculum and course outlines was contradicted by the tutors' and students' lived experience and the network of social relationships they developed as a consequence of that experience.

Moreover, some attempts to empower students had the adverse effect of further empowering the tutors. By explaining away or justifying distressing or contradictory clinical experiences rather than acknowledging the validity of the students' interpretation, tutors may have been comforting students but they were not empowering them. These responses undermined the students' moral agency and brought students face to face with their own powerlessness - their inability to control their own environment or their own destiny. It also convinced students that tutors were as powerless as they felt they were to change the practices, procedures, rules and regulations which prevented them from providing the kind of nursing care they had been taught was desirable.

Therefore, tutor and student responses were to negotiate the structural constraints as far as they could and to create their own individual social processes of teaching, learning and nursing within these structures. Their resistance or challenges were expressed in the day-to-day realities of constrained teaching/learning processes in the polytechnic and the clinical agencies. There was little opportunity to surface and discuss the nature and effects of these constraints. Their concerns were not expressed at the level of collective analysis that might have brought about some structural change in the provision of the course. However, as Fay (1987:174) suggests, the "ideal of collective autonomy should be tempered with the possibility of rational disagreement". There were good reasons for tutors to retain their personally constructed accounts of their experience while remaining receptive to other explanations.

Notwithstanding all of the above, it is possible that tutors (and students) may have effected structural changes if there had been a longer time frame for this study. Indeed when the final draft of this report was discussed with the tutor participants, they described changes that they had initiated since the formal study had finished eighteen months previously. Significant changes included the restructuring of the third year teaching team; teaching methods had been examined and changed; student peer support groups had been established; and regular nursing practice seminars had been instigated to examine students' contradictory experiences. (One tutor described my involvement in the research as "working at the back of the tapestry where you can't see the finished picture").

The artificial time boundary of this research meant that reflexivity was suspended at the level of individual practice. Tutors explained that they had a moral and educative responsibility to get students through to the state examination; and

students were focussed on completing the course at almost any cost. During this study it became obvious to me (tutors already "knew" this) that structural change or educational transformation during the time frame of this study, would be so disruptive to the usual functioning of the school that it was very unlikely that it would occur. This "ethical limit to the power of reason", as Fay (1987:145) describes it, was a point beyond which rational reconstruction would be dysfunctional for these tutors and students. Several years may be required for tutors in particular to uncover structural constraints to the extent that they might be compelled and empowered to act collectively to change them.

HEGEMONY AND CONSCIOUSNESS

That tutors and students could not and did not act personally or collectively to transform the structures which limited their practice, reveals the intensity of the effects of the hegemonic ideology which shaped their world views. A hegemonic ideology, by definition, requires that particular interests be reformulated and presented as general interests (as explained in chapter three). To become an "effective instrument of consent", hegemony must meet two criteria (Gramsci, 1971:181-2).

First, hegemony must foster the belief that the system of privilege, status and property it defends, operates in the interest not only of elites but also of subordinate groups whose compliance or support is being elicited. To do this, implicit promises of benefits for subordinate groups must be apparent and will serve as the stake which they too have in maintaining the prevailing social order. The dominant class must make good on at least a portion of those promises if it is to gain compliance.

Tutors received many rewards for maintaining the status quo. For example, they retained considerable power over students (and their colleagues) through the ways in which self directed learning (packages) operated. Their relative isolation in each module maintained the myths and mystery surrounding their particular teaching area. The data relating to polytechnic culture revealed a distinction between two sets of ideals held concurrently by tutors and students. Tutors espoused education based ideals or epistemic principles as simply superior to practice ideals which, they believed, were based on habit and tradition. They were obliged, often unknowingly, to maintain this polytechnic culture to justify their interpretation of the contradictions in the clinical area. Thus they could discount their lack of ongoing clinical experience, although at times this lack damaged their credibility with students and clinical nurses. Tutors retained job security through making "the system" work (refer p108-109).

For students the benefits in acquiescing to the demands of "the system" were also obvious. Because they were committed to becoming registered nurses, they were dependent on satisfying those with more power so that they could pass the practical and academic course and be a "fit and proper" professional (refer chapter one). Students were careful to couch their opposition in ways which would not jeopardise their chances of finishing the course which gave them access to the state examination for registration.

The second criterion that hegemony must satisfy is that some diversity is possible which nevertheless must serve the interests of the dominant groups. Both the polytechnic and the clinical agencies tolerated different views and practices. Tutors 'belonged' to the polytechnic and although it was considered that they ought to perform at the level of a practising nurse in a clinical area, it was understood by all

concerned that they could not be expected to. In the polytechnic tutors were able to make some autonomous decisions about the specific content of their module and the teaching methods they would use.

Students were considered to be relatively ignorant learners who required 'training' but were tolerated only to the extent that they were 'safe'. Opportunities were available for students to express their concern about the contradictions and structural constraints that prevented them from realising their personal goals. This opposition, however, was managed so that students were unable to effect significant change or even to see the results of their expression of concern.

Thus dominant hegemonic ideology was manifest in the educational experiences of tutors and students. The values and beliefs of policy and decision makers in education and clinical practice hierarchies did permeate and dominate the worldviews of tutors and students. It induced their consent and approval of an educational order which did not serve their real interests. It functioned to conceal or misrepresent the real conflicts of interests - and to make tutors and students, in effect, conscious participants in their own domination.

However, tutors and students were not ideological dupes. They did have, to a greater or lesser extent, the capacity to penetrate at the level of practice, the elitism of the beliefs of those with more power. They knowingly chose to perpetuate those beliefs for their own "survival" (refer to pp109,175). As Willis (1977:175) says:

social agents are not passive bearers of ideology, but active appropriators who reproduce existing structures only through struggle, contestation, and a partial penetration of those structures.

CULTURAL PARADOX AND COMPLIANCE

It is clear from the account in chapters five and six, that tutors and students adhered to the conventional view that the clinical area is the setting in which concepts, principles and skills taught in the classroom are applied and practised. However, when students found that the clinical area did not easily accommodate classroom ideals contradictory conditions of practice were produced (Higgins, 1989).

Students found that they faced complex issues in the clinical area for which their classroom experience ill prepared them. These issues were not so much to do with theories or epistemic principles but rather were to do with the relationships, practices, attitudes and values they encountered in the course of their clinical experience. As explained in chapter one, and demonstrated in chapter six, it is the clinical area where students come face to face with their education based ideals. It is here that students believed that 'real' nursing takes place and they believed that nurses in clinical practice were 'up to date' while tutors were not. Thus students experienced a disjunction between a 'polytech education' culture and a 'clinical' culture. However the structural constraints in both the polytechnic and the clinical area (such as hierarchical relationships, rigid time boundaries, institutional regimes and rules) were experienced as similar.

Tutors, on the other hand, experienced a disjunction between the structures of education and clinical practice and a similarity of cultures. The rules, regulations, procedures and hierarchical relationships of the two institutions were experienced as different by tutors. The knowledge, values and beliefs that were thought to underpin nursing education and practice were similar. Where discrepancies arose in these two cultures, tutors tended to discount practice values and beliefs in favour of the

education based 'ideal'. They believed that students should learn to practice in ways that were different from traditional expectations.

The exception to this was one of the psychiatric clinical areas where student discourse reveals congruence between their clinical and classroom experience (refer to p163). Here students discussed the ways in which their interaction with tutors in the polytechnic and the emphasis tutors' placed on introspection and self development, communication and therapeutic relationships, prepared them for the processes they met in the clinical area. Evidence of the tutors' acceptability to those in the clinical area gave students more confidence in their education based ideals.

Tutors and students in general recognised and described the ways in which this psychiatric nursing experience was a catalyst in the students' educational experience. For example, tutors described students as being "more mature" following this clinical placement, and students explained that they now understood the "use of self" in a therapeutic relationship.

However, even in the psychiatric module, students were also exposed to a 'clinical' culture (a covert curriculum) which they recognised and complied with. For example, students described practices and procedures that they were obliged to carry out which conflicted with their education based beliefs and values. In a group interview students discussed the dilemmas they faced in one psychiatric area where the "staff just sat around" and where the patients "just sat" (refer to p139) and students were obliged to "fit in" with this custodial rather than nursing care.

Higgins (1989) and Smyth (1986) rightly point out that it is not appropriate to deny the reality of the tension between these two cultures, or curricula, and that this

tension should be seen as a starting point for the realisation of curriculum goals. However, this arguably idealistic position discounts the intensity of the effects of ideological hegemony in the teacher-learner relationship that this present study clearly demonstrates. Because of the imbalance in the relations of power between tutors and students they could not become united in their pursuit of common goals. The hegemonic effect is that dominated groups are set up to be in conflict with one another to the extent that communication undistorted by ideological positions is difficult. Tutors, who exercised more power, could not afford to align themselves with the weaker group who in turn felt unable to communicate their concerns.

Tutors and students were not independent agents; they were shaped by traditions and dual cultures, and by the immediate social relations and structures of nursing education. They were not able to be autonomous agents because of the strength of the prevailing norms which they accepted as legitimate. They described and clearly understood the dynamic relationship between tradition, context, individuals and the contradictions they encountered, but were reconciled to being able to do little to change it. It was simply "the system".

SOCIOPOLITICAL DOMINATION

A system of social domination often appears inevitable and taken-for-granted assumptions become embedded in common sense. Once considered inevitable, social domination is apt to be considered natural even by those disadvantaged by it. As explained earlier, institutionalised power relations produce conditions which reinforce habitual responses and conforming behaviour. Shared understanding of social norms and unconscious affective mechanisms bring about illusions so that the taken-for-granted order remains unchallenged (Fay, 1977:214; McCarthy, 1978:86).

And, as Scott (1985) points out, there is a tendency to consider whatever is natural to be also just or legitimate.

No matter how conscious students were of having to comply with practices they found repressive, the daily pressure of having to meet course requirements and the risks of open defiance (especially in the clinical areas) were usually enough to secure their compliance. When students said "nothing can be changed" (refer pp171, 174) they were not unknowing victims of ideology. They were expressing what they felt to be a realistic pragmatic view of the situation as they experienced it. They complied with, and by their actions appeared to support, institutional ideologies. But an attitude of pragmatic resignation prevailed rather than active ideological support. Resignation to what seems inevitable does not necessarily afford it legitimacy or approval. The interview transcripts and journal entries provide evidence that students retained intact autonomous beliefs and values arising from their personal lives and educational experiences rather than adopting those values that prevailed in the institutions.

The domain of action is where dominated groups are most constrained and it is at the level of beliefs and interpretations where they are least constrained (Scott, 1985). Institutions can neither insist on private ideological conformity, nor do they need it to perpetuate the dominant worldview. However, conforming behaviour is inevitably achieved. There were well established rules, regulations and traditions in both the polytechnic and the clinical areas governing what tutors, and especially students, could do.

However, it is not a question of whether domination was inevitable but rather the extent to which a system of domination can be so pervasive that it appears inevitable

to those who experience it. In the material presented in chapters five and six, it can be seen that both tutors and students were able to engage in ideological critique. However students in particular seemed unable to translate this critique into action at the time of this study. They were constrained by the necessity to prove their acceptability in clinical areas and to prove their academic ability to pass the course.

Tutors, too, participated in their own domination. They explained that they were inevitably constrained to act in ways that supported institutional practices and the prevailing beliefs and values, even though these were antithetical to their own education based principles and what they thought they were teaching students. For example, tutors experienced dilemmas when they attempted to demonstrate or demand that students display their education based principles in unfriendly clinical environments which were not conducive to student learning (refer to p142). Their pragmatic solutions were to justify or excuse the unsatisfactory conditions of practice and to point out to the student that this was 'reality' but not the way that they should practice when they were registered nurses (refer to p143).

Tutors and students in this study were more likely to be radical at the level of ideology than at the level of action where they were more effectively constrained by the daily exercise of power (Scott, 1985). There were situations during the course of this study when the mask of conformity or symbolic compliance was lifted to expose more radical personal values and beliefs. For example, during group interviews, students expressed their collective frustration that they could not materially alter the unsatisfactory aspects of their educational experience. They often described what they thought to be more appropriate knowledge for practice derived from their clinical experience but which they felt would not be legitimated by tutors. Students used their journals to express their personal frustrations and anger about the personal

compromises they were making in conforming to the demands of institutional regimes.

Students extended this personal autonomy to construct a peer culture not entirely controlled by those with more power. This should not be seen as a failure of hegemonic ideology to shape student interaction, however. Rather, peer culture and the opportunities it provided for private critique could be seen as a necessary outlet for dissent while maintaining the smooth functioning of the institutions. Students could and did use these means to share their educational and clinical experiences with each other (and with me during this study) thereby dissipating any challenge to the status quo.

This existence of relatively 'safe' discourse is a necessary precondition for the development of symbolic resistance, or distancing, constituting a social space in which the definitions and performances imposed by domination do not prevail. This social space was defined by the absence of vertical power relations among students and between the students and myself during the interviews. They understood that they were all (like me) sharing the same resentment of the constraining conditions of education and practice. They also understood that they shared a vision that was congruent with the goals of the profession at large - they wanted to provide high standards of patient care.

In this study, tutors were more likely than students to attempt to transform those conditions that constrained their practice, in part because they had relatively more social power and were more independent than students. They were also motivated to improve their practice as teachers. Their efforts, however, were limited to trying

to transform negative effects of power imbalances within the classroom into positive ones (Ellsworth, 1989).

KNOWLEDGE AND POWER

Between tutors and students there were sometimes competing views of what counted as knowledge or, more particularly, what counted as useful or valuable knowledge for clinical practice. For example, tutors used various strategies to "draw out the theory" that they had given students in the classroom (refer to p137). Students, however, often placed more emphasis on knowledge they had acquired experientially - it was "real" in the complex, unpredictable world of clinical practice. Thus they attempted to theorise (make sense of) their own practice but they were neither overtly encouraged nor motivated to move beyond the received (classroom) knowledge.

In the context of this study this conflict arose from different cultural perspectives, implicit in the different beliefs and values held by tutors and students and reinforced by the practices and social relationships each group encountered. For example, students explained that although they were in the clinical areas for relatively short periods (two to three weeks), tutors were often just "in and out" each day. This meant that it was students who must relate to clinical staff on a more intensive ongoing basis and it was students who had greater knowledge of the specific culture of the clinical area. Therefore, students often felt that they were the ones who "knew" (refer to p155).

Tutors, however, appeared to assume that knowledge could be independent of the historical, social and political context in which it is produced and therefore separate

from personal, social and political interests (Habermas, 1972; Freire, 1973:99). In this way they could justify the primacy of theory (classroom knowledge) over practice and could insist that theory be applied to practice. There was little room for students to formally express ideas derived from their own interpretation of practice, or to critique the status quo. Students were encouraged to be self critical, but not socially critical, of the experiential knowledge they developed in clinical placements.

On the formal level the polytechnic 'education' culture assumed authority. Through the structure and content of the overt curriculum and the processes of the covert curricula a 'polytechnic' view of what counted as legitimate knowledge for practice was entrenched. This was taught in the classroom and through the packages, then formally tested. Mastery of it was necessary for gaining the credentials to pass from one module to the next and for access to the state examination.

Students recognised the power of this knowledge in so far as it was an introduction to the medical and nursing conditions they might encounter in clinical practice. Mastery of this knowledge led to the credentials they required to pass the course. They were also aware that in the polytechnic, if not in the clinical setting, tutors' knowledge had socially sanctioned authority and the tutors had a socially sanctioned status as experts.

The authority and status of tutors and education based knowledge did not always extend to the clinical area, however. This created contradictions and dilemmas for both tutors and students. As can be seen in the account presented in chapter six, on the whole students did not openly challenge these contradictions but found ways to work around the inevitable dilemmas that ensued.

A common sense solution to this paradox would be for tutors to help students integrate the polytechnic curriculum and their clinical experiences (Higgins, 1989). In this way "the insistent and legitimate demands of the latter can be acknowledged without detriment to the enriching concept of nursing which the polytechnic education of nurses is mandated to uphold" (Higgins, 1989:124). Furthermore, Smyth (1986) suggests that students, both at the polytechnic and in the clinical agencies, would be engaged in a process of systematic enquiry in which the student "focuses on observation, description, analysis and discussion of the institutional contexts and practices with which they would be interacting" (Smyth, 1986:12).

Both Higgins and Smyth suggest that such an orientation (which can involve trying out new ideas) is at variance with the unquestioning acceptance of routine practices and utilization of knowledge created by others. If they followed this course of action as Smyth (1986) says,

"students would recognise that knowledge is socially constructed - as being available for disciplined debate and critique - and they would be provided with a climate that would permit and encourage autonomous enquiry ...During clinical placements students should be personally responsible for identifying issues and problems for investigation under the guidance of experienced on-site clinicians, and with the close collaboration of their tutors"

Asking students to reflect on their actions, to explain what they did and why they did it, and to present their methodologies to open scrutiny might appear reasonable. It might seem equally responsible for tutors to enable students to uncover perplexing and confusing situations which cause them concern and to enable them to see the possible avenues open to them to resolve the personal and professional dilemmas which ensue. Moreover Smyth (1986) goes on to suggest that the onus should be placed on the students individually and collectively, and in consultation with

clinicians and tutors, to offer suggestions as to what should be done in problematic situations.

Underlying all of this is the assumption that students are active participants in the creation and interpretation of their social environments. While they may be so at the level of individual practice, this study has demonstrated that at the level of ideology and structure, students (and tutors) were unable to transform those sociopolitical forces which shaped their understanding and constrained their actions. Although they passively resisted some attempts to encourage them to conform, for the most part they accepted their acquiescence and conformity as natural and perceived the constraining effects as intrinsic to the system. In the context of this study students indicated clearly that if they uncovered contradictions or "suggested solutions" to the situations which caused them concern they risked censure or worse from nurses who had more power.

These solutions, then, like those of previous studies (refer chapter two), discount the ways in which institutional ideology shapes the consciousness of tutors and students to accept the dominant views of what constitutes legitimate knowledge and how that may be obtained. That is, as demonstrated in this study, merely having insight into themselves and their situation, or engaging in ideology-critique, was insufficient for tutors and students to effect the social transformation required for their emancipation.

TUTOR - STUDENT RELATIONS OF POWER

The account presented in chapters five and six demonstrates the hierarchical relationship between tutors and students. This relationship had the unintended consequence of ensuring that tutors did not have access to the personal evaluations of the course that students were constantly making. The concept of communicative competence (refer to p66) suggests that people often do not speak - not because they are incapable of doing so but because they are prevented by covert power structures from expressing their 'true' interests. Whereas students were capable of providing information and critique about their clinical and classroom experiences, as evidenced by their interviews and journal entries, they did not do so directly or intentionally to tutors. Thus tutors missed valuable information about the nature of students' educational experiences.

However, as Tripp (1987) points out, it is easy to translate personal-professional decisions conditional upon circumstances into generalised normative ones. It may well have been professionally safer for tutors not 'to know' through students' experiences, since they too were caught up in relations of power which prevented them from acting in ways which would enhance student learning. In other words they could not do anything other than excuse or justify those experiences or conditions which students reported were distressing to them.

Allowing students to air their grievances during classroom feedback sessions, or through the post module evaluation forms, was a safe way of diverting student challenges to the status quo. In this way, apparently rational deliberation, reflection and consideration of other viewpoints could become just a vehicle for regulating conflict and the power to speak - for transforming conflict into rational argument by means of universal capacities for language and reason.

This hierarchical relationship between tutors and students resulted in a 'banking' concept of education (refer p11) rather than a dialogic relationship, which Freire suggests is an "active, critical and criticism stimulating" method of teaching. This is brought about by changing the power imbalance between teacher and taught so that they have a "relation of empathy" and are "engaged in a joint search" for knowledge (Freire, 1973:78). A dialogic relationship results in "conscientization" where students may feel in control of their own thinking. For this to happen tutor and student need to engage together in a socially critical approach to teaching and learning in which the ideological positions of each interest group is exposed. Thus students would gain an awareness of their place as subjects of knowledge rather than 'objects' of power (Foucault, 1977). 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)

This study demonstrates the extent to which hegemonic conditions of education and practice limited opportunities to develop a dialogic relationship between tutor and student in the comprehensive nursing course. For example, when tutors negotiated with students to write their own learning objectives, the results were not only unhelpful they exacerbated the very conditions which prevented student autonomy. Students saw this strategy as embodying authoritarian social relations or imposing upon their time in a way that would not result in any change to their usual experience.

A dialogic relationship also assumes that tutors would be able to cast off the privileges, interests and social subjectivity that they brought to the tutor student

relationship. It assumes a commitment on the part of the tutor to unproblematically affiliate with the student, or to be a disinterested mediator (Ellsworth, 1989). As this study suggests, tutors were as much constrained by their own 'herstory' and coercive conditions as the students were.

Freire and Shor (1987:99) suggest that undistorted communication is one way to challenge existing domination. Both teacher and student become learners where the "object to be known" is exposed for mutual enquiry. Freire and Shor (1987) accept that the educator has prior knowledge but this does not mean that the teacher has exhausted all possibilities and dimensions in knowing the object. The tutor therefore, would relearn aspects of nursing practice through studying them with the students. This, of course, assumes that rational discourse can afford teachers and learners equal weight and legitimacy. Such debate however, could not be free of conscious and unconscious concealment of interests or assertion of interests which some tutors would hold as non-negotiable no matter what arguments were presented.

Under the hegemonic conditions described in this study, this strategy to make the teacher more equal with the student by redefining the teacher as learner of the students' reality and knowledge, may simply enable the teacher to devise more strategies to bring the student up to the level of the teacher's knowledge and understanding (Giroux, 1986:66). In this sense it is as inherently manipulative as a hierarchical relationship because the resulting student empowerment and the 'capacity to act reflectively' is defined by the tutor. Teaching and learning thus occurs in a way that fails to challenge any identifiable social or political position, institution or group.

Recent calls for a "curriculum revolution" in nursing education are an example of this (National League for Nursing, 1989). They leave unexamined the assumptions that teachers and students will be able to effect a "radical democratisation" of nursing schools and "abandon metaphors of paternalism" (Allen, 1990). Expecting the least powerful and most oppressed groups in nursing education to effect radical structural change is inviting failure. A new and different educational order requires that changing the structures, norms, values and attitudes of dominant groups would have to come from within those groups themselves. Yet this is unlikely since they are the ones with the most power and privilege to lose.

In the context of comprehensive nursing education, tutors and students may be able to identify and discuss the mismatch between education ideals and institutional ideology and the conflicting demands and values of the clinical environment (Higgins, 1989). Tutors may be able to develop a dialogic partnership with students to realise common goals (Allen, 1990). They may not, however, be able to use this knowledge to effect change to the structures which currently impede the realisation of their educational and practice ideals. Therefore structural constraints and the reproduction of culture and received knowledge may continue to obstruct the progress of the discipline towards the creation of the knowledge and structures it requires for autonomous practice.

In the next chapter some of the limitations and the implications of this study are explored and some suggestions for future research are made.

CHAPTER EIGHT

REVISITING THE STUDY

Nursing education takes place in the context of a wider society where official discourse has always favoured the ideology of dominant groups and, increasingly, favoured economic expediency. Political and economic reforms have changed the underlying philosophies and structures of health care and of education. This has created a level of political, social and cultural upheaval in recent years which has affected the lives and health status of all New Zealanders. Devolution of responsibility and funding from central government to area health boards has altered the shape of nursing services. The advent of 'Learning for Life' and the resultant ideological and structural changes in tertiary education have created both difficulties and opportunities for nursing education.

Nursing has always had difficulty in gaining access to policy and decision making at central and local government levels. Nurses often do not value their own legitimate professional concerns about nursing and wider social and health care issues. Neither do they present their ideas forcefully in a political forum. Hence nursing research, knowledge and skills are often little understood or valued in relation to the knowledge and skills of other health professionals. Nursing's contribution to society is therefore limited by nurses' own views of their relative worth and by the preconceptions of those with greater access to policy making.

It is suggested in this thesis that through the processes of cultural reproduction nurses maintain and perpetuate the conditions of their own domination. This limits

the ability of nurses to exercise autonomy and self-determination - to control what counts as knowledge in their field, to create knowledge about professional nursing practice, and to use that knowledge in appropriate ways for health care. Nurses themselves must discover and uncover the social structures which support the sources of power limiting nursing autonomy in every area of nursing education and practice.

This thesis uses the assumptions of critical social science to claim that the educational experiences of nursing tutors and students are part of a hegemonic process. Hegemony ensures that they accept as inevitable the constraints which prevent them from realising their full potential as autonomous professionals. It is this political process and its paralyzing effects which are revealed for critique and transformation using critical reflexive methodology.

It is claimed that this methodology motivates research participants themselves to become aware that their preconceptions are shaped by aspects of the prevailing social order such that they are prevented from achieving their nursing ideals and educational goals. The original intention of the research was that this enlightenment would be translated into practical action to transform oppressive conditions into conditions which enhance personal and professional autonomy. In this way, nursing education could be a vehicle for challenging and changing those sociopolitical forces, and thus cultural processes, which appear to limit professional autonomy and the development of the discipline of nursing. That these expectations were not fully realised is due in part to the processes specific to this study and in part to the limitations of critical social science.

The intent and the processes of this research were designed to be emancipatory for all concerned. However this was only partially achieved, partly due to the artificial time frame imposed by meeting the requirements of a Doctor of Philosophy degree. Although participants increased their individual reflexivity, they were unable to act collectively, during the study, to bring about change to their conditions of practice. It is possible that a longer time frame may have been more productive at this level. However, the extent to which emancipation at the level of political action which brings about structural change is ever realised (even in a longer time frame) has not been fully explored in this or previous studies.

Tutors and students found participating in this research exciting and stimulating. In the final discussion session eighteen months after the formal conclusion of the study, tutors expressed their enthusiasm and satisfaction with their intimate involvement in the study. They were particularly pleased to be consulted at many points during the study and to have the opportunity to revisit their ideas expressed during interviews through the return of transcripts and draft reports. This final session was empowering for all of us and I felt that I had met the ethical and personal research goals that I set out to achieve. Students also expressed their satisfaction during their final discussion at the formal end of the study. They were pleased to be part of research where someone "from outside" had taken time to listen to their concerns, had consulted them at points during the study, and had fairly represented their views in the written draft report. Thus all the participants in this study have gained a commitment to the positive value of research, which may not be achieved through participating in other kinds of research.

However, my intention was that tutors and students would "actively own the data" generated from interviews and journals but this was only partially achieved. To

fully engage in emancipatory research requires that participants share with the researcher all the theoretical and practical aspects of the study, including design, analysis and writing. Although we shared a desire to increase our understanding of educational processes, including bringing classroom and clinical work closer together, the participants did not share in the design of the study. This produced difficulties in dealing with unanticipated situations.

For example, I thought that participants' would extend their insights and understanding beyond the situation in which they occurred, to bring about collective outcomes. This did not happen at the time of the research (although some collective action by tutors has occurred since) largely due to the highly individualistic and isolated nature of tutors' work. Moreover, they were unused to considering the structural basis to the constraints under which they worked and the broader sociopolitical effects of those structures. Tutors had had no previous experience of acting collectively to bring about structural change which would enhance their own or the students' autonomy. There was little provision in the research design for discussion about our different expectations and for modifications to occur.

Furthermore, the inevitable unequal relations of power between the participants and myself created unanticipated effects on the research process. For example, tutors tended to agree with my interpretation of their situations, rather than defining them for themselves or arguing the case, and to take up my suggestions or definitions of the problem. I became aware of this in the early stages of the study and consequently became less willing to express my views and analysis during interviews and discussions. In retrospect, it would have been more in keeping with the emancipatory intent of the study to surface this concern with the participants and to discuss with them the origins and nature of the problem and its possible solutions.

There is a degree of gender blindness in critical theory which means that it cannot adequately address some dimensions of nursing education. For example, all the participants were women and the extent to which this influenced the research is not addressed. Constructs such as communicative competence and distorted communication have been partially explored, in terms of critical theory, but these could be further developed in relation to women's experience within educational and health care institutions.

Although all participants were highly cooperative and self critical to the extent that they wanted to take responsibility to improve their own practice, this was largely focussed on the technical, rather than sociopolitical, dimension of their practice. The way that nurses commonly focus their motivation on improving technical, rather than sociopolitical, knowledge and skills may be dysfunctional for their pursuit of autonomy. The meaning that this technical focus has for nurses as women and its implications in the larger world of nursing education and practice, has not been explored in this or other studies. Nor were women's ways of knowing, women's knowledge of healing or women's approaches to teaching and learning explored. Future research utilising post modernist feminist theory may address these crucial issues.

A further limitation of this study relates to its evidential base. Because the focus of this study was on the reflexive understanding of the participants, and to the extent that interview and journal excerpts were representative of common themes that arose during the course of the study, it is considered that these data sources are sufficient as a basis for interpretive critical analysis. Any attempt to broaden this focus to include analysis of institutional and wider social contexts would have required additional data sources.

The analyses of the data, however, take account of each piece of evidence being interpreted in the context of the total situation being reported by the participant. Furthermore, each participant had the opportunity to revisit and endorse their disclosures. In this way a measure of contextual and face validity was achieved where the whole model comprising theory, method and explanation was especially suited to the phenomena being studied. However this research account cannot provide a *general* account of the experiences of teaching and learning for all students and tutors in all nursing education contexts. It is argued that such generalisability is not appropriate in research using interpretive critical approaches. An opportunity for the reader to arrive at a tacit knowledge of the professional experiences of these students and tutors has been provided.

There are other more general limitations of critical social science many of which have been discussed throughout the thesis. Those deficiencies pertinent to this research are highlighted in chapter seven and demonstrate the extent to which critical research is likely to fall short of its emancipatory intent as expressed through sociopolitical action.

CONCLUDING STATEMENT

This research has been successful in unmasking some of the ways in which sociopolitical forces constrain and shape personal and professional choices for action in the context of comprehensive nursing education. The processes of posing the central research problems, designing, negotiating, planning and engaging in this research have enhanced my own development as a nurse, as an educator and as a researcher. The insights I have gained have both enlightened and empowered me in my search for new understandings of nursing education and practice. The respect I

held for nursing tutors and students has increased through the insights they shared with me in our endeavour to uncover the hidden limits to autonomy, happiness and rationality that constrain and shape their day-to-day understanding and practice.

APPENDIX 1

Document for the Ethics Committee for Research on Human Subjects

A study of the generation and transmission of nursing knowledge during the third year of comprehensive nursing education

Researcher: Judith Perry RGON MA (First Class Hons)
Lecturer, Dept Nursing Studies
Massey University

OUTLINE

This research is an attempt to describe and explore the educational experiences of third year comprehensive nursing students and their tutors both in the classroom and in clinical settings. As the research approach requires active participation, students and tutors will take part in audiotaped individual and group discussion and will keep a professional journal for a period of six months.

The research is the fieldwork associated with a PhD thesis which will be finished in 1990. It is anticipated that parts of the material will be used for journal articles and research reports.

CONFIDENTIALITY

Since the principal method of data collection will be tape recorded individual and group interviews the following safeguards to confidentiality will apply:

- a) All data for the study will be collected by the researcher.
Code names will be used for all participants and actual names or other identifying characteristics will not appear on any transcript material or used in any publications or reports of the study.

- b) The nature of the study will be fully explained to the potential participants including the likely consequences, risks and benefits. Participants will volunteer without coercion to take part in the study and they will be informed that they can withdraw at any time. Once their informed consent is obtained participants will be given written assurance of confidentiality as part of the consent form signed by them and the researcher prior to their participation in the study.
- c) The reflexive nature of this kind of research provides the conditions in which the participants are able to see their actions and situation differently and to act on that knowledge. Therefore, as well as giving their informed consent, participants will be expected to comprehend the nature of the study being undertaken. Each participant will have opportunities to view and confirm all fieldwork transcripts which relate to them and written documentation will be available for comment at the conclusion of the study.

APPENDIX 2

CONSENT FORM

As a participant in this research you will not be identifiable in any written documentation and all audiotapes will be confidential. As this kind of research has the potential to change your usual practice sufficient time will be available for informal discussion. You will be free to withdraw from the study at any time and all material relating to you will be destroyed.

DECLARATION

I have had the nature and likely consequences of the proposed research fully explained to me and have read the attached explanation. I understand that as a participant in this research I will not be able to be identified in written material and that my right to privacy will be respected such that I can divulge as much or as little information as I myself decide. I also understand that I can discontinue my participation at any time and if I do so all material relating to me will be destroyed.

I therefore give my informed consent to participate in this research.

DATE.....

SIGNED.....
(PARTICIPANT)

DATE.....

SIGNED.....
(RESEARCHER)

APPENDIX 3

PROJECT TIMETABLE

1987

September - Research proposal accepted by the Doctoral Research Committee,
Massey University

November - Submitted research proposal for approval from Ethics Committee,
Massey University

November - initial correspondence
to February - visit to polytechnic and clinical agencies
- permission to enter the field given
- initial interview times arranged

1988

March - Approval from Ethics Committee, Massey University

April 5-8 - four days in the field
- initial interviews
- explanations, interview and journals explained
- consent forms signed with eleven tutors and thirty eight students
- first interview times arranged
- hard backed notebooks given to tutors and students

- April 29**
- first tutor interview
 - read three journal entries from tutor journal
 - received photocopies of first tutor journal entries
 - initial analysis of journal entries
- May 22-27**
- five days in the field
 - interviews with nine tutors (1-2 hours) on campus and/or in clinical areas
 - interviews with five groups of students (5 -8 per group, 1 hour each) on campus and in clinical
 - interview with individual students (3)
 - collect and photocopy journal entries (tutors)
 - ongoing journal analysis
- June 14-17**
- four days in the field
 - nine tutor interviews
 - two group student interviews
 - collect journal entries - photocopy
 - ongoing journal analysis
- July 4-8**
- five days in the field
 - nine tutor interviews
 - three group interviews with students in clinical area
 - collect journal entries - photocopy

September 14-16

- three days in the field
- nine tutor interviews
- two student interviews
- ongoing journal analysis

November 22-24

- three days in the field
- five tutor interviews
- two group interviews with students (last 'interview' two two hour sessions)
- collected all student journals
- collected all tutor journals

1989 - analysing, transcribing, writing, reading

1990 - analysing, writing, reading
 - interim report sent to and discussed with tutors

1991 - first draft of the thesis completed

March 20 -24

- two days with tutors - group and individual sessions discussing and debating the final report (chapters 5-7)

May - Final draft completed

APPENDIX 4.1

EXAMPLE OF INTERVIEW TRANSCRIPT (TUTOR)
 (researcher's comments in bold print)

KAREN (INTERVIEW 2) - 26/5/88

I actually had something I wanted to talk to you about -

Yes sure -

- thinking about the last time and it's gone, so I'll have to get more disciplined and write it down, because I haven't got my diary with me -

Is it something you wrote down?

No - I've written nothing since I've been here in this week.

Oh well...

But I mean, I wanted to - I mean that was my purpose - and I don't know what that indicates really - I mean first of all it indicates that I've had 34 contact hours -

I should think that's enough for anybody.

And - um - like last night I chose to go to the films and -

Yeah, well why not -

And the other two nights I have been working on the curriculum. I actually find that I don't resent the time but I find it takes me - say, you know half an hour would be no time for me writing in my journal - I need that time. I don't plan to have it like that but I find half an hour is nothing - even writing in pencil with a rubber - Yes. So what I want to say is I'm disappointed, you know I'd like to actually reflect on what's actually happening in the same ways that I seem to be able to in the clinical

area when I'm working. I'm disappointed that - I don't know, we'll see, because the last week of last term when I was - you know, operating the journal, it is the beginning of the term and it doesn't seem to be any different, so I'll just see what happens.

Mm. Maybe if it's um - maybe if you just keep your journal with you and jot down notes during the day you might even be able to expand on those notes at some quiet time?

Yes. I might have to sort of - even end up during the class weeks, it might be a list of items -

Mm. things you thought of -

Yes things I'd thought of, perhaps particular points rather than actually thinking about it in depth and then choosing - maybe looking through it and choosing to talk about something with you when you come down. I might try that approach, because you know I'm disappointed I haven't had that time.

Mm. You were saying before that Tech for tutors is a place where you can open out and be a bit creative and be yourself more so than in other teaching situations.

Oh I think so, yes.

But when I asked you if that was so for students you had a very immediate reaction to it?

Oh I don't really think it is - no. And um - I think here, I do think we are closer, and I can only compare it with my experience as a student in a Polytechnic system also, and my experience was just sitting for 32 hours a week and that was learning - and I'm sure the most creative tutors I had did their best, but they were working within the constraints of basically that we had to be sitting there and they had to be there also.

So the difference is now the packages and the students -

So there is a difference yes. I think there is far more flexibility and time when you choose to learn and how much you want to give to a particular thing - and for myself - as a tutor now in that system - that's one of the reasons why I just never will get all my packages in - in fact I've never really had all of my packages in.

Do you mean the students keep them?

Well we get them in to check them over, see what they've written.

Oh I see.

I never build anything in like tests or something like they do at the finish, that's directly related to the material - I never do that unless I give them the answers at the bottom. I've discovered a few of my packages I've accidentally left out (a), (b), (c), (d) and (e) or something saying that that's the answers - because I don't know, I like to leave that to them. I like to give them the opportunity and leave that to them and not -

So they really are free to do as much or as little as they like.

Yes. And in fact knowing full well that some of them may choose to do very little - less than what I would, and I just feel that that's part of -

Being an adult.

Yes - and making that choice - and it's a risky choice at times.

Where does that process start? It obviously doesn't happen in first year - does it happen in other modules?

Yeah definitely. It starts actually - my understanding that until probably very recently in this thing, in this department it has been implemented right from the first year from the time they come in. A lot of it has been modified of late.

How much checking up though would tutors do - I mean is it usual?

Well ... they did little I believe. Well I mean if you can believe what is reported and discussed in the Staff meetings. I began to question this and ask outright at the end of last year - I just asked. I said "How many people get their packages in? - you know, just at our staff meeting. And I discovered that there is quite a few people get their packages in and look at them.

So you are almost back to the old way of doing things, except that instead of standing in front of the student and giving her something and then her giving it back its written? - Yes, yeah. - That's interesting isn't it? Is it to do with keeping control?

Yes. And the fear that somehow or other they mightn't be learning and its kindness - its out of kindness that somehow or other they mightn't be learning and you might only discover it at the last minute when they've failed the exam or something - and it's too late to - I was going to say "rescue them" - I hope it's not that, but it's too late. Maybe they've got to pass onto the next module or something. - Um I do have some thoughts about this student-centred learning in that I wonder if developmentally the average seventeen year old - the only thing is that I have some conflict there is that at University when I was checking up on them and there's still the same seventeen year olds - or are they? - are they somehow or other a different group that comes in here, but I'll assume they are not - got an awful feeling that had better not go on ...

(INTERVIEW INTERRUPTION)

...What I'm wondering is that if the group of students who enter a Nursing Studies course aren't more - a little more dependent - a little more potentially compliant.

But... we are getting much larger numbers of people who are older or who have degrees coming into a course.

Yes. We had a few down here too I think. But then I think when I'm talking about dependent compliant - They are the younger ones I'm talking about. The younger ones that come straight from school. I'm not talking about the older students, I don't know how you classify them.

And yet lots of programmes now don't allow people to come in at seventeen, they have to work until they are eighteen.

At the present time we are still letting seventeen year olds in. I know that. And um - looking at the latest issue of the journal I see the research has finally got in. And I think she demonstrated quite clearly that the younger they are - it's a greater risk... that's one factor that seemed to be clearly associated with not getting there.

Yes. Except that what was missing out of that piece of research was the kind of programme that those students were put through - and the kind of support systems that were available.

Yeah. It is probably fair to say that the support in here is extremely benevolent and very close. It is very hard to actually miss on our course I think. Very very hard not to make it.

Well - would you say then that this programme is supposed to be student-centred but in reality tutor-directed.?

Yeah, and it still is - because we design - we set the objectives - we set the learning objectives - I mean that always follows after I've decided what the content is going to be - but anyway - some objectives end up there and I say to them "Look these aren't just words, they are to try and aid you". If you feel "Where am I going?" - look back and see those objectives and see if you could meet them, and it might give you some support if you feel you have ... your way through a whole package - you don't know where you are going - but I mean and us setting the objectives, I know that we - the only thing that we are not setting is the amount of time they are going to give to something, whereas when I was a student - if you worked for 32 hours anyway fully and we weren't able to control that, that only left us with a few hours in which to develop something further, or spend more work if you wanted to, and that was in our own time. So - you know, we were fairly spoon fed. These students aren't as spoon fed, aren't quite as spoon fed, that's my view - my students I don't think they're quite as spoon fed but I'm still setting the objectives, I'm still deciding.

(134)

Mm. I know A talked with you the other day about students setting their own objectives. Yes that's right. How did you feel about that?

Well actually I think it's a really good idea. And actually it's terribly safe, I don't think actually anything could go wrong. I mean, that's what I said to A - clinically I mean it's really sound. I still feel that necessity to say this is a learning objectives. I feel that you might need it if you are going to have a reasonable education as a nurse.

Oh that's fair enough, because you have a level of knowledge and expertise that the students don't have.

Yes. And um - so actually we are going to implement it. I've drifted a wee bit, but what I want to say is that my reason for not dragging packages in - even though I've said that these are the objectives and therefore what I might test you on - I've still given them freedom which I didn't have - was whether to do that package or not - or whether to give it more than cursory attention - whether to work in a group and one person does one page and another person does another page, but if you are satisfied with people working in a group that's fine, as long as they are just not copying each other's work - because I don't think they learn to the best ability then, it's only second best - and so they still have some choice there.

Mm. But wouldn't they just copy from the text book?

Yeah. But they'd have to sort of have a hunt through. They've had to have a think. They've had to digest - "Is this what this person wants?" - and when I find students come to me and ask me for something, they'll say "Am I right, is this what you want" - you know, is this the answer. And I'll say you know well that's what Wilson and T.. says, and you know those sort of ideas are right and that's fine. And um - so I like the package learning from the point of view that they are - I think they do start exercising some judgement about what's important and how much time they are going to give to it. And I would ruin it by bringing in packages because then they would - I think it would take a courageous student to miss out a whole couple of pages or a big gap because maybe they were bored stiff, they couldn't follow it or it didn't seem important so they just missed it out and then submit it to my roving eye.

But it seems to me that in this module there's a very flat relationship between tutors and students.

What do you mean by "flat"?

Well I mean, you know you say you don't like bringing in packages because of that power thing - it would take a very brave person to miss out two pages because of what might happen -

Yes.

And also in the clinical area you tend to talk to them and value them - you know you've told me that you value their knowledge and so on.

Oh yes, oh yes, I do.

So there's not the hierarchical relationship that you get in some other places?

I don't think it's as evident. No I personally don't think it's as evident.

You think it's still there though?

Well I suspect its because it's from my position. I think if you were to speak to the students and ask them, they could still identify points of power - heaps of points of power.

Yeah. Because ultimately you are the person who passes them.

Yes that's right. There's heaps of points of power. I must have some. I'm sure I have - and I'd have to reverse it and sit there and be in that position to see a bit differently. But that's my reason. I actually think it contributes to their professional development to have to make that choice and then take the consequences if it's not quite right.

Perhaps the ability to make those decisions rubs off on their clinical practice, so that if they become more aware of being able to choose - more autonomous with their package then they might be more autonomous in the clinical context?

Well I think if they've had to in their three years here - and you know - there's still to be fair huge numbers who wouldn't get all their packets in, and they certainly have some packets passed. If they'd had to consistently in three years make that kind of judgement, like "I'm going to miss this out - I'm not going to do this one (200)- I'll work really hard on this because I think that's important - that kind of thinking is going to help them when they have to make those kinds of decisions only it's with real people and with their own practice.

Yeah right. So it's all tied up.

Yeah it is tied up. As you know we've been talking and () had said that one thing that she thinks about that she is going to - she wants to get more packages in - and I just said to her that you know that's fine but that I won't be doing that because I want to leave that to my students. What I've been meaning to - I want to actually get some packages in - I don't know, it's more for my evaluation, I'm not interested in what the individuals have done with the material, I'm wanting to see if there's any sort of pattern I would do it from that point of view - there's kind of an evaluation of the actual material.

Um - you could do that in a number of ways though - you wouldn't necessarily have to get the package - you could actually go through a package in a class and say "Ok, if you have trouble with this or that..."

Yes, why I think I haven't done that - it's not been a high priority and I think one of the reasons is that I must be getting enough feed back that I'm satisfied with what they are doing - and I actually talked to them at the beginning of the module about that - I say that on the whole in this module we don't get the packets in - that if we are - because it's written in to somewhere in the evaluation policy that we put a rider to ask for the packages at a certain time - and give them notice and ask for it - and I say that we don't do that - but if we are, individual tutors might choose, and it's as much for their knowledge as to see what the students are doing and that they are

given plenty of notice and that I'd say - just name the packages that I do and I won't be asking for mine for this particular module - and you know I'll continue like that really - I just would - it's a lot of work and I think it's unnecessary, because what I might get in a package that looks right but do they know anything more - and are they going to pass the exam? And I have to put pass in the exam as important because that is one of the things that they are going to be measured as succeeding and moving on from my module so I have to try and help them with that. We do this criteria and reference marking here - for better for worse we try to do it and the questions that I have had to prepare for the exams now using that method I find now that when I'm teaching the lessons, at the finish I feel obliged to say things, and I said - "Now I use this sort of material frequently in my exams because I think it is an important area and this is an example of what I might look in", and then I give them this (a) (b) and (c) criteria and say "This would be the critical key - the critical point. Sometimes I notice the comprehensives write it down other times they just sit there and listen but I'm not concerned about that - I mean that's up to them, if they are going to review it on what I've said and I choose to put that in the exam even at the end of this module for them I'm not concerned because there's tons of other materials that they'll have to learn as well.

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Sure. Do the students take those packages out into clinical with them?

Yeah they do.

So they use it as reference material?

Yeah and I try to get them to do that. Yeah, they take them out. I actually - when they go to (other areas) I have to caution them because actually there's some of their packages started disappearing - and that's a real disaster for a student when their packages starts to disappear because that's all their work in it and um -

Other students do you think or tutors or..?

Well you know, there's really paranoid reasons about why they had disappeared, so I do caution them that they might lose it and they've lost a big document if they have.

Mm. Does the (support) tutor get the package?

Well I give them my - I have a sort of Admin book, you know with due dates and assignments - I give them all that, but you see we must have about ten packages at least in our module - and I actually don't feel very comfortable sharing with other tutors.... I like to have an open relationship with an individual rather than just wholesale sending the package off - and like I've developed a relationship a wee bit like that with some of the (tutors from another city) people because of going to tutor training and they teach the same subject as me and we've talked with them and we've been over with some of the problems. One tutor said to me she had an awful time getting it into a nursing focus rather than a medical - and I said well I think I had checked this and I didn't mind her having it and she taught exactly the same subjects and she's got it, but I'm selective and like - I won't give it to them either, because I just don't know what they are going to do with them - and -

Yes.

Well it's not original - I mean it's bits from here, bits from there, thoughts put together -

But it's original the way it's put together -

And I just would feel as if it was the same as having someone in and evaluating you in the classroom, so I'm a bit careful about it. (pause) So um - I was just talking about the setting of objectives - X has already had a quick talk to the students and they are not very comfortable about it.

No, well ...

No so I said to X - I still want to continue with it. When we've talked about it - what I'd really like to do is - they have still set some and that we use that as we sort of have a wind down feed back in week eight when they come back from their big four weeks blocks and that we use that as sort of the tool - them having the power though to reveal it if they feel OK, because we can still talk - there's plenty to talk about it - and then see maybe if they can set a new set of objectives, having learnt

from some other their peers might have said and they've had some reality and see if there's something left or something they'd like to adjust, and then if we don't do it with this group - I mean I will be trying it again with - I like it, I like the idea a lot - I just don't know how it will go with lessons.

But it doesn't mean that you don't set anyhow. You can still set yours and even say to students - "Look these are my objectives, and I set them knowing what the content is and so on, but they may not suit you, let's have a look at the objectives you would set".

Yes, yes. That's right.

Well you can do it. You can do it lots and lots of different ways. What I was really - what I was talking about with X - she has probably told you this anyway - she was concerned about the control that was being exercised over students and we just sort of came to the -

The possibility, yes - yes she said that. We talked about that.

- about students setting their own. But it doesn't necessarily mean that the students set all the objectives, you can still have your teaching objectives and they can set some learning objectives or whatever - or you could - um - you could do it so many different ways, and you could look at classroom objectives and clinical objectives as being different too - so that maybe you would want to set the classroom ones and perhaps they set the clinical ones knowing what it's all about.

You see the big joke is - I mean these objectives, I've been on the receiving end of them - I try to go back to when I was a student here and I'm sure I spent ages and we never had anything like objectives - so we still had the lessons, and then the objectives started appearing, and we used to get a big book of them at the start of the term, and honestly, look I just threw it away - I was really quite motivated to learning new things, somehow or other it just didn't seem relevant to me.

Were they behavioural? The student will ...

Yeah, and - they weren't broad things, they were measurable - you could state six facts or list eight items or sometimes it was "describe something" or "discuss something" and that and I don't know how measurable that is - but nevertheless there were those sort of matters, and honestly I threw them - it's not that I was indifferent to them, they just didn't seem to be part of what I was learning, so I am aware even now when I - when I made this decision with this bridging class that's bringing institutional neuroses in - they talk a lot - a lot to share and it's really hard to get through it. Get through it with the comprehensives. So institutional neuroses was looming up - and I don't know - OHP of objectives - a whole OHP of objectives - and um normally with these students - um ?prompts - I would give it to them - and they would write them down dutifully and I'd just leave them on the table. I just thought oh it was just one more thing - so I just left them on the table and they just had the lesson.

Wouldn't that the whole OHP of objectives demonstrate that beautifully, that if they go and write down all these objectives which really have nothing much to do with them at all - quite irrelevant to ..?..

They were a lot to do with my lesson, but how much of it had got to do with them.

Yeah, well doesn't that demonstrate institutional neuroses though, because here they are all getting all anxious about meeting these objectives which are not relevant?

(laughs) Yeah, oh well - it was relevant for me! I actually -

Yes, but not for them.

And I actually - one of them said to me "Now you could - you could get institutionalised in your workplace". And I said "Well actually .." and then I gave me as an example - I said now the kinds of characteristics I will have - if I was institutionalised - but I never thought of the fact that I had rejected that - that never crossed my mind. (laughs) I said like I'd never change - all the material that I've

done So I don't know. I think they are very important in the sense of - even if you do it back to front - I think when you are preparing a lesson you do end up looking at something systematically -

Sure, sure.

And sometimes you can - I don't know I've done it when I've cut something out and thought "Well that's really not that important" and eliminated say perhaps that focus after a few times of teaching it - but -

Yeah. Students need a framework too don't they?

Yeah. But I don't - well I could be doing them an injustice - one of these days I might ask them if they ever do look back at the objectives. I never did. I can't ever recall. I had a go when I was sitting finals. But the objective - objectives aren't much use for deciding what critical facts are - they are just a bland list of everything, and you can't learn everything.

Yes that's right.

So, you know - we talked about this in the staff meeting and - one of the tutors said "Well maybe if we are going to have criteria and reference marking maybe we should then identify the key objectives?" - Well I sort of opposed that too because that then means that everything is directed towards the damn exam and it isn't - it's an education, so -

You are able to challenge that view?

Um - slightly, slightly. I do slightly, yes - A few people agree with me and manage to agree with a few elements of what I say - but no I am - but I was outspoken as a student too you see.

So you are used to it?

Yeah.

Yes, exactly (laughs). Oh, it's just the bare bones, there's nothing - to think a student can get through just on the bare bones. The State Finals - that's probably good, because hopefully the education has been achieved beforehand and people are in or out depending on their abilities, but I don't know about within the structure we have here. But I understand the reason why we are moved towards this is because you know, we may well not have State Finals -

Oh yes, yes.

- and we will have to have some objective measurable ways that we can say "Yes" or No".

We will - you will have to be able to satisfy an accreditation authority - probably by 1990 I would say.

Yes. Well it was with this Picot thrust and a few others now, yes -

Yeah, it might be that central body.

Yes.

Mm. It will be interesting. Because nursing is really quite different from anything else in the Polytech.

It is. It is. If we maybe have Physiotherapists or Occupational Therapists or something ...?...

A lot of what we do is interpersonal and based on subjective judgement.

Yes. Exactly. But that is not everyone's perception of nursing and um - it's not even - well the perception of well-educated - some well-educated experienced really safe good nurses wouldn't necessarily have that perspective either.

No it's true.

So. I don't know. We are thinking about how we are going to measure that. We have got a clinical evaluation which we do try and measure interpersonal interaction and knowledge and preparation and a few other things like that -

Mm. .. judgement -

Yeah - and that would become our critical factor... still clinically if and when we move to that - but we would have to improve the tool that we measure it with - it's still very subjective.

Mm. And yet nursing is a subjective science.

Yes but you see I don't know whether half of this profession will allow us to be subjective - even professionally subjective - there's a terrible fear of that happening - somehow or other that's a backward step.

It's amazing isn't it?

Yeah. So I guess I mean I find myself um - I'm going to miss it when I - see I've virtually finished tutor training now because I had access to better sources of journals and things up there and I find myself when I go up there scanning through every sort of education journal and psych journal I can find to try and get some ideas for that very thing - like some clues how you would measure if someone's been giving empathy.

Yeah.

Now I've seen things like certain body postures and everything. And I mean we say otherwise who's going to accept it? It will just be me. And I've found when I write progress notes about students and I've said this to you too - it's OK for me to say a really good student - excellent and so on, but the moment I begin to have some doubts like maybe that they are a little anxious or whatever, I mean I'm not allowed to write that without absolutely qualifying every word. I suppose that's correct, but

it's very hard at times. I mean it is correct I suppose and of course the students certainly are free to read that and they do - they do all read their progress notes.

Mm. Seems to be quite a double standard then doesn't it because tutors quite freely in my experience talk about the anxiety levels rising, somebody being depressed, not necessarily psych tutors, but tutors in general, and yet when -

Yes. We have to - we can't write that - I guess I suppose at times there's been sort of gross injustices done, and there it is written and a student's furious and unhappy and it's done, and it's written there and um - you know anything could happen to it. I guess it has to be balanced, but I don't know where the balance is.

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(END OF INTERVIEW)

APPENDIX 4.2

EXAMPLE OF INTERVIEW TRANSCRIPT (STUDENT GROUP)

(researcher's comments in bold print; different student speakers indicated by ordinary print, or [, or {)

STUDENTS 3b - GROUP INTERVIEW 2 - 17/6/88

What sort of things did you learn there?

Nothing really. (laughs) It was very frustrating work in class actually.

Was it? Yes. Because you had done it before - or what was frustrating?

The organisation actually. Yeah we sort of found it really wondering actually what we were supposed to be learning. There was a communication thing that we were supposed to do one afternoon - and we found since we had done Psych that interviewing skills and what have you were quite good - I mean we all passed our Psych, critical interviews quite well. And some of the questions that we were supposed to have in this interview - Where do you go to be alone? - What do you most often dream about? Um, things like that which we felt were really - I mean you wouldn't - they might be something you might talk about to a close friend but it is not something that you are going to talk about in an interview that is going to be reported back to class, and I just dislike this invasion of privacy and didn't want to do it. (laughs) That was collective side of that - the whole class decided it didn't want to do it - that we - you know that we could cope without it. It was a very useful handout because it had pointers for interviews and it was good to have it to refer to but we found that we were actually doing all those things without actually having a label on them.

Right. So you felt pretty competent?

Yes.

Did you discuss that with the tutor?

Yes, we discussed that, but the thing is that now - We missed it in first year, but now they do do that in the first year, so it is just because we missed out that they were doing a catch up thing, but by now we have picked it up through experience.

Right, right. OK. So - um - What were the other frustrating things?

I just found the whole week - we'd either done it all or -

[Yeah there was a lot of - like professional development it was called, but it was more or less the same as professional studies which we did in our first year - and it was all just -]

What sort of - what did that involve - what sort of things?

It was just like talking about NZNA - it's role and the Health Department, the Nurses' Union and things like that - and things that we already did anyway, as in confidentiality, and how we treated our patients and -

[Things that if we hadn't learnt by now well we should -]

Had there been some new information, it would have been useful, but it was rehashing what we already were well aware of I think, it was the frustration - we couldn't quite handle that.

Mm. Were you able to say all these things to the tutor and have things changed - or did you just put up with it?

We did the first day, communication issue -

[Mm. - we did actually say we didn't want to do it, we thought it wouldn't do us any good, so we didn't have to do it. But the rest of the week - yes I suppose we did - sort of thought "well what the hell" -]

We did have an exercise where there were folders of information on geriatrics and tapes on nurses in power and the role of women and areas to change - and we had to go away and read them and listen to them and report back on them.

Yeah. Was that useful?

Well we had the option of handing in - just a little summary of it - so most of us did that so we didn't sort of hear what everybody else had learnt. You know - but I - listening to the tape of values - you know Women and values to change - it was alright, except that the tape - the last set of dates referenced to us was 1979 so we felt it was too far out of date with the statistics on it to be relevant really.

Mm. The world's changed since then.

Yeah, it has changed a lot - I mean - (laughs).

[Our tutor out at (the clinical area) did say that we are the furthest through our course to actually do our geriatrics ever, didn't he? -]

(group reply): Mm.

[- so that may be why we get so bored with it and - because we are - like we've done a lot of it in psych and most other areas]

So I wonder when geriatrics is usually? - Is it usually in the second year?

{It usually starts in a block course - like we do six weeks or something - but our year - the ones that were saddled doing psych - the first ones who had done psychogeriatrics and that - we are the first year to do it this way.}

[Mm. Our whole class is divided in three, and we are rotating and we've done the other two so we've probably got a lot out -

- The whole class going through the whole lot at once - just do geriatrics and crisis care as a block and then psych wasn't it? -

{ Yeah, something like that - so we're the - }

Does it help to have psych first before you go up to geriatrics?

Hell, no.

You know you were saying before that your interviewing skills were quite well developed because of psych?

I think it makes you more aware of things like Alheizemers you know and the reasons behind some of the demented behaviour, because you've done psychogeriatrics for a week as well. And what I found really valuable was the charge nurse and the tutor sat down and went through the differences between Alzheimers, Dementia, and Confusion and how you would - you know like Dementia is measured in years, whereas confusion is measured in hours and days type of thing, and how you go about dealing with confusion to get to the underlying cause, and that was really good, and then she explained the physiology - the A and P of it all, and that was - I found that really valuable, I really learned something there so -

So, right - and that was the charge nurse there?

Yeah.

[My - one of my patients that I actually had out there was actually a psychiatric patient - that I had nursed before - that is in the Psychiatric Unit - last year when I was there, so psych was quite helpful there]

{ Because they are getting more and more psychogeriatrics out there, and I mean it's - now that there's a label for it - I mean I used to work out there as a Nurse Aid when I was at school and now I sort of see that what we just thought was old age has now got a label - It was very interesting for me going back, because I know all the staff and most of the patients, and to go back as a third-year nurse and not an Aid, it was quite an interesting experience }

Yeah. Did you find that your approach to patients was different?

{ Yes, a little bit different, but that is a really good hospital and I find that the staff are really caring and really think about the person as a whole anyway - there mightn't be so much emphasis on the psychological - you know - side of the patient but they do think of them as a whole. And I really noticed it because I've worked in quite a few different homes and hospitals. }

Yes. A couple of staff out there - you know when I worked there, that really annoyed me the way that they talked to the patients - "Come on dear, it's time for dinner" !!! *(spoken in high pitched voice)*

[I know I'd have really hated that - I was lucky that I was on a ward with good patients, patients who really thought of staff]

- But this was to patients that are probably just as capable as you and I at feeding themselves - I thought - that's the other thing you've got to watch - is that in a task, where people become task-orientated - they are inclined to get on with the job and get things done rather than leaving people with the time to work things through themselves so that they keep the skills that they have -

[They are fairly good at leaving them to their own devices.]

So what - at the hospital itself, what did you learn that you didn't already know?

(All laughed)! -

Nothing. I might of - um - I didn't learn anything - the only thing I did was probably improve a few skills that I hadn't done much of.

[I think the basic feeling of the group of us that were out there was that we were just .. you know .. we were waiting until we got back into the real world - I - again we were going into a crisis situation - which is - you know something really exciting to look forward to - you know].

Would you - as staff nurses next year - would you apply to go to there?

NO. (a group reply)

Why not?

Because I feel that it would be dead end in my career -

And yet it takes incredible skill to do it properly?

Mm.

[Yeah, that's right, you know - but you sort of feel, that - well for a start off you would be burying yourself in a place like that - unless you were travelling from (*the city*) - and even to me that's liberty for a while for all my life and self, and I don't want to stay down here, I'm not even going to bother applying anywhere in the South Island. - I want to apply to the North Island, but if I don't get to a job, well too bad! - you know. (laughs) It's just my -]

So you want to get out?

[Mm]

One of the charge nurses out there is actually a Comp. Nurse and she went straight from her training - it must have been about ten years ago I think - and she's excellent. She came and got us and we looked in ears and things, and had a lovely time.

{Mm. But the comment from the staff was there's a new - a girl that's come out from Ireland - and they have really noticed a difference when she's on the ward because she - gets in and helps with the ward work and they said that the Comp one did the same when she first got there, but now after about two and a half years that she's been there, it's dropped back - she doesn't get in and help as much - you know, it's quite interesting the way the staff respond to the different personalities of the registered staff.}

Oh, yeah, that's right, and the way they - it's a very common story actually - to see a comprehensive nurse who's gradually sort of pulled into the institution and gradually takes on the administrative aspects and leaves the nursing to students and unqualified staff - Is that going to happen to you?

No. I hope not.

[No]. (laughs)

{I think that - actually I think we are really lucky because when we talk about these things to you it makes us aware of them all - you know, it makes you more aware of just how you are going to end.}

[It would be so easy though - because like out at (*the clinical area*) there's very few staff nurses and it's so easy for them to get pulled in to doing administration and everything else that other people can't do - you know a lot of them do - the nursing staff]

Mm. Personally that's not why I trained to be a nurse - it's just an administrator.

{No.}

It's just like more nurses are going to have to look at improving their administration skills (laughs)

Can you talk to your tutors about these things?

I think you probably could, but you have to be careful who you approached. [Yeah].

Why would you have to be careful?

I just sort of feel that it's not a situation that we are in yet - and when we are in it, well we won't be anywhere near our tutors.

{ And with some of them I get the impression that - not that it wouldn't worry them - but it would just be something that - oh yes, when it actually happens to them they'll handle it sort of thing.

Yes, and yet you just said that talking to me makes you think about what's going to happen - I mean - couldn't you talk to your tutors in the same way?

It's that you're impartial.

[You are not our tutor, you are not involved with this Polytech or this Hospital. A lot of them have ties of loyalty to the hospital because they've worked here, and you're a third party altogether you see.]

So you see me as relatively powerless to affect your future?

(general laughter) No you can reflect our problems and give us ideas on how to cope with them - so we feel we are getting value - it's like having our own counsellor (laughs).

But you haven't got a particular tutor that you could go to and have the same kind of relationship? - Sort of an impartial relationship - someone just to - you know - just to -

{ I had quite a good chat to X yesterday, but she's not really involved with our third year classes, you know. }

But would it help if you had - say you had a tutor that you had right from the first year, and you followed it through with that particular person for the whole three years, got to know them quite well and think just go and bend their ear whenever you had a sticky problem?

In the second and third years there was a tutor that I thought if I ever have any problems um - in nursing - not that I would go and talk to though - that I felt that I could go and talk to, and I had a warm reception and they would actually - you know, talk back to me -

You know how you were always taught that you had to be a patient advocate?

Mm.

Have you actually done that? Have you had an experience of doing anything?

Not really.

[Um - I suppose we all must have - not in a direct way, but then you are always working for the patients, and you are always encouraging them to be assertive, in what they want from the hospital in a hospital situation, and not just sort of be submissive and shut up when the doctors go past - ask questions, and you know, and not to be afraid to ask -

Have you ever intervened for them, when they haven't been able to do that?

[I've gone away and asked tutors, and with one patient - he and I looked through the text books, he was waiting for a heart valve transplant operation and was interested in his condition.]

But you haven't intervened and gone to the ward staff, and said "Look Mr So-and-so is doing such and such and needs some more information and needs to talk to the doctor"?

[No I think you tend to shy away from the ward staff because you don't always get a good reception so you sort of take it to the tutor]

{The only thing I can think of doing is - I had a patient who was really scared that they were going to find cancer - she said this to me - so I told the doctor, and he went away and told her - that you know she was scared that they would find it and not tell her - and he went away and had a talk to her and that}

So you did act on her behalf?

{Mm.}

Um - how would you learn to do that? Um - do tutors - are tutors student advocates? - If you get into a situation in the ward where you need someone to sort of back you up or support you or to change whatever is happening in the ward. Do tutors act in that role?

Basically, they really don't want to rock the boat because - a lot, we've been told a lot of times - if they go along and we do something to annoy the staff, they can quite easily decide you know, well we don't want your students in the hospital anyway, and that would just be our course.

Would they decide that - is that real?

Well I don't really think so, because they'd have no nurses coming up, but -

[There's that one incident - th that woman and the second years - and...

Yeah that is the only one that I can think of.

Do you want to tell me about that?

Um it was - um - We were having a lot of trouble as students with the charge of the ward. I remember I just nearly left the ward crying one day the way she had talked to me in front of the afternoon staff.

Was that because you were a comprehensive student, or was that more personal or what?

No, it was because I think we were students. I was told - I didn't have my priorities right - that I had better learn to get my priorities right. And I was only passing on a message from my patient to her, so that maybe the afternoon staff could do something about it - because it was, you know - And - Ok, that was OK, and that week passed and I was quite glad to get out of the place, and we got back to Tech, and the person that was with me - the other student - neither of us liked her, we sort of saw her coming and took off! - But we came back into class, and it would be your class, [], - some of the students out there -

[Yes, what happened, was a particular lady came into the ward, and I had looked after her in the old people's home that she was resident in and I knew that she had cancer, and she had just decided that - Right, she wouldn't go through all the trauma and what-have-you of them doing operations and giving her treatment. stop taking medication, stop eating, and just die quietly in her own way. And so when she came in, she was, you know - she had slipped into a semicoma and she was sort of in and out of consciousness, but they had bandaged her hands when she was pulling her drip out, but the charge went to give her her medication, and she pushed the charge's hand away as she was going to pop it in her mouth, and so the charge slapped her hand, and so she slapped the charge's hand back and then the charge slapped her across the face. And one of the students saw and reported it to the tutor and so the charge was given a week off to just sort of pull herself together - whatever, whatever. And that was that situation anyway.]

And the head tutor the second week, she went and told her that it wasn't good enough, etcetera.

And was that all explained to you, and were you involved in the whole thing?

Well it was all pretty hush-hush.

[Mm, we just sort of - you know -]

We just sat there, and we heard of through the grapevine, but -

The tutor didn't come back and talk to you about it?

Oh no, but the tutor that I told I had this run in with the charge nurse, it was also over medication - by us sort of giving medication that she had given out - and to my patient because - I didn't know what it was - I wasn't going to give it -

Mm.

And she - got really snotty about it - and - "Can you not lift up a paper cup full of tablets?" - I got this all the way down the ward when I was following her. And I just thought "Oh stuff her!" - And it makes you feel about this big.

[Yeah]

- But the tutor came back to me, and talked it over with me and so that was good anyway.

[Mm, that's the problem we have with medications - it's a bad problem - you know because - lots of registered nurses never do it by the book - and it's really hard.

Yes and I suppose you've all had it drummed into you about safety and -

MM. { We are just told if there's not a registered staff that we check it out with, well we just can't give them }

[Yeah, and if it's on name bands as well, so we can't do anything with drugs that are written - because if we went round and put name bands on everyone - yeah - that had medication - like at lunch time. But it's so easy just to pop a pill under someone's mouth, then run away. Do you do it. Because most people understand. What they do, is they dish them out, down in the office into little round packets, and then the charge walks around with them and the ones that are doing feeds, comes along and tips the pill on to the spoon about to go into somebody's mouth, and -

So although you actually give the medication - you wouldn't have a clue what the pills were - and ?

They are all the same - ..

{ This was actually told by one of the staff nurses - I was doing a medication thing - what did she say? - remember? - We'd actually had instruction, and she called it something because it was digitalis - you know well she called it something else, but to me it meant pharmacology, and if you'd had instruction in that, and you like - gave out a drug like that without checking the pulse to see if it was over 60 or that - and you gave it and something happened to that person, then you would be accountable. So I thought that was quite interesting, because I didn't even really know that - I knew that we were responsible for drugs -

Mm. That's right. Professional responsibility. (pause) - Um what sort of things have you done during the last couple of years that would allow you to initiate some kind of change either to get the ways that the drugs are given out changed, or would allow you to be more directly the patient advocate? Have you been learning those things as you go along? Have you watched tutors change things in wards, and challenge the status quo?

Well we don't actually go back - you see, we write our evaluations, and what we didn't like about it and what we did like about it and we just carry on in our courses.

You don't ...?

- And then another class writes theirs up so we don't really know what happens about change -

[- unless it is something really really drastic which I haven't heard anything of]

NO

[- like the second year seems to me to be exactly the same]

{The ones that went to the um, workshop -

(OH, YES)

{- now they've instigated a change there, because they went to the IHC workshop, they were disgusted with the way one particular staff member picked on a particular - she always picked on the one that was seen to be the less capable in a group, and would reduce the girl to tears and what-have-you, and it ruined the Behaviour Modification Programme that one of the students was doing because the girl was so ridiculed by all the others that she wouldn't - she was - she had set up an exercise programme, because she had a problem really, and the girl wouldn't do it because everybody laughed at her, and she And so they complained to the manager and what-have-you and the woman has been removed from the situation, you know she is in another part of the building, she hasn't been removed completely, because I

mean it was a problem that the manager had been unable to do anything, because you have to have three warnings before you can fire somebody. And everytime he had given her a warning, she had - well her parents who thought she was good had backed her up - and her mother had written in complaining about the harsh treatment her daughter had been - and sort of everybody else had ostracised her, so it was quite a bad situation. So that case - the students were able to do something -}

[Actually there was another one of our homes as well - the students weren't allowed to go to this time because they had trouble last time as well.]

MM.

You know how you told me - and other students have told me that right from the first year, you were told that you were guests in the hospital and that you've got to be careful and um - and as you say "not rock the boat" - do you really believe that, are you guests in the hospital?

We are not treated like guests - like you would expect guests to be treated.

LAUGHTER -

[We do seem to be treated as something different, like you've got your staff there, and you've got your students way over here with their tutor hovering over them] -

MM.

What would happen, if you decided, say in second year when you were doing Med-Surg that when you saw instances of poor care, you know, that you decided as students, that this care was not good enough and that you really wanted to change things before you moved out of that clinical area and that you had a very supportive tutor who said "Right, go to it, let's work out a programme of change, how we are going to go about it, who our supports are, what the time span is, and so on" - Would you want to do that? Would you be able to do it in an ideal situation?

Well it's quite difficult really, because you are only there for two weeks.

[It isn't an appropriate time as a student to try and make your change - maybe you just learn the skills of giving good care and of being assertive, but not aggressive in the way you approach other staff, so that when you get on a par with them, that you can make some changes - or even -

{Like (*the tutor in one clinical area*) said, she said that if you are a good role model, if you are student, people will be watching you, and if they see you doing something, and they've been doing it wrong, then they may think "Oh, well this might be the better way to do it" and if they try it and find that this is much better than their way, then they will probably change themselves.}

Do you think that would happen - like for instance, next year when you get out - as a new graduate in your first year?

No, because you are just the bottom of the pile.

(ALL - LAUGHTER) MM.

When you are not at the bottom of the pile, where would you have to be on the ladder to be able to do what you want to do?

I think if you firmly believe that something has been done that wrong, and that it really does need change for the patient's sake, or even their comfort, then I think that you should do something about it even if you are a new graduate -

{Or even a student }

Yeah, I think that you can still query, but you've got to be very diplomatic in the way that you do it.

Why do - surely all the nurses in the ward

(ALL TALKING AND INTERJECTING AT ONCE): -

Everybody - they don't like the insinuation that they might be -

[Especially if we come barging in instead of - you know]

"You are doing this all wrong" you know "You do it like this and this"

(laughter)

{ I spoke to the principle nurse at my clinical placement yesterday before I left and she was saying how one particular student they had there - when the doctor did his round, said... - now what was it going on, oh yes something about diuretics - and said "He's on too much for his bodyweight!" - Just like that. With X saying "You know you can see he's on a diuretic and .. and when she explained that to him - he said "It could have been something else" I mean, it merely put the doctor on the defensive you know. And she said it was quite a bad situation. She said, you know, if you don't come in here looking down at your nose at us as if to say "Well we just know what to do, and you know we are better than you", etc, etc. - she said it makes it a lot easier to come in and just play a low key you know. }

Is that good advice for next year?

Mm. {Mm.}

When you bring problems to one of your friends by being aggressive in an clinical situation eh!

So you need all your communication skills?

Mm. {Mm.}

On two different levels, one with the patient, and this ..

It's pretty complex situation - (laughs)

END OF INTERVIEW

APPENDIX 5

EXAMPLES FROM FIELD NOTES

24/5 Analysis notes from journals for interviews 14/6

Ann - ask about balance between students treating people as individuals and the student's responsibility to the ward team. Seems to be ambivalent here - focus on teaching but what does the student actually learn?

Jane - Ask about learning through doing - seems to want to look at learning through clinical experience - tutor as problem solver, resource - how could these ideas be incorporated in this curriculum? Still hooked on safety.

Karen - Are you a teacher, a nurse or both? What are your ethical responsibilities when you make clinical judgements about STUDENTS? But what do students bring to the situation? Recognise weaknesses rather than student's strengths. Does any theory come from practice?

9/7 Notes following student group interview.

Students seem to have amazing insight into their own practice and that of others - observers of practice - ? is this theorising? Do tutors have access to this student-knowledge?

Met with seven students for three hours during their clinical placement today. We sat in the visitor's room at the entrance to the ward and as the clinical areas were

very quiet the students had asked if they could have time out to talk with me. The session started off with the usual questions about their day and the patients they were responsible for - and there were the by now usual comments about never wanting to work in this kind of area when they graduate.

After about half an hour I asked "what are you learning here" and they said "nothing" and laughed. Then as a group they started to discuss what they meant by communication skills since that seemed to be the basis of their clinical practice there.

Communication to them meant "awareness" in the sense of being aware of 'self' in a specific context or environment; aware of listening with all the senses; aware of choosing words that conveyed specific meanings to often distressed or disoriented people; aware of space or distance between self and client; aware of using knowledge and skills to discover or explore the clients feeling state. They decided that they got this knowledge through finding a "good" nurse and working with her, from the "good" tutors and from reading about different conditions.

All students participated in this discussion - I said very little - there was no opportunity. They went on to discuss the difficulty of keeping their own personal feelings out of the professional relationship and agreed that it could not be done - it is not possible to separate the personal and professional worlds.

Students were quite clear that what was personal was also professional - need to ask tutors about this distinction. From discussions so far most tutors would think that these are able to be separate - that it is possible to leave personal values etc and take on professional ones.

23/7 Notes to remind myself of purpose of interviews.

Two interviews today that tutors did not want taped - frustrating for the purpose of my thesis but OK for the research. Discussed some of the difficulties they're having because of being part of this research - makes them aware of frustrations that they seem unable to do anything about. Discussed ways things could change but all suggestions seem unworkable to them. Need to get past this block - they seem to think they have too much to lose to try to change anything - although one of them is trying in a round about way. I have an ethical responsibility here!

Need to ask less directive questions and just chat - to be supportive and remember that I can just walk away at the end - they have a stake in maintaining good working relationships with all concerned - and that seems to mean fitting in to the status quo.

APPENDIX 6

Example of letters sent to participants

25 July 1988

Dear (tutor),

I trust the rest of the term is going well and life is not too hectic for you. I wonder how your journal writing is going?

I think we should change the emphasis in the journal a bit so that as well as describing significant events you could describe situations where your teaching / nursing 'made a difference' to..... As well as description could you try writing an analysis of the situation or event or action. I know that this is going to take extra time and effort but it will provide more insights into your experience as a tutor/nurse for both of us. It will also enable us to see more clearly where changes might occur - and I mean structural change not personal change necessarily.

Before I come this time (from 14 Sept) I hope to have carried out a major analysis of the data collected so far. Perhaps you could do the same? Have a look at what you have written and the ways the insights you have had has influenced the work that you do - perhaps write about that in your journal.

I'd like to spend some time with groups of people - ideally I'd like all tutors together over 3 or 4 periods of two hours. I know that's asking the impossible - or is it? Would it be possible to timetable at least one or two sessions where we could all

meet each time I come? If not I'd like at least one two hour session with tutors in each module together - each time. Could this be discussed amongst you to see if it's possible? It's times like this when it's a pain being so far away!

The dates for these visits are as follows (subject to your approval)

Sept 14 - 16

Oct 5 - 7

Oct 26 -28

Nov 21 - 24 (I'd like to spend a lot of time with students if possible)

Good writing!

Regards

Judith Perry

25 July 1988

Third Year Student

Department of Nursing Studies

Dear (student),

This is a letter to all of you engaged in research - I didn't get to see all of you last time so I trust that you are still writing furiously and gaining further insights into your experiences as students in the chaotic world of nursing education. Some people I spoke to last time suggested that I could give them a blank tape so that they could record spontaneous discussions they had when I wasn't there. If anyone else wants to do that please drop me a note and I'll send you a tape which you could either leave at tech for me to collect or post to me here.

I would like to change the emphasis in the journal a bit so that as well as describing significant events you could describe situations where your knowledge / nursing 'made a difference' to..... As well as description could you try writing an analysis of the situation or event or action. Perhaps you could try to work out where the knowledge for your practice came from? - a tall order I know! I know too that this is going to take extra time and effort but it might provide more insights into your experience as a student/nurse/ for both of us. It will also enable us to see more clearly where change might occur - and I mean structural change not personal change necessarily.

The dates for my next visits are as follows

Sept 14 - 16

Oct 5 - 7

Oct 26 -28

Nov 21 - 24 (I think I've got two days with you all this week)

I hope to see some of you in (...) at these times but for those elsewhere and those I don't get to see I hope you enjoy your option experiences and that preparation for 'States' and the exam goes well. I look forward to hearing all about it next term.

Good writing!

Regards

Judith Perry

REFERENCES

- ADAMS, J. and KLEIN, L. (1970) Students in Nursing School: Consideration in assessing personality characteristics *Nursing Research*, 19:362-366.
- ALLEN, D., BENNER, P. and DEIKELMAN, N. (1986) Three Paradigms for Nursing Research: Methodological Implications, in *Nursing Research Methodology*, ed. Chinn, P. USA: Aspen.
- ALLEN, D. (1985) Nursing Research and social control: Alternative models of science that emphasise Understanding and Emancipation *Image*, 17(2):58-64.
- ALLEN, D. (1990) The curriculum revolution: Radical Revisioning of Nursing Education *Journal of Nursing Education*, September, Vol. 29, No. 7.
- APPLE, M. (1979) *Ideology and Curriculum*, London: Routledge and Kegan Paul.
- APPLE, M. (1986) *Teachers and Texts: A Political Economy of Class and Gender Relations in Education*, Great Britain: Routledge and Kegan Paul.
- BAILEY, J. and KLAUS, K. (1969) Comparative analysis of the personality structure of nursing students, *Nursing Research*, 18:321-326.
- BALBUS, I. (1987) Disciplining Women: Michel Foucault and the power of Feminist Discourse in *Feminism as Critique*, ed. Benhabib, S. and Cornell, D., UK: Polity Press.
- BARRETT, M. (1980) *Women's Oppression Today: Problems in Marxist Feminist Analysis*, London: Verity.
- BASSETT-SMITH, J. (1988) Midwifery Practice: Authenticating the Experience of Childbirth. MA Thesis, Massey University.
- BATES, R. (1979) On the theory and methodology of role: a contribution towards and interactive paradigm. *PhD Thesis*, Massey University.
- BECKER, H., GEER, B., HUGHES, C. and STRAUSS, A. (1961) *Boys in White: Student Culture in Medical School*, New Brunswick: Transaction.

- BENNER, P. (1984) *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*, California: Addison - Wesley.
- BENNER, P. and WRUBEL, J. (1988) *The Primacy of Caring: Stress and coping in health and illness*, California: Addison - Wesley.
- BERNSTEIN, B. (1977) Towards a theory of Educational Transmissions, in *Class Codes and Control*, 3, London: Routledge and Kegan Paul.
- BERNSTEIN, R. (1976) *The Restructuring of Social and Political Theory*, United Kingdom: Blackwell.
- BEVIS, E.M. (1973) *Curriculum Building in Nursing: A Process*, St Louis: C.V. Mosby.
- BEVIS, E. and CLAYTON, G. (1987) Needed: a new education paradigm for professional nursing education. Unpublished paper, Massey University.
- BEVIS, E. and WATSON, J. (1989) *Toward a Caring Curriculum: a New Pedagogy for Nursing*, New York; National League for Nursing.
- BEZUIDENHOUT, F. (1982) Socialisation of the Student Nurse in the Nursing profession. *Curationis*, 5(1):11-16.
- BLUMER, H. (1967) Society as Symbolic Interaction in *Symbolic Interaction: A Reader in Social Psychology*, eds Manis, J. and Meltzer, B. Boston: Allyn and Bacon.
- BOGDEN, R. and BILKEN, P. (1982) *Qualitative Research for Education: An Introduction to Theory and Methods*, Boston: Allyn and Bacon.
- BOGGS, C. (1976) *Gramsci's Marxism*. London: Photo Press.
- BOTTORFF, J. and D'CRUZ, J. (1985) The nursing curriculum and knowledge of most worth in *The Australian Journal of Advanced Nursing*, 2(3):11-16.
- BOURDIEU, P. (1977) *Reproduction in Education, Society and Culture*, London: Sage.
- BOURDIEU, P. (1981) Structures, Strategies and the Habitus, in *French Sociology: Rupture and Renewal since 1968*, ed. Lemert C., New York: Columbia University Press.
- BOWLES, G. and KLEIN, R. (1983) *Theories of Women's Studies*, London: Routledge.

- BRUYN, S. (1963) *The Human Perspective in Sociology: the Methodology of Participant Observation*, New Jersey: Prentice Hall.
- BUCKENHAM, J. and (1983) *The Social Reality of Nursing*, Sydney: Adis
McGRATH, G. Health Science Press.
- BURGESS, M. (1984) *Nursing in New Zealand Society*, New Zealand: Longman Paul.
- CARR, S. and (1983) *Becoming Critical: Knowing Through Action
KEMMIS, S. Research*, Victoria: Deakin University.
- CARPENTER, H. (1971) *An Improved System of Nursing Education for New Zealand*, Wellington: Department of Health.
- CHICK, N. (1975) Interpersonal needs, norms and performance in nursing, *Thesis PhD*, Australian National University.
- CHRISTENSEN, J. (1988) The Nursed-Passage: A Theoretical Framework for The Nurse-Patient Partnership, *Thesis PhD*, Massey University.
- CODD, J. (1984) Epistemology and the Politics of Educational Evaluation, *Educational Research and Perspectives*, 11(1):60-70.
- COHEN, H. and (1972) Dropouts and failures: A preventive program,
GESNER, P. *Nursing Outlook*, 20(11):723-725.
- COMSTOCK, D. (1982) A Method for Critical Research, in Bredo, E. and Feinberg, W. (eds), *Knowledge and Values in Social and Educational Research*, Philadelphia: Temple University Press.
- CORNBLETH, C. (1984) Beyond Hidden Curriculum?, *Journal Curriculum Studies*, 16(1):29-36.
- CORWIN, R., (1961) Professional Disillusionment, *Nursing Research*,
TAVES, M., HAAS, J. 10:141-144.
- COULSON, M. (1972) Role: A redundant concept in sociology, in *Role*, (ed) Jackson, J., Cambridge: University Press.
- CRAIB, I. (1984) *Modern Social Theory: From Parsons to Habermas*, Great Britain: Wheatsheaf Books.
- DAVIS, M., (1975) *Nurses in Practice*, St Louis: C. V. Mosby.
KRAMER, M.,
STRAUSS, A. (eds)

- DAVIS, P. (1988) Objective measures of social well being, in *Royal Commission on Social Policy*, Vol 3, part 1, associated papers 343-362, Wellington: Government printer.
- DEPARTMENT OF HEALTH (1986a) Background Paper Prepared for The Review of the Initial Preparation and Employment of Nurses, Wellington.
- DEPARTMENT OF HEALTH (1989) The Nursing Workforce in New Zealand, Wellington.
- DIXON, A., and PATERSON, B. (1987) Working Together, A paper presented at the Critical Practice Workshop, Massey University: Department of Nursing Studies.
- DOWNEY, M., and KELLY, A. (1979) *Theory and Practice of Education: An Introduction*, London: Harper and Row.
- EDWARDS, C. (1963) Cultural dissonance and dissimulation: A study in role conflict, *Journal of Consulting and Clinical Psychology*, 32:607-610.
- ELLSWORTH, E. (1989) Why doesn't this feel empowering? Working through the repressive myths of critical pedagogy, *Harvard Educational Review*, 59(3):297-323.
- FAY, B. (1976) *Social Theory and Political Practice*, Great Britain: George Allen and Unwin.
- FAY, B. (1977) How People Change Themselves: The relationship between critical theory and its audience, in Ball, T. ed., *Political Theory and Praxis: New Perspectives*, Minneapolis: University of Minesota Press.
- FAY, B. (1987) *Critical Social Science*, Cambridge: Polity Press.
- FIELD, P. (1983) An Ethnography: Four Public Health Nurses' Perspectives of Nursing, in *Journal of Advanced Nursing*, 8.
- FORBES, H. (1990) Nursing Students' Perceptions of their Education, *MA Thesis*, University of Canterbury.
- FOUCAULT, M. (1977) *Discipline and Punish: The Birth of the Prison*, London: Penguin Press.
- FOUCAULT, M. (1979) *The History of Sexuality*, Vol. 1, London: Penguin Press.
- FREIRE, P. (1970) *Pedagogy of the Oppressed*, New York: Seabury Press.

- FREIRE, P. (1973) *Education the Practice of Freedom*, London: Writers and Readers Publishing Co-operative.
- FREIRE, P. and SHOR, I. (1987) *A Pedagogy for Liberation: Dialogues on Transforming Education*, London: Macmillan.
- GEUSS, R. (1981) *The Idea of a Critical Theory: Habermas and the Frankfurt School*, London: Cambridge University Press.
- GIDDENS, A. (1979) *Central Problems in Social Theory: Action, Structure and Contradiction in Social Analysis*, London: Macmillan.
- GIDDENS, A. (1981) *A Contemporary Critique of Historical Materialism*, Vol. 1, Power, Property and the State, London: Macmillan.
- GIDDENS, A. (1982) Power, the Dialectic of Control and Class Structuration, in *Social Class and the Division of Labour*, eds, Giddens, A. and McKenzie, G., Cambridge: Cambridge University Press.
- GIROUX, H. (1980) Beyond the Correspondence Theory: Notes on the Dynamics of Educational Reproduction and Transformation, in *Curriculum Enquiry*, 10:3.
- GIROUX, H. (1983a) *Theory and Resistance in Education: A Pedagogy for the Opposition*, Massachusetts: Bergin and Garvey.
- GIROUX, H. (1983b) *Critical Theory and Educational Practice*, Victoria: Deakin University.
- GIROUX, H. (1986) Radical pedagogy and the politics of student voice, *Interchange*, 17:48-69.
- GORDON, D. (1988) Education as Text: The varieties of educational hiddenness, *Curriculum Inquiry*, 18(4):425-449.
- GRAMSCI, A. (1971) *Selections from 'Prison Notebooks'*, London: Lawrence and Wishart.
- GRIMSHAW, J. (1986) *Feminist Philosophers: Women's Perspectives on Philosophical Traditions*, Great Britain: Wheatsheaf Books.
- HABERMAS, J. (1971) *Knowledge and Human Interests*, (trans. J. Shapiro), Boston: Beacon Press.
- HABERMAS, J. (1974) *Theory and Practice*, London: Heinemann.
- HABERMAS, J. (1984) *Theory of Communicative Action: Reason and Rationalisation of Society*, U.S.A.: Beacon Press.

- HARRIS, J. (1988) Discussion in Practice: Theorising structure and Subjectivity in teaching and learning, *British Journal of Sociology in Education*, 9(2):205-221.
- HELD, D. (1980) *Introduction to Critical Theory*, London: Hutchinson.
- HICKSON, P. (1988) Knowledge and Action in Nursing: A Critical Approach the Practice Worlds of Four Nurses, MA Thesis, Massey University.
- HIGGINS, L. (1989) — Students' perceptions of priorities in nurse education: research findings and their curriculum implications, *Higher Education Research and Development*, 8(2):117-127.
- HOLDSWORTH, J. (1969) A Creative approach to Curriculum Development, *Journal of Nursing Education*, April, pp3-10.
- HOLLY, M. (1984) *Keeping a personal-professional journal*, Victoria: Deakin University.
- HORSBURGH, M. (1987) Graduate Nurses' Adjustment To Initial Employment, MA Thesis, Auckland University.
- HUSEN, T. (1988) Research Paradigms in Education in Keeves, J. *A Handbook of Educational Research*, Oxford: Pergamon Press.
- HYMAN, P. (1985) Some Controversies in the Education of Nurses in New Zealand, Great Britain and the United States, *Studies in Higher Education*, 10(2):205-222.
- JAY, M. (1973) *The Dialectical Imagination: A History of the Frankfurt School 1923-50*, Boston: Little Brown.
- JAYARATNE, T. (1983) The value of quantitative methodology for feminist research, in Bowles and Klein (eds) *Theories of women's studies*. London: Routledge.
- KERR, J. (ed) (1968) *Changing the Curriculum*, London: University of London Press.
- KETEFIAN, S. (1974) Trends in Curricular Innovations in Nursing Education, *International Nursing Review*, 21(5):139-142.
- KING, B. (1968) Study of selection, achievement and loss of student nurses from one school of nursing in New Zealand, *Thesis MA*, University of Canterbury.

- KINROSS, N. (1984) Politics and Power, in *Objects and Outcomes: New Zealand Nurses Association 1909-1983*, eds. Smith, M. and Shadbolt, Y., Wellington: Westbrook House.
- KRAMER, M. (1974) *Reality Shock: Why Nurses Leave Nursing*, St. Louis: Mosby.
- LATHER, P. (1986) Research as Praxis, *Harvard Educational Review* 56(3):257-277.
- LAUDER, H. (1987) The new right and educational policy, *New Zealand Journal of Educational Studies*, 22(1)3-23.
- LÉVI-STRAUSS, C. (1979) *The Raw and the Cooked*, New York: Harper and Row.
- LEININGER, M. (1980) Caring: A central Focus of Nursing and Health Care Service, in *Journal of Nursing and Health Care*, October, 16-24.
- LINCOLN, Y. and GUBA, E. (1985) *Naturalistic Inquiry*, California: Sage.
- LINTON, H. (1972) Cited in Jackson, J. (ed), *Role*, United Kingdom: Cambridge University Press.
- LUKES, S. (1974) *Power: A radical View*, London: McMillan.
- MALCOLM, M-J. (1988) Restructuring the state: restructuring society, in *Royal Commission on Social Policy*, Vol 3, Part 1, Associated papers 405-423, Wellington: Government Printer.
- MARK, M. (1980) Report on Research into methods of Assessing the Clinical Competence of Student Nurses, *Nursing Council of New Zealand*, Wellington.
- MARTIN, J. (1976) What should we do with a hidden curriculum when we find one?, in *Curriculum Inquiry*, 6(2).
- MCCARTHY, T. (1978) *The Critical Theory of Jurgen Habermas*, London: Hutchinson.
- MENZIES, I. (1960) A Case Study in the Functioning of Social Systems as a Defence Against Anxiety, *Tavistock Institute of Human Relations*, Great Britain.
- MEPHAM, J. (1974) The Theory of Ideology in Capital, *Cultural Studies*, 6, Birmingham Centre for Cultural Studies.

- MERTON, K. (1968) *Social Theory and Social Structure*, New York: Free Press.
- MIDDLETON, S. (1987) The Life History Method in the Sociology of Women's Education, *Women's Studies Association (NZ) Newsletter*, (8)3, May:15-21.
- MIDDLETON, S. (1988) Researching Feminist Educational Life Histories, in Middleton, S. (ed), *Women and Education in Aotearoa*, Wellington: Allen and Unwin.
- MILLER, N. (1978) The Problems Experienced by graduates of Student Based Comprehensive Nursing Programmes as they provide Nursing Care in General Hospitals, *Thesis MA*, University of Auckland.
- MISCHLER, E. (1986) *Research Interviewing: Context and Narrative*, Cambridge: Harvard University Press.
- MOUFFE, C. (ed) (1979) *Gramsci and Marxist Theory*, London: Routledge and Kegan Paul.
- MUFF, J. (ed) (1982) *Socialisation, Sexism and Stereotyping: Women's Issues in Nursing*, St Louis C.V.: Mosby.
- NATIONAL LEAGUE FOR NURSING (1989) Curriculum revolution: reconceptualising nursing education, New York: NLN.
- NIGHTINGALE, F. (1875, 1970) *Notes on Nursing*, New York: Dover.
- NURSING EDUCATION IN NEW ZEALAND (1972) Report of a Ministerial Committee Considering Recommendation 1.6 of the Carpenter Report on an Improved System of Nursing Education For New Zealand.
- NURSING COUNCIL OF NEW ZEALAND (1977) Supplementary Instructions: Comprehensive Nurse Programme, New Zealand Government.
- NURSING COUNCIL OF NEW ZEALAND (1986) Standards for the Registration of Nurses from Technical Institutes: Assessment Guide.
- OAKLEY, A. (1981) Interviewing Women: A Contradiction in Terms, in Roberts, H. (ed), *Doing Feminist Research*, London: Routledge and Kegan Paul.
- OLESEN, V. and WHITTAKER, E. (1968) *The Silent Dialogue*, San Fransisco: Jossey Bass Inc.
- PARSONS, T. (1967) *Sociological Theory and Modern Society*, New York.

- PATERSON, B. (1989) Making a Difference: The Lived World of Nursing Practice, *MA Thesis*, Massey University.
- PERRY, J. (1985) Theory and Practice in the induction of Five Graduate Nurses: A Reflexive Critique, *MA Thesis*, Massey University.
- PERRY, J. (1985b) Has the discipline of nursing developed to the stage where nurses do 'think nursing'?, *Journal of Advanced Nursing*, 10:31-37.
- PERRY, J. (1986) Professional Socialisation: A Political Process?, *Nursing Praxis in New Zealand*, 1, 2.
- PERRY, J. (1987) Transition From Student to Graduate: Phase One, Profile of Third Year Comprehensive Nursing Students (1986), Massey University, Department of Nursing Studies.
- PERRY, J. (1988) Transition From Student to Graduate: Phase Two, Profile of Comprehensive Graduates (1986), First Year Post Graduation, Massey University, Department of Nursing Studies.
- PERRY, J. (1989) Transition From Student to Graduate: Phase Three, Interviews with First Year Comprehensive Graduates (1986 cohort), Massey University, Department of Nursing Studies.
- PERRY, J. and MOSS, C. (1989) Generating Alternatives in Nursing: Turning Curriculum into a Living Process, *The Australian Journal of Advanced Nursing*, 6(1):35-40.
- PITTS, T.P. (1985) The Covert Curriculum: What does nursing really teach?, *Nursing Outlook*, 33(1):37-39.
- POLANYI, M. (1958) *Personal Knowledge: Towards a Post Critical Philosophy*, London: Routledge and Kegan Paul.
- PRING, R. (1976) *Knowledge and Schooling*, London: Open Books.
- RAMSAY, P. (1978) The Vocational Commitment of Student Nurses and Student Teachers, *Thesis, PhD*, University of Waikato.
- RAMSAY, P. (1983) The Autonomy of New Zealand Teachers, in *Delta 32*, Massey University.
- RASMUSSEN, D. (1990) *Reading Habermas*, United kingdom: Blackwell.
- REASON, P. and ROWAN, J. (1981) *Human Inquiry*, New York: Wiley.

- RICOEUR, P. (1981) *Hermeneutics and the Human Sciences*, (ed) Thompson, J., Cambridge: Cambridge University Press.
- RORTY, R. (1982) *Consequences of Pragmatism*, Minneapolis: University of Minnesota.
- RYLE, G. (1949) *The Concept of Mind*, Harmondsworth: Penguin.
- SALMOND, A. (1982) Theoretical Landscapes, in *Semantic Anthropology*, (ed), Parkin, D., London: Academic Press.
- SANDELOWSKI, M. (1986) The Problem of Rigour in Qualitative Research, *Advances in Nursing Science*, 8(3):27-37.
- SCOTT, J. (1985) *Weapons of the Weak: Everyday forms of peasant resistance*, New Haven: Yale.
- SCHATZMAN, L. and STRAUSS, A. (1973) *Field Research: Strategies for a Natural Sociology*, Englewood Cliffs: Prentice Hall.
- SCHON, D. (1983) *The Reflective Practitioner*, New York: Basic Books.
- SHERIDAN, A. (1980) *Michel Foucault: The Will to Truth*, London: Tavistock.
- SIMMS, S. (1977) Nursing's dilemma: The battle for role determination, *American Journal of Nursing*, 78:1032-1034.
- SMART, B. (1985) *Michel Foucault*, London: Tavistock.
- SMYTH, J. (1986) *Reflection-in-Action*, Victoria: Deakin University.
- SMYTH, J. (1986b) The Reflective Practitioner in Nurse Education, Paper presented to the Second National Nursing Education Seminar, S.A.: Deakin University.
- SPENDER, D. (1980) *Man Made Language*, London: Routledge and Kegan Paul.
- STEIN, L. (1988) The doctor-nurse game revisited, *The New England Journal of Medicine*, 322(8):545-549.
- STENHOUSE, L. (1975) *An Introduction to Curriculum Research and Development*, London: Heinemann.
- STEVENS, P. (1989) A critical social reconceptualisation of environment in nursing: Implications for methodology, *Advances in Nursing Sciences*, 11(4):56-58.

- STREET, A. (1989) *Thinking, Acting, Reflecting: A Critical Ethnography of Clinical Nursing Practices, PhD Thesis*, Victoria: Deakin University.
- TANNER, C. (1987) *Research on Clinical Judgement*, in Holzemer, W. (ed) *Review of Research in Nursing Education*, New Jersey: Slack.
- TAYLOR, A., SMALL, D., WHITE, J., HALL, P., FENWICK, P. (1981) *An Evaluation of Courses in Technical Institutes*, Wellington: Department of Education.
- THOMPSON, J. and HELD, D. (1982) *Habermas: Critical Debates*, London: Macmillan.
- THOMSON, M., KINROSS, N., CHICK, N. (1977) *People in Hospital: A Surgical Ward*, New Zealand, Massey University.
- TORRES, G. and STANTON, M. (1982) *Curriculum Process in Nursing: A Guide to Curriculum Development*, New Jersey: Prentice Hall.
- TRAVELBEE, J. (1971) *Interpersonal Aspects of Nursing*, 2nd edn Philadelphia: Davis.
- TRIPP, D. (1983) Co-authorship and negotiation: The interview as act of creation, *Interchange*, 14(3):32-45.
- TRIPP, D. (1987) Teachers, journals and collaborative research in Smyth, J. (ed), *Educating teachers: Changing the nature of pedagogical knowledge*, London: The Falmer Press.
- TYLER, R. (1949) *Basic Principles of Curriculum and Instruction*, Chicago: University of Chicago Press.
- VAN DEN BERG, A. (1983) Social theory, meta theory and lofty ideals: a reply to Wexler, Parke and Ashley, in *American Journal of Sociology*, 8(6):1250-1257.
- VAN MANEN, M. (1977) Linking ways of knowing with ways of being practical, *Curriculum Inquiry*, 6(3).
- WALKER, J. (1987) Knowledge, Culture and the Curriculum, in Smyth, J. (ed), *Educating Teachers: Changing the nature of pedagogical knowledge*, London: The Falmer Press.
- WALTON, J. (1989a) *The Night-time Experience of Elderly Hospitalised Adults and the Nurses who Care For Them, MA THESIS*, Massey University.

- WALTON, J. (1989b) *Nursing Practice in New Zealand Hospitals*, Wellington: Department of Health.
- WILKES, C. and SHIRLEY, I. (eds.) (1984) *In the Public Interest: Health, Work and Housing in New Zealand*, Auckland: Benton Press.
- WILLIAMS, R. (1977) *Marxism and Literature*, Oxford: Oxford University Press.
- WILLIS, P. (1977) *Learning to Labour: How working class kids get working class jobs*, Great Britain: Saxon House.
- WILSON, T. (1971) Normative and Interpretive Paradigms in Sociology, in Douglas, J. (ed), *Understanding Everyday Life*, London: Routledge & Kegan Paul.
- WISE, R. (1976) The Use of Objectives in Curriculum Planning, *Curriculum Theory Network*, 5(4).
- WITTGENSTEIN, L. (1953) *Philosophical Investigations*, Trans Anscombe: G. Oxford, Blackwell.
- WU, R. (1979) Designing a Curriculum Model, *Journal of Nursing Education*, 18:13-21.