Learning to nurse and learning to be a nurse: an analysis of perceptions of nurses' education and performance

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Learning to nurse and learning to be a nurse: an analysis of perceptions of nurses' education and performance

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ABSTRACT

The present study is an investigation of current approaches to the education of nurses. It is an examination of the influences the transfer of nurse education from the hospital to the tertiary system has had on nurses and nurse education. It investigates the extent to which the shift in nurse education has overcome many of the inadequacies perceived in the apprenticeship system of training.

An analysis of selected historical sources identified how various groups of stakeholders have influenced and continue to influence the knowledge and positioning of registered nurses. Registered nurses were also interviewed in order to determine how they perceive themselves to be positioned and how they position themselves. Some of the tensions experienced by nurses are attributed to the conflicting demands placed upon them.

The psychology of learning and adult learning theory have also been analysed in order to understand the significance of the shift away from learning within a framework which encouraged learning through direct observation and experience. The nature of “experience” as explained through relevant learning theories and as described by registered nurses has been explored in order to understand how the nurse is positioned during learning and performance by themselves and others.

Despite the transfer of education to the tertiary sector a gap between what is taught to nurses and what is required of the nurse in the hospital still exists. The education of nurses in the tertiary sector whilst offering nurses an education rather than a training for service prepares nurses for a system that remains essentially unchanged. Whilst the move to tertiary institutions was reflective of ideas encapsulated in theories of adult learning, the conclusions drawn in this study suggest that implementation within the university learning environment is not in accord with adult learning theory; and that the hospital system does not operate in a manner that is reflective of the autonomy or caring implied by adult learning theory and professionalisation.
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6.1 Introduction

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CHAPTER ONE

AN INTRODUCTION TO THE STUDY

1.1 A Statement of Aims

This thesis examines the means by which one becomes a nurse. It also tracks nursing status in its evolution from a master-craftsman/apprentice system of instruction to a tertiary based system of formalised learning. Historically, nursing has been plagued by tensions about the means and ends of nursing education. Despite recent developments in nursing education and the transfer of nurse training from the hospital to the university sector, a discrepancy still exists between the theory as taught to students and the reality of nursing practice. This fuels the debate about the appropriateness of current teaching strategies for nurse education.

Historical documents, other literature, curricula, and interviews have been used to investigate different perceptions of what it means to be a nurse and to seek to explain the tensions resulting from these differences. In particular, the thesis will refer to:

- how history has influenced the current status of nurses; that is, what it means to be a nurse; and
- how the nature of various conditions, workplace and educational institutions, influence the positioning of the nurse as well as how they learn.

The findings of this thesis should enable the reader to:

- understand the tensions within nursing education and the profession;
- develop understanding of the gap between the theory and practice of nursing; and
- improve nurses' understanding of how current educational theory and practice serves to place them as learners and as nurses.
1.2 **Background and Rationale**

An examination of historical accounts of what nursing entails yields three important perspectives, namely:

- historical forces in the development of nursing education;
- the status of nursing; and
- a critique of the beliefs about learning to nurse and learning theory.

*Historical Influences on Contemporary Nursing.*

Historically, learning how to nurse has been fraught with tensions. In Australia, a series of reports highlights this continuing concern. The first major report into nurse education is the Kelly Report of 1943 (Kelly 1943). Its primary purpose was to improve the “status and training of the nurse” through a re-organisation of the profession.

One outcome of this was the active pursuit by senior nurses in New South Wales of a move to the tertiary sector. In addition, during the last two decades it has become necessary to redefine assumptions about the basis of nursing practice due to advances in technology and educational theory (Miller 1985). Research into “traditional nursing practices” has shown them to be too limiting to cope with the increased skills that nurses are now required to possess in order to keep up with contemporary health sector practices (Menzies 1960). It has been necessary for nursing education to transcend the hospital setting and prepare a practitioner who can function effectively both as a self-directed individual and a highly educated team player who can function within both a hospital and community setting (Chittick 1969, Sax 1978, Sax 1979, Chapman 1983, McGrath 1984, Parks 1984, Rosenthal 1985). University nurse education was perceived as the means to improve nursing practice, while at the same time enabling nurses to develop a responsibility for contributing to social change.
Prior to 1985 the training of nurses was directed towards the provision of hospital health care needs; that is, the provision of service needs of the hospital, with little consideration of community health needs, and little consideration of nurses' learning interests. Nursing education has historically been heavily influenced by doctors and hospital administrators, and was directed towards teaching the nurse how to function within a particular role (White 1975, Thompson 1981, Bolton 1981). After many years of pushing for an improved education, nurses and senior nurse academics were excited by the political decision to transfer nursing into the university sector, which was seen as an opportunity to enhance the nurses' professional development in a way which would enable them to be actively involved in the decision-making of patient care, and health care delivery, previously the domain of the doctor (Thompson 1981, Bolton 1981, White 1985). According to Parry (1984) both nurses and patients would benefit from upgrading nursing education.

From an educational perspective, White (1985), an Australian nurse academic, suggested that the move into tertiary education for student nurses would represent a change from learning by experience, which results in a "change in behaviour", to learning which results in a "change in the meaning of experience". Understanding the significance of this change in the meaning of experience is one of the central inquiries of this thesis, and will be explored more fully in the subsequent chapters.

Status of Nursing

Nurses, as an occupational group, have performed an important and valued service to society. Experience gained by the nurse meant that on completion of a three or four year course, s/he was able to manage a ward. The move to tertiary education constituted a change in the physical location of nurse education but it did not guarantee a change in the means and ends of education. Whereas the transfer was viewed as a means of professionalising nursing, some would claim that this has not occurred (Game & Pringle 1983, Herdman 1992). What remains important, however, is that on
completion of a University program the new graduate should be confident about his/her ability to function as a registered nurse. There is still some question about whether this occurs. While the old system placed emphasis on the action of nursing, the current system places greater emphasis on cognitive and affective skills, that is thinking and feeling skills. This can create a personal strain on the new graduate and result in unfair assessment by certificate qualified nurses, who often feel that the new graduate has not achieved an acceptable level of competency. A reaction to the transfer has found nurses from the certificate/apprenticeship system questioning about who would now teach the new graduates to become “real nurses” (Cowan 1984:11). Fears held about the transfer have led to the creation of a “them and us” mentality which is unhelpful for nurses in either system.

**Beliefs about Practising Nurses as Learners**

The Nightingale model of nurse education had its own theoretical approach to teaching and learning, which was to instruct learners in ways which resulted in a change in their behaviours (White 1985). Changes in behaviour were seen as an indication that students had learnt something. The traditional approach to learning nursing involved teachers instructing nurses in the knowledge they were expected to accumulate and put into practice (Ashley & Labelle 1976, Bolton 1981, Gibb 1991, Lauder 1992). In this way nurses became receivers of information, who were not meant to develop ideas of their own or make independent workplace decisions.

The transfer of nurse education into the tertiary sector exposed students to more formal learning, requiring more self-directing ability on the part of the learner and less instructional teaching on the part of the teacher. A change in teaching approach was also believed to be accompanied by a change in how the nurse was expected to function as a professional.
Some of the tensions experienced by nurses are attributed to the conflicting demands placed upon them. More significant for this thesis, however, is the tension between beliefs about adult learning theory and the realities of adult learning styles in both tertiary and workplace systems.

This study originated from a need to determine the direction of teaching of nursing; to identify a rationale for nursing education; and to identify what constitutes meaningful learning or development for nurses.

1.3 Methodology

A qualitative research approach has been employed with this thesis, which aims to deconstruct the underlying, subjective meanings attributed to various approaches to nurse education. The study looks at the issue from:

- an historical perspective;
- the perspective of interpreting the meanings from the texts of nurses' talk obtained through interview; and from
- a critique of beliefs about adult learning theory.

The empirical data was collected through interviews with the intention of providing an analysis of various stakeholders' perceptions of what it means to be a nurse, and specifically an analysis of nurses' opinions about the production and reproduction of understandings about being and becoming a nurse.

A number of registered nurses was interviewed. A set of assumptions about the nature of adult learning, based on Malcolm Knowles (1975, 1984) theory, formed the basis for the interview structure, which was semi-structured and consisted of thirteen questions addressing the following:
• opportunities or influences which have contributed to the participants learning of nursing;
• a focus on what constitutes the most valuable dimension of learning how to become a nurse; and
• identification of occupational and professional performance in nursing.

The interviews were tape recorded, transcribed and analysed. Early interpretation of the data was attempted using Knowles' theoretical framework. This was found to be limited and not very useful. Its limitations will be discussed further in Chapter Two, Chapter Four, and Chapter Five. As a consequence, a coding and classification process to map concepts and classify data was adopted. Analysis of the data occurred in conjunction with a modified form of discourse analysis to illuminate ways in which nurses constructed meanings of how they positioned themselves and others.

1.4 Thesis Outline

This thesis is presented in six chapters. The introductory chapter establishes the need for the study and provides a background for some of the questions being asked. Chapter Two outlines the research design and methods. Chapter Three reviews the historical significance of experience in nursing education. The fourth chapter reviews the meaning of experience according to some of the educational literature that is not commonly referred to in nurse education. The fifth chapter reports on the analysis and findings of the study. Conclusion and recommendations form Chapter Six.

1.5 An Autobiographical Note

The researcher's experience and subjectivity is an important factor in the selection of the topic, the methodology and the explanatory theory and requires an autobiographical note.
Firstly, I am an educator committed to promoting learning, to allow individuals to develop their thinking and abilities as adults so that they can employ the education necessary to be competent and find satisfaction in a challenging vocation.

In an ideal world, the education of nurses in the tertiary sector would result in registered nurses who were self-directed, critical thinkers, reflective, confident and safe practitioners, who effectively communicate with the patient to enhance the patient's ability to accept a degree of responsibility for their own well-being. This can only be achieved if nurses recognise that they have a significant role to play which requires a departure from their traditional positioning as health-system handmaidens. Recognition of the above premise relies upon acceptance of the nurse as a fully functional health professional.

I initially trained within the hospital system as a general certificate nurse. Subsequently, I undertook two more certificate courses in Coronary Care and Midwifery. I have accumulated more than twenty years of nursing experience within the hospital system. Working in an intensive care unit, in the mid 1970s, placed enormous responsibilities on nurses. Intensive care courses were not readily available. At the same time I also became aware that nursing administration played a large role in selecting and encouraging staff to undertake post-graduate courses. I also discovered that many senior nursing staff were not happy about registered nurses determining their own course of study, nor the direction of their own professional development. Working and learning on the job showed up the different levels of knowledge used to explain patient progress between the different groups of the health profession. Doctors could stand in the middle of a busy corridor near the sister's station and engage in interesting lengthy discussions about the physiological developments or otherwise of their patients. A lot of information could be gained from listening to doctors talk to other doctors about a patient's progress and physiological functioning — often, far more than could be gained from directly approaching them for explanations.
The development of intelligent, thinking nurses was not encouraged, and it was hard to comprehend why nurses as a group thought so narrowly about their work. Efforts to promote self-education through discussion with doctors and more senior nurses frequently proved unsatisfactory. It was recognised that more information was needed to be able to make more appropriate assessments about nursing practice for patients in the unit. There were few senior nurses with whom discussion of topics could be opened. Frequently a reply would be given which indicated the senior's opinion of what s/he thought was needed to be known. Unfortunately much more information was needed to develop a deeper level of understanding. Nurses being denied a thinking role within the system was a source of immense personal frustration.

In the 1980s I pursued an interest in teaching. My approach focused on adult education and tertiary education theory and practice, in particular those adult education principles proposed by Freire (1972) and Knowles (1975, 1984). The model of adult education proposed by Malcolm Knowles defines a person as being "adult" from a psychological perspective, when they have attained a perception of themselves whereby they consider themselves to be responsible for their own learning (Knowles 1975, 1984:53). This model encourages the student as an adult and a critical thinker, not as a child and empty vessel to be filled up with knowledge gained through rote learning.

The study of adult education encouraged me in my positions as learner, nurse and educator. It came as a surprise to find that on taking up a teaching position that newly gained knowledge, ideas and approaches about learning met with little approval, particularly when working with registered nurses and students in a ward environment. Senior people continued to treat other nurses and patients like children and educational dialogue had little place.

The most uncomfortable experience was that of questioning practices that seemed unsettling and even threatening for registered nurses. It is from my most recent
experiences as a nurse educator within both the certificate and tertiary nursing programs that this thesis is driven. The reflective nature of this thesis is inspired by a need to reconcile personal conflict within the new system; a conflict that is shared by many other nurses. Understanding some of the influences driving changes within nursing education and by examining how the knowledge and beliefs of different groups of people and nurses influence the teaching of nurses might lead to establishing a method of teaching which promotes dignity in learning and competence and understanding in performance.
CHAPTER TWO

METHODOLOGY

2.1 Introduction

This chapter provides a rationale for the research methodology adopted for this study, and the particular method used to collect and analyse data. The interview technique is described and the reasons for selection of the method, its advantages and its limitations are discussed.

2.2 The Research Methodology

A qualitative approach was adopted in this study as being more consistent with the purpose of examining nurses' perceptions of "meaningful learning" in relation to learning how to nurse and how to be a nurse. A series of exploratory interviews was conducted in order to identify problematic aspects of nursing education.

Qualitative methods have traditionally been used to examine properties, traits and features that distinguish subjects of research from one another (Woods & Calanzaro 1988, Seaman 1987) and are, for example, concerned with understanding the subjective meanings that nurses attribute to their learning experiences.

The qualitative approach of this thesis diverges somewhat from the disproportionate emphasis on quantitative research methods in nursing literature which is more concerned with the number of times one event is associated with another and the differences and similarities between events rather than the interpretation of nurses "experiences" (Duffy 1985). The use of qualitative research methods for nursing is supported by a number of nurse researchers (Duffy 1985, Duffy 1987, Sandelowski 1986, Morse 1991). It allows beliefs, values and social perceptions to be explored in order to understand the
underlying and subjective meanings attributed to phenomena such as nursing and nursing education.

The empirical data which supports this study were collected through open-ended interviews. These provided information about nurses' perceptions of nursing and nursing education (Polgar & Thomas 1991:97). The style of the interview process allowed the investigator to pursue leads which appeared hopeful, to ask for elaboration of points and to clarify questions. A flexible schedule of interviews with the target nurses made for deeply probing questions and allowed for unexpected responses and interpretations during the process of data analysis which would have been far more difficult to obtain from the administration of a questionnaire.

2.3 Research Design

A design which allowed for collection and analysis of data from three dimensions was considered appropriate for examining nurses' perceptions of meaningful learning. This structure provided signposts and allowed for movement between the historical perspective of nursing education, a critique of beliefs about learning theories and the empirical collection of data through interview.

2.3.1 Selection of Subjects

Permission was obtained from the Illawarra Area Health Service Board, the Area Director of Nursing and individual Directors of Nursing within the region to conduct this research and to interview registered nurses. Permission was also sought from the Nurse Unit Managers within both the hospital and community environment to approach registered nurses for interviews.

Eighteen registered nurses working within the Illawarra area were interviewed. They were chosen by random ballot selection from the list of employee names made available
by the Area Director of Nursing. The data gathered was analysed to identify meanings of nurses' experience of learning.

2.3.2 Interviews

In designing the questions used as the basis for the interviews, the researcher used a set of assumptions about the nature of adult learning based on Knowles' theory of adult learning (1975) as explained in detail in Chapter Four. It was expected that responses from the interviewees would illuminate the extent to which they believed their own learning occurred according to those principles. Table 2.1 shows the questions asked of respondents and lists assumptions about anticipated answers.

The interview, as stated previously, focused on a set of thirteen guiding questions which were devised by drawing on assumptions of adult education principles (Knowles 1975). The concept of experience is central to Knowles' thesis, consequently further questions about learning were drawn from this position. They focused on nursing from the angle of past learning experiences, collegial learning experiences and workplace experience of nursing and tertiary education.

The interview was trialled using practising nurses and was discussed with an educational psychologist (who was my supervisor at that time). The results of the trial seemed promising and a decision was made to continue.

The interviews lasted from twenty to forty minutes. Variations in time were due to supplementary questions and probing for information. Cohen & Manion (1989:319) suggest that an interview approach in research complements interpersonal encounters and that people are more likely to disclose the deeper aspects of themselves during a face to face encounter than they would in a less direct situation. The interview situation also allowed for inconsistencies to be queried.
Table 2.1 Interview Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Anticipated themes derived from Knowles' theory</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  When/where during training did you think that you learnt most?</td>
<td>Time frame, context of situations, assumptions about experience/classroom/context of learning</td>
</tr>
<tr>
<td>2  What was the most valuable thing that you learnt during your training?</td>
<td>Special interests</td>
</tr>
<tr>
<td>3  In what way was your learning helped by colleagues?</td>
<td>Reciprocal relationship</td>
</tr>
<tr>
<td>4  Do you ever decide to learn something for yourself?</td>
<td>Self-directed learning</td>
</tr>
<tr>
<td>5  Do you know how your superiors decide what is required or is valuable for you to learn?</td>
<td>Problem solving v teacher directed</td>
</tr>
<tr>
<td>6  What area of nursing gives you greatest enjoyment?</td>
<td>Traditionally, nurses express a preference</td>
</tr>
<tr>
<td>7  What areas of nursing do you dislike most?</td>
<td>Express dislike</td>
</tr>
<tr>
<td>8  Do you think that you are a “good” nurse?</td>
<td>Ways of assessing a nurse</td>
</tr>
<tr>
<td>9  Do you think that nursing is an occupation or a profession?</td>
<td>Many nurses in the ward regard nursing as a profession</td>
</tr>
<tr>
<td>10 What makes a profession?</td>
<td>Mixed responses</td>
</tr>
<tr>
<td>11 How do you think patients view nurses?</td>
<td>Expect positive response</td>
</tr>
<tr>
<td>12 How do you think doctors view nurses?</td>
<td>Mixed, personal experience</td>
</tr>
<tr>
<td>13 What makes you professional in your practice?</td>
<td>Something about performance &amp; status</td>
</tr>
</tbody>
</table>

2.3.3 Procedures

The initial approach with prospective interviewees was made by phone to ascertain their willingness to participate. Most of the interviews were conducted within the work environment, in a small office, a sitting room or a selected area within the ward environment away from other people. The researcher was particularly aware that registered nurses still held responsibility for patients in their care on the ward. This awareness meant that the researcher felt a certain amount of conflict in terms of the time taken for the interviews. Minor interruptions did occur during some interviews but on the whole they were undisturbed by work demands.

The interviews were recorded on audio tape and with the permission of the participants. Each interview was transcribed in full, and the participants were given a pseudonym. Audio recording was selected because it allowed for the possibility of replaying the previous section of the tape to facilitate continuity where interview interruptions...
occurred. Most interviews were conducted during the participants' work time, and interruptions were anticipated because of their work responsibilities. Field notes were recorded following interviews and were my own reflections on the context of the interview. Contact with interviewees made after the interviews was done to ascertain their involvement in the upgrading of their own credentials and this was taken into account in the analysis. After the interview tapes were transcribed the interview data was coded and categorised so that trends or themes could be identified.

In considering the validity of a qualitative rather than quantitative methodology for gathering information it is useful to re-examine the purpose of the research. The aim in qualitative research is not measurement but rather,

> gaining knowledge and understanding of the true nature, essence, meanings, attributes and characteristics of a particular phenomena under study (Leininger 1985:68).

Even though reliability and validity are important to any research, this thesis does not compartmentalise them as rigidly as empirical research requires. A semi-structured interview framework is used which is flexible enough to allow interviewees to give free rein to their thoughts. Further opportunity was made available to analyse data using a modified form of discourse analysis. Categories were not always pre-set, and more analysis was undertaken on how the interviewees positioned themselves as nurses. This ability to probe and to allow digression from pre-set questions provided a more reliable basis to analyse subjective judgements than would a set of questions that might lead the interviewee along restrictive, perhaps more predictable ways of thinking.

Potter & Metherell (1987) affirm that interviews conducted for the purpose of discourse analysis differ from others in that respondents are allowed more freedom to talk around a subject than is normally the case. The interview is seen as a “conversational encounter” with the researcher's questions becoming as important in analysis as the interviewee's answers. Rigidly structured interviews in which there are pre-set
categories threaten “the variability which discourse analysis celebrates” (Parker 1992:124).

The interview allowed for the expression of telling misconceptions and the probing of tentative responses. It focused on nurses' subjective experiences, allowing the researcher to:

- test the validity of hypothesis; and
- ascertain unanticipated responses to the situation,

thus giving rise to further hypotheses (Cohen & Manion 1989).

2.4 Data Analysis

Four approaches were used to code the data. These were:

- cross-checking with Knowles' set of assumptions;
- mapping the categories to see if there was another set of assumptions which were closer than Knowles';
- analysing text with a modified form of discourse analysis to illuminate ways in which nurses constructed meanings of how they positioned themselves and others; and
- grouping the responses into two sets of illustrative data, according to the respondents' experience in certificate and tertiary nursing studies.

Each coding approach will be discussed in detail.

The original research proposal to use Knowles' theory of adult learning as a basis for collection and interpretation of information did not translate easily to the nursing situation. In particular, a cursory analysis of the interview tapes during the process of transcription indicated that the respondents' references to responsibility and self directedness for learning did not always fit with Knowles' theory. In keeping with
assumptions about adult learning, however, they were working in an occupation of their choosing and they had past experience with formal learning as well as extensive work experience as nurses. Experience gained through working closely with someone more senior was very apparent, as was their extensive experience in communication and exercising responsible practices with patients. The respondents also had many years of nursing experience and expressed a readiness to learn, which was supported by the number of nursing certificates held by different respondents.

Most respondents considered themselves to be professionals, even though the classical definition of a profession does not include nursing. Paradoxically, their level of involvement in learning to nurse suggested a heavy and intense reliance on being directed by others, whilst simultaneously indicating a degree of self-directedness.

Unable to ignore the discrepancy between the researcher's and the respondents' experience of adult education, it was necessary to find a way around the fact that the Knowles' theory did not fit comfortably with the perceptions of these respondents. Rather, it seemed necessary to identify why there was a poor fit between Knowles' theories of adult learning and nurses' perceptions of learning. Given a lack of congruence with Knowles' theory, coding proceeded with the use of a second strategy, namely, concept mapping, in conjunction with a modified form of discourse analysis. Concept mapping allowed for the identification of concepts and the relationship between concepts in the interviews (Novak & Gowin 1984). Discourse analysis allowed for the identification of beliefs within the interview text (Lupton 1991).

"Discourse" is defined as "the verbal and non-verbal constructions of meaning that occur in the wider sphere of ideological practices" (Macdonnell 1986:4). Several writers have identified some of the different discourses that operate within nursing (Miller 1985, Lawler 1991, Johnstone 1994). This thesis focuses on discourses that relate specifically to nursing education, considered from an historical perspective of
experience in learning to nurse, and from the angle of experience as described in learning theories where they relate to nurse education. They are then compared and contrasted with practising nurses' accounts of nurse education.

Discourse analysis has been used in different ways. These range from the broad historico-political approach taken by Foucault (1971) in his analysis of power relations inherent in institutions such as mental hospitals and medical clinics, to Lupton’s (1992) use of linguistic research into conversation at a micro level. This thesis uses discourse analysis in context-bound situations to identify how nurses position themselves in their environment or are positioned by dominant discourses. The dominant discourses which define what it means to be a nurse will be emphasised in order to highlight the inequalities in power relations which exist in nursing.

Discourse analysis places the text in context, whereas similar approaches such as content analysis are concerned with identifying concepts and counts of various categories within the data. “Discourse approaches language as both reflecting and perpetuating power structures and dominant ideologies in society” (Lupton 1992:145). Discourse analysis seeks to position the speaker within the socio-political context. To validate the analysis extensive use is made of textual material, so that the researcher's interpretations and reasoning process may be followed to their conclusions. With discourse analysis the emphasis is not so much on the “message” itself (as in traditional content analysis), but on the elements and influences in the discourse process as a whole (Wolf 1988, cited in Lupton 1992).

As the process of concept mapping proceeded, subtle differences emerged between the respondents' perceptions about learning to nurse and self-directedness. It seemed that some respondents who held tertiary qualifications often continued to describe phenomena from the point of view of their experiences from within the hospital learning environment. Discourse analysis provided the means to understand the multiplicity of
different meanings and the social context in which nursing is learnt and practised; to identify the meanings produced by practising nurses, together with the historical and cultural sources of these meanings.

2.5 Limitations of the Study

Eighteen respondents were interviewed. This would create problems if this study placed emphasis on a quantitative approach to nurses experience. However, as most of the interviewees and the researcher have had many years experience of “learning and teaching of nurse”, this thesis' validity rests on the quality and depth of the data gathered rather than its quantity across a large range of participants.

Historical literature sources have been used in this thesis to examine changes in perception of the nursing role rather than providing an historical detail of nurse education per se which has been amply covered in other works, such as (Menzies 1960, Abel-Smith 1964, Creighton & Lopez 1982, Sax 1978, Sax 1979, Castle 1987, Short & Sharman 1987, Russell 1990, Johnstone 1994).

2.6 Conclusion

This chapter has discussed the underpinnings which support the thesis' qualitative research approach and various aspects of its methodology. Whilst Knowles' theory places considerable emphasis on past learning experience, it also accommodates formal professional education. An incongruity exists between experience as described in Knowles' approach to learning and the notion of learning through experience which held a central position in certificate nursing programs. Because of this incongruity the use of concept mapping in conjunction with a modified form of discourse analysis allowed for more critical analysis of the data. With nursing education now located in tertiary institutions there is a shift from the traditional meaning and role of experience in
learning to nurse. This has often meant a tension between the meanings of experience and the experience in learning in the university and experience in learning to nurse in the hospital environment. The next chapter of the thesis will explore these shifts in the concept of experience as they relate to major developments in nurse education.
CHAPTER THREE

THE HISTORICAL CONTEXT OF EXPERIENCE IN LEARNING TO NURSE

3.1 Introduction

This chapter reviews the historical place of experience and formal education in learning to nurse, from the early master craftsman apprenticeship system to the move to tertiary education in New South Wales. This provides a basis for understanding the historical positioning of nurses in relation to education, and their experiences of learning to nurse. An examination of the history of nursing is required in order to identify an intrinsic rationale for the development of nursing education and how current notions of experience differ from its earlier use in nursing.

The chapter will begin with an overview of the master-craftsman apprenticeship system and continue with a discussion of developments of the apprenticeship system within the framework of the Nightingale reforms. The development of nursing within New South Wales will be explored in an endeavour to trace the movement away from the Nightingale model of nursing, to the period immediately prior to the introduction of the tertiary model of nurse education.

3.2 Setting the Scene

Prior to the Nightingale Reforms period in England, the notion of women in the workforce was “tolerated only for those women who needed wages to feed themselves and their families” (Whittaker & Olesen 1981:204). A few apprenticeships were available to “genteel” women at this time. These were in millinery, dressmaking or domestic service. The “employment choices for working class women were limited to places like factories, mines and hospitals” (Whittaker & Olesen 1981:205).
In the early 19th century hospitals were very much a microcosm of the larger society and the level of knowledge about hygiene that the general community and nurses had was poor. Writing in the 1860s, Florence Nightingale observed that the nurses within a London hospital lacked the knowledge necessary to provide quality patient care:

nurses did not as a general rule wash patients, they could never wash their feet...and it was only with difficulty and only in great haste that they could have a drop of water, just to dab their hands and face. The beds on which the patients lay were dirty. It was common practice to put new patients into the same sheets used by the last occupant of the bed, and mattresses were generally flock, sodden and seldom if ever cleaned (Woodham-Smith 1976:57).

In addition to working in hospitals, nurses also nursed people in their homes (Abel-Smith 1964, Waddington 1984). Home nursing was described as domestic service. Regardless of whether the nurse worked in hospitals or in homes, the doctor was regarded as the master. Before 1860 the relationship between doctor and nurse was unequivocal: the nurse was the skilled servant who operated “in strict obedience to the physician's or surgeon's power” (Johnstone 1994:14).

One of the features of nursing at that time was the assumption that women could become nurses through working on the job. Those employed as nurses relied more on ad hoc instruction from doctors on a day-to-day basis rather than from formal learning or teaching. The exceptions, which more closely followed an apprenticeship-like training, were those established by religious orders (Herbert 1981).

3.2.1 The Master-craftsman Apprenticeship System

The master-craftsman apprenticeship system of teaching and learning was the main form of occupational training used by the crafts and guilds from medieval times up to the mid 1800s (Reid 1986). Learning occurred through the transmission of occupational skills from master to apprentice, through workplace practice and experience. After a number of years the apprentice emerged as a journeyman-tradesman.
This is the model which informed the training of nurses until the recent move of nurse education into the university system. The form of the apprenticeship changed most notably with the reform initiated by Florence Nightingale, but essentially the assumption has been that women learn to be nurses through their association with a trained and experienced “master”.

Formal education for women prior to the 19th century was usually frowned upon by those in authority and consisted mainly of tutoring for ladies in the middle and upper classes to helping them acquire the appropriate “accomplishments” necessary for “establishing a place in the courtship and marriage market”, the only place for which women were destined (Whittaker & Olesen 1981:205). However, for Nightingale these women were invaluable to her program at St Thomas’s Hospital.

As learning by the experience of doing the work is a feature of the master-craftsman apprenticeship system, it is hardly surprising that the place of experience should be emphasised in such a system of learning to nurse. For instance, in her ‘Notes on Nursing’, Nightingale emphasised practice as the handicraft of nursing which she believed was “... impossible to learn from any book” and only “...thoroughly learnt in the wards of a hospital” (Nightingale, cited in Herbert 1981:144).

3.3 The Nightingale Reforms

Following her return from the Crimean War in 1856, Nightingale became engaged in the development of a more systematic approach to the education of nurses. Nightingale felt that nurse education was important in the provision of an appropriate standard of patient care. She considered that nurses should receive formal training and that an overall improvement in environment, work and living conditions for the nurse would contribute to achieving better standards of patient care. According to Nightingale’s biographer, Sir Edward Cook, the Nightingale Reforms brought a stamp of respectability to nursing (Cook 1913).
Nightingale proposed that the inadequate educational system necessitated the establishment of a school of nursing which should follow at least three main principles:

- The school must have an independent educational institution;
- The school must have its own independent funds; and
- The school must have its own board of trustees (Cook 1913:460).

Nightingale believed that there was a need for a school which dealt specifically with formal education. A school established under these circumstances would allow for the achievement of a nursing program able to produce a nurse:

who could undertake bedside care of the sick and to teach simple rules of health and hygiene (Cook 1913:447).

It was also proposed that nurses:

should have their technical training in hospitals specially organised for the purpose (Cook 1913:447).

Nightingale felt that nursing should be taught in all public hospitals because individual hospitals would not be eager to have groups of nurses who were not accountable to them (Baly 1987).

The establishment of the modern hospital system provided further impetus for reforms to nursing education. The modern hospital was linked to the expansion of the general hospital system which became known as the public hospital system (Maggs 1987). With the development of the public hospital system came the need to provide adequately trained nursing staff on a regular and regulated basis. The Nightingale School of Nursing was established at St Thomas's Hospital in London in 1860. Formal, systematic and measurable learning was inherent in Nightingale's approach, as Cook points out:
Decidedly Miss Nightingale emphasised the educational side of her new experiment. No public school, university or other institution ever had so elaborate and exhaustive system of marks. Equally thorough and scientific are the General Directions which the Resident Medical Officer, presently drew up at Miss Nightingale's request (Cook 1913:461).

Besides formal learning, Nightingale argued that the role of the nurse would be improved by acknowledging and demonstrating certain behavioural attributes which are the inheritance of today's nurses. The nurse was to be:

sober, honest, trustful, trustworthy, punctual, quiet, orderly, clean, neat, patient, cheerful and kindly (Cook 1913:446).

Nightingale believed that there was a relationship between the education of nurses and the provision of patient care. To secure this relationship, which was intended to unify nursing education and service, a matron was appointed. Nightingale insisted that:

the entire control of nursing staff as to the discipline and teaching should be taken out of the hands of men and lodged in those of a woman who must herself be a trained and competent nurse (Calder 1960:47)

The matron was responsible for the control and education of nursing staff (Russell 1990). She was also head of the training school (Baly 1987). This was expected to strengthen the relationship between the education of nurses and the provision of patient care.

The three main benefits arising from the Nightingale reforms relate to:

• a recognition of the need for education of nurses;
• a change in the role and status of the nurse; and
• order and organisation within the hospital system (Cook 1913).
Nightingale believed that reforms to nursing the sick could be attained through educating nurses in accordance with her proposals. The Nightingale School of Nursing's utilisation of the notion of formal education was a radical departure from the preceding domestic and hospital practices of learning how to nurse and the Nightingale reforms provided a level of organisation within hospitals which had previously not existed.

3.3.1 Learning to Nurse in the Nightingale School of Nursing

A nurse's training program in the Nightingale School of Nursing consisted, initially, of one year training (probationary) and three years hospital service (Russell 1990). Formal teaching took place in the classroom as well as in the work environment (Cook 1913). Accounts about how, when and where teaching occurred show that lectures were delivered by ward sisters, matrons and doctors. Lectures included anatomy and physiology and practical information about:

- how to bandage, make poultices, ventilation, cleaning and hygiene measures, particularly in relation to sepsis and asepsis (Cook 1913:446).

The teaching program focused on the management of illness and disease in keeping with the purpose of nursing as described by Nightingale. As learners, nurses have historically received information from others. In the Nightingale School of Nursing lectures were one of the main methods used to deliver information. Records of lectures presented by a surgeon, Mr. Croft, suggest that the main admissions to St Thomas's Hospital were acute cases amenable to the surgery of the day (Cook 1913).

According to Bevis & Watson (1989) the regular duties of the nurse from the Nightingale School required her to competently perform functions and demonstrate skills. For instance, the Duties of the Probationer under the Nightingale Fund (1867, cited in Bevis and Watson 1989:20) strongly suggest that nursing continued to be considered primarily as a practical activity.
You are expected to become skilful:

- In the dressing of blisters, burns, sores, wounds, and in applying fomentations, poultices and minor dressings.
- In the application of leeches, externally and internally.
- In the administration of enemas for men and women.
- In the management of trusses, and appliances in uterine complaints.
- In the best method of friction to the body and extremities.
- In the management of helpless patients, i.e. moving, changing, personal cleanliness of feeding, keeping warm (or cool), preventing and dressing bed sores, managing position of patient.
- In bandaging, making bandages and rollers, lining of splints.
- In making beds of patients, and removal of sheets whilst patient is in bed.
- You are required to attend at operations.
- To be competent to cook gruel, arrowroot, egg flip, puddings, for the sick.
- To understand ventilation, or keeping the ward fresh by night as well as by day; you are to be careful that great cleanliness is observed in all utensils; those used for the secretions as well as those required for cooking.
- To make strict observation of the sick in the following particulars:
  The state of secretions, expectorations, pulse, skin, appetite; intelligence, as delirium or stupor, breathing sleep, state of wounds, eruptions, formation of matter, effect of diet, or stimulants and of medicines. And to learn the management of convalescents (cited in Bevis & Watson 1989:20).

These duties suggest some of the everyday learning experiences that a student nurse in the Nightingale School of Nursing may have received. The development of psychomotor skills for nursing was a feature which occupied much of the curriculum (Reilly & Oermann 1992). Indeed, it has been argued that psychomotor skills constituted nursing, a notion possibly reinforced through recognition that in the main psychomotor skills are learnt through repetition. Despite her emphasis on formal learning, Nightingale did little to devise a theoretical curriculum for nursing (Perry & Jolley 1987). The connection between theory and practice therefore, can be seen to have remained limited and tenuous.
The medical practitioner's knowledge was prescriptive for managing the medical state of the patient, and was partially incorporated into nursing knowledge. Nursing adopted a mode of teaching in which the student was instructed towards "what" to do, and "how" to do it, and to a limited extent also "why". These aspects of instruction were delivered at the level of description, and prescription, and explained simple causal physical relationships, rather than more complex abstract theoretical positions. This has influenced the manner in which the nursing profession views phenomena which relate to the patient in terms of symptoms, disease and surgery (Melias 1991).

Incidental learning in the wards usually occurred as pupil nurses performed their allocated work. The instruction in the ward and at the bedside was given in the same way as in the master-craftsman apprenticeship model of learning. Teaching emphasis in the Nightingale apprenticeship was on instructing what to do and how to do, rather than helping students to develop skills in "how to observe", "what to observe", "how to think" and "what to think" (Reilly & Oermann 1992:15). Although ward sisters were responsible for teaching and practical instruction (Prince 1984) students rarely worked constantly with the ward sister. More frequently, they worked with someone in one of the student groups more senior to them. This meant that there was no one under whom students could serve as apprentices in the original sense of the word, and consequently their ward learning had a lower status than an apprenticeship. In addition, the expediency of providing care for the sick in a modern hospital meant that teaching occurred through social interaction between student nurses in the workplace. As a consequence it was inconsistent and unsystematic.

Evaluation of nursing students' progress in the Nightingale School of Nursing occurred partly through tasks requiring reflection (Cook 1913). For example, students were required to keep diaries of work progress which were to be examined by Nightingale. However, these diaries seemed more like a record of the work or incidents encountered by the student than a reflection on a particular critical incident as is more likely to be the
case today. Probationers (pupil nurse or nursing student) were also assessed on their moral behaviour, as well as being required to sit oral and written examinations on a monthly basis. Ward sisters were responsible for keeping records of instruction given to students and the type of clinical experience gained (Russell 1990:13). Despite these measures Baly (1987:33) has suggested that the assessment process was less than adequate, and that the person responsible for “assessment sheets” at the Nightingale School at St Thomas's Hospital often neglected to fulfil this role responsibly. Abel-Smith (1964) claimed that what the nurse was taught, who taught her, who examined her, were all questions left unanswered in the historical accounts of nursing. Waddington (cited in Reid 1986:126) argued that examinations, intended as a feature of formal and objective assessment of students, functioned more as a form of quality control.

Nightingale wanted nurses to have “the morality and spiritual devotion of religious orders, the education of the middle classes, together with the hardiness of working class girls” (Baly 1987: 37). On reflection, these attributes reflect domains of learning, namely affective, cognitive and psychomotor. Baly (1987:37) also suggests that by the time the contract with St Thomas's Hospital was drawn up, Miss Nightingale had come to the conclusion that “working class girls would be good for her experiment”. As a probationer a working class girl would be expected to work hard and set a moral example which other students would emulate. Despite the preceding claims about the class of female desirable to be a nurse, the Nightingale School had two types of probationers: lady probationers and ordinary probationers (Abel-Smith 1964, Calder 1960, Bolton 1981, Baly 1987, Bevis & Watson, 1989). Ladies who paid for the privilege of training were more likely to rise to superintendent or leadership positions (Baly 1987:40). Such a rise was due to their past education, and “invaluable experience” (Bennett 1981:15) so the positions were, therefore, also tied to social class, despite protestations by Bennett to the contrary.
3.3.2 In Hindsight

It has been argued that the developments which occurred under the influence of Florence Nightingale have been overvalued. Baly (1987) has suggested that many of Nightingale's biographers, taking Cook's original work as a source of authority, are guilty of presenting inaccurate interpretations of archival material. She argued that historians have misinterpreted the importance of the Nightingale reforms, which she sees as:

...a humble experiment of compromise, and a battle between the Nightingale Fund and St Thomas's—the experiment was lauded into the Nightingale system and ossified as tradition (Baly 1987:34).

Baly suggested that those who elevated the 1860 scheme into a blueprint for nurse training forgot that Miss Nightingale herself said: “We must proceed slowly and by experiment” (Baly 1987:34).

Contradictions about the position of nursing have existed since the time the Nightingale School of Nursing was established. When Nightingale organised nursing as an occupation she wanted nursing to be seen as a calling rather than a profession. She was concerned that if it was viewed as a profession it would become fashionable and hence lose the earnestness which she had worked so hard to encourage. As a professional group, nurses might become more concerned with the begetting of money than caring for the sick (Thompson 1981).

Learning to nurse through the Nightingale system might seem to present a superficial resemblance to the master-craftsman apprenticeship system, but variations in the two approaches are evident. Where the medieval apprenticeship system provided instruction on an informal, and irregular basis, the Nightingale system had a more systematic but still somewhat inconsistent approach to education. It also introduced formal teaching and objective assessment, with lectures and examinations becoming an integral part of a nurse's professional training (Reid 1986).
The establishment of the Nightingale School of Nursing did not greatly alter the power balance of practical nursing. It is clear that nurses were still to be accountable to the particular institution in which they were employed. Other parties such as doctors continued to make decisions about the nurse's role, what the nurse would do, how she would do it, and when she would do it. Baly (1987:44) has suggested that "student nurses received little formal training and were subjected to a great deal of discipline". Ashley & Labelle (1976:52) described the Nightingale System of Nursing as one which required "constant obedience to the medical profession and a selfless attention and devotion to the patient". Reverby (1987:1) has gone further to describe this model of nursing as "labour shaped by an obligation to care", which was a feature of preceding nursing practices. The status of nurses within the workplace of the hospital was unchanged from pre-Nightingale times. On the other hand, as an occupational group, nurses gained a measure of public respect and "for some nurses social and economic mobility and respectability became possible" (Whittaker & Olesen 1981:208). The success of the Nightingale model of nursing has been acknowledged by Russell (1990:15) who claimed that "its improvement of nursing services made Britain a recognised leader in this type of training. Its structure and methods were exported to many other countries and remained a dominant approach to teaching and learning for nurses for almost a hundred years".

3.4 Parallels Between the Nightingale School of Nursing and the Australian System

When Australia was settled as a colony, the system which provided for the sick followed the English model. In 1788, untrained convicts provided the only nursing care available. Two years later, when the second fleet arrived, a portable hospital was set up and staffed with untrained nurses (Short et al. 1993:172). Thus, learning to nurse in the very early stages of European settlement occurred through the experience of doing the work, without a system of formal learning.
In 1868, Lucy Osborne and five other Nightingale graduates established nurse training in Australia. The Sydney Hospital, funded from the profits of the rum trade, became the site for hospital-based training (Russell 1990, Short et al. 1993). However, “there was no specific pattern for general nurse training until 1924” (Russell 1990:38). Most teaching and learning prior to 1924 occurred in the ward while doing the work. Student nurses paid for their training by working in the hospital as cheap labour (Russell 1990, Short et al. 1993). The conditions and work environment closely matched those of St Thomas’s Hospital in London which were demanding and disciplined.

In 1925, the Nurses Registration Board was established and assumed responsibility for the training of nurses in New South Wales. A more specific pattern for general nurse training was established. A nursing syllabus, with standards for both the theoretical and clinical components of general nurse training was developed in order to meet registration requirements and make nursing more professional (Creighton & Lopez 1982). The program contained three components, namely: “theory, clinical and examinations” (Russell 1990:38). The clinical or practical component was considered the most important, for two reasons. Firstly, the hospital's purpose was to ensure that clinical treatment needed by patients was provided. Secondly, it was assumed that students, through their practical work, would learn how to provide nursing care (Russell 1990) that is, they would learn from the experience of doing the work. This is an assumption which still has strong proponents in the debates around tertiary nurse education. For instance, Reid argues that the essential tasks of all practical occupations are still learnt in the traditional way of “sitting next to Nellie” (1986:127). She believes that theory cannot teach students about the learning which occurs in practice, even though concern exists about the quality of learning in the practical workforce certificate level nursing programs.

The early New South Wales nursing syllabus placed emphasis on the physical aspects of patient care but formal and educational provision for the psycho-social aspects of care
were overlooked (Creighton & Lopez 1982:188). By 1938, forty-eight hours of formal tuition were given during a four-year training program in order to become a general nurse (Creighton & Lopez 1982, Russell 1990). The classroom learning experience might involve lectures from doctors on a pathologic phenomenon followed by lectures on the nursing role in regards to that phenomenon. This, in turn, meant that medical information was incorporated into nursing knowledge for nursing practice. Whilst instruction covered the requirements of the curriculum, it was always directed towards the practice of nursing in a particular hospital. As learners, nurses were instructed in what they were expected to know, how to apply that knowledge in practice, and why, even if this was only at the simple level of physical cause and effect.

Up until the second World War, nursing education was described as a process of practical training (Castle 1987, Russell 1990, Short et al. 1993) occurring almost entirely on the job with a small theoretical component “just fitted in” (Castle 1987:12) which focused on the learning of tasks. Tasks are the procedures that the nurse does in order to perform patient care. Since the time of Nightingale nursing education has emphasised the tasks, procedures or skills required of a nurse. It might be said that formal learning began with learning “basic nursing” tasks (Abdellah et al. 1965, McFarlane 1976, Lawler 1991). These relate to the basic physical needs of patients, and regardless of the patient's ailment they are integral to nursing. “Technical” nursing procedures performed relate to the patient's disease and medical interventions (McFarlane 1977, Lawler 1991:31). The teaching of nursing tasks was organised hierarchically so that student experience began with doing low status tasks and moved to higher status tasks according to seniority. This progression also included a move from doing the dirty procedures involving a lot of body contact, to cleaner procedures with less body contact (Lawler 1991:31). Knowing a range of basic tasks meant that the student could be rostered to any ward in the hospital. Generally, student nurses were expected to know a lot about the tasks they were performing, and to have an understanding of the related anatomy and physiology for both tasks and disease
conditions. They were taught less about what was going on for patients. It was, however, the practice of senior staff in each ward to encourage trainees to learn about this aspect during their interactions with patients in the ward.

After 1954 the formal component of nursing became more important with an increase in the number of hours from 78 to 242, and the number of subjects studied was increased from 6 to 16 (Russell 1990:67). In 1979 the total number of hours spent in formal learning was increased further to one thousand hours and the overall training period was reduced from four to three years. Prior to the 1960s students' attendance at lectures was compulsory, but in their own time, without any consideration being given to work hours (Creighton & Lopez 1982, Russell 1990). As a consequence student nurses were often tired when they attended lectures and very likely too tired to learn. Lecture presentations continued to follow the format of earlier years. They were didactic and exchanges between students and teachers during a lecture were minimal and not encouraged (Perry & Jolley 1987:3).

If in keeping with Creighton & Lopez (1982) and Russell (1990), we subscribe to the assumption that “theory and practice to be meaningful and efficient must be correlated” (Creighton & Lopez 1982:222), then there were severe limitations to the application of theory to practice. Separation between formal classroom learning and ward practice went beyond physical separation. Administrators who were responsible for ensuring service needs were fulfilled were often either unable or uninterested in rostering staff to areas which would provide practical exercises which would link with classroom theory (Creighton & Lopez 1982). The nurse educator had control over the student during formal learning and assessment only. Nurse educators rarely taught in the ward environment but they were responsible for assessment of practical ability in the school laboratory at examination time.
Ward learning was the responsibility of the charge sister, and occurred during work time. The model of teaching in the ward closely resembled the traditional apprenticeship model with variations, namely, that students worked irregularly with a master and worked more closely with people often immediately senior to them. Teaching emphasis was directed towards helping students perform practical nursing work, which included learning how to observe, what to observe, and how to think and what to think (Cowan 1984, Reilly & Oermann 1992).

Teaching in the ward was informal, often incidental, spontaneous and irregular. The methods included direct instruction, and demonstration by both doctors and ward sisters. Students sought learning from more senior nurses in order to gain explicit instruction on how to continue with certain procedures required for performing patient care. Training and work were inseparable entities (Bolton 1981). Staff working most closely with students were constantly involved in questioning students as to their knowledge about ongoing patient management. The rotation of students through the hospital ward areas was conducted by Nursing Administration. Negotiation between student and administrators as to choice of work and learning area was not permitted, nor were students permitted to be self-directing in their learning (Menzies 1960, Bolton 1981, Creighton & Lopez 1982).

Teaching in Australian Nursing Schools involved instructing students with the knowledge they were expected to apply in a practical environment. The underlying assumption was that an acceptable level of knowledge can only be transmitted in this way. The approaches of teachers and the conditions in which student nurses worked meant that they learnt about practical nursing through repeated, almost rote-like, performance.

Emphasis was placed on the notion that the ward environment is supportive of nursing as a practical discipline. As learners, nurses were often powerless in developing their
own interests. Students were often required to perform nursing procedures without previously having been taught to carried them out. If the student had observed the performance of a procedure beforehand, the experience would have served as the basis for practical performance of the new procedure. Learning was often assumed to have occurred through observation and practical experience. The trial and error learning that this implies would seem to be out of place in a context where people's lives are at stake.

3.5 Nightingale and Australian Nursing Systems in Practice: Experience and Education

The establishment of the Nightingale School of Nursing at St Thomas's Hospital in London, and its intended reforms were not accepted without criticism in Britain and the United States at the time and later in Australia. The form that formal nurse education was supposed to follow was a major area of concern for the medical profession.

For instance, some historical accounts describe how Nightingale had to argue that nurses needed to be trained because most people, including men, believed that nursing could be learnt by intuition (Calder 1960:46). Doctors, whose own education at the time of the Nightingale reforms in nursing, had only recently become based on scientific method within the university, “regarded intuition as being unscientific, irrational and unacademic ”(Reilly & Oermann 1992, Johnstone 1994:146). Intuition was thought to be associated with learning from experience as opposed to learning through a scientific method.

The president of the College of Surgeons criticised the Nightingale project. He argued that “nurses learnt by experience, and could only learn by experience” (Cook 1913:446). It can be assumed from his comments that he considered the nurse to be a person who learnt through experience and intuition rather than through a rational education program. The same surgeon was doubtful about the contribution of trained nurses to an overall improvement in standards of patient care. He stated that he was:
not at all disposed to allow that the nursing establishment of our hospitals are inefficient or that they are likely to be improved by any special institution or training (Cook 1913:446).

Many doctors were fearful about nurses being educated. They were concerned that their authority might be diminished and they reacted by supporting measures designed to keep nurses in a subordinate position. For instance, a doctor claimed that:

nurses did not need education or training, in fact they might even prove a menace (Pavey 1944:297).

Doctors also passed comment on the nature of knowledge that nurses required. They considered that instruction on “what to do”, and “how to do it” was adequate training. It was also felt that because nurses were women, they would cope by instinct. Cook has quoted the president of the College of Surgeons as suggesting that:

As regards the nurse or wards maids, these are in much the same position as housemaids and require little teaching beyond that of poultice making (1913:446).

The stereotypical view that “nurses were born and not made” or that any “good woman” could walk in off the street and become a nurse (Johnstone 1994:113) was an unacceptable position for Nightingale who argued that nurses needed to be educated about the performance of nursing practice.

The education of women was something that many medical men found difficult to deal with. Johnstone (1994) has discussed the medical construction of the nurse’s duty to obey, suggesting that, from the time of Nightingale reforms, the law has regarded the nurse as the “natural” subordinate and inferior of the medical practitioner. It determined that the nurse’s primary duty was one of obedience to the medical practitioner. She explained that, through the use of the law, medical men and their male supporters have portrayed the nurse as suffering from a “deficiency in judgement” as they were “lacking a judicial mind”. Consequently, they were expected to defer to the “rational wisdom” of
their male superiors. Johnstone (1994) further argued that women, as nurses, were seen as lacking certain necessary “qualities of mind” by male doctors and hence needed to be controlled. The language which described the attributes of women as nurses is as much about controlling the thinking of women as it is about a requirement to obey the medical man. By comparison (male) doctors were described as being endowed with:

natural faculties [which] have adapted them to frame and accept certain codes of professional law and etiquette not so easily recognised by the frailer sex (Kyogle 1908, cited by Johnstone 1994:128).

It was claimed that the doctor is by nature “more suited” than the nurse to engage in professional activities:

A clever doctor is consistent and logical, his professional knowledge is built upon accepted facts and careful deductions, the treatment of his patients is based upon well-conceived theories, the result of wide experience. But with women it is different; their method of calculation is not the same; they fly to results without weighing evidence. To make up for this deficiency in judgement, Nature has endowed her daughters with a strong power of intuition and a swift perception of the drift of vague ideas. These are most valuable attributes in a Nurse, but they do not compromise that other quality [the capacity to judge fairly and rightly] which makes men more suited for business habits and professional concerns (Kyogle 1908, cited in Johnstone 1994:129).

While Johnstone has carried out extensive research into the medical subordination of the nurse, it should be acknowledged that her findings reflect stereotypical nineteenth century attitudes towards all women. Conway (1987) discussed gender ideology and its relationship to the goals of American education of the 1840s, in which she provided numerous examples of claims to woman's supposed lack of rationality. Nursing and teaching were both considered appropriate occupations for women: nursing because of its nurturing, caring, human concern for the sick, and teaching because “women were considered to influence children’s behaviour through their emotions” (141).
The issue of education for women as nurses is as important today as it was in Nightingale's time. The nurse, who is still most likely to be a woman, experiences not only a lack of power in everyday learning but also a low status within the hierarchy of the health care system:

Although most women in health service see themselves as helping patients, and went into health work for that purpose, the actual decisions they can make and the actions they can take are controlled from above. They are taught in training programs and on the job that they should not take independent action, they should not challenge their superiors. In short, they should know their place (Brown, cited in Chenervert 1985:97).

There were many close similarities between the British, the early American and Australian systems of nursing. Nurses were taught information in order to develop behaviours which could be used to perform their work. To be a nurse meant being subservient to the requirements of those making decisions in the hospital. Nurses were not permitted to be involved in determining what knowledge they would require for nursing. As many nurses came from a working class background it was assumed that they had done hard work before. Their past experience of labour was assumed to be an adequate prerequisite for knowing how to nurse. Nursing knowledge was thought to be an extension of domestic competency. While historical accounts record Nightingale's desire for nurses to receive a formal education, this education was highly constrained. Even though the Nightingale system of nurse training was an improvement on the apprenticeship system, nurses still had to endure considerable hardship in return for on the job instruction, some formal learning, assessment and finally a qualification which carried no professional status.

In all countries which adopted the Nightingale model of nursing, there were, however, continual developments and increases in the amount and type of knowledge nurses were expected to know in order to perform their duties. In particular, there was a lessening of the more domestic type of activities performed by the nurse, such as preparing the food, cleaning and dusting, and changing the water in flowers. There was, however,
an increase in the developments of medical science. In turn, the performance of nursing care became more complex in relation to the treatment of patients and involved a greater use of modern technology and medical science.

3.5.1 The Nurses' Relationship with the Hospital

Employment Conditions

Experience and education were aspects of an exchange system, whereby the trainee nurse did the work in exchange for some on-the-job instruction and a very minimal formal program which prescribed what she would do and understand. Paradoxically, the nurses' training relationship at the beginning of this century was described as one of mutual benefit. Through her experience in the hospital the nurse was expected to undergo a positive social and economic transformation:

The student nurse, if we would join in her fairmindedness and honour, must understand from the beginning that her relation with the hospital is a perfectly dignified, well-balanced arrangement whereby she gives three years of service in return for technical training that lifts her forever from the ranks of unskilled labor (Flash, 1915:442, cited in Johnstone 1994:42).

Experience had a price. Johnstone (1994) has suggested that nurses were usually disadvantaged by being expected to provide a source of cheap labour in return for a questionable level of nursing experience through practice. Employer demands and poor working conditions meant that the level of nurse education and experience was rarely balanced or effective. Johnstone regarded such conditions as barriers to education. The emerging nursing profession was seen to be a victim of:

long hours, poor pay, a beggar's diet, high morbidity and mortality rates, severe staff shortages, rigid discipline and a short career span became the dominant characteristics of the modern nursing profession (Johnstone 1994:42).

Parallels in nursing work conditions between Australia, England and the United States of America have been described by Johnstone (1994). She described work conditions
in all three countries as being characterised by "intolerable living conditions, excessively long hours, the undertaking of strenuous tasks and being used as sweated labour by the hospitals" (Johnstone 1994:50). The nurse who was able to persevere with the duties demanded of her was labelled a "good nurse" (Johnstone 1994:50). Exhausting work experiences were not the only a feature of nursing schools based on the Nightingale model of nursing. Hospital labour in America, England and Australia was performed in the main by pupil nurses. The so-called "education" of students consisted of ninety-five per cent service and less than five per cent instruction in theory, and even this "education" was considered "too much" by doctors who complained that nurses were being overtrained (Kalisch & Kalisch 1975, cited in Johnstone 1994:54). This meant then that experience comprised ninety-five percent of a training program and formal learning five percent.

Johnstone (1994:50) reported that nursing conditions in Australia in the early part of this century were described by one nurse as akin to "white slavery". There is also a suggestion that hospitals were more concerned with students labouring, than providing them with an education. The outcome from a Victorian wage case for shorter working weeks illustrates such an argument:

> it was not desirable in the public interest that (nurses) should be included in the general declaration of standard hours of 44 hours week for the following, amongst other, reason, namely, (1) that 44 hours week would be detrimental to nurses training, in that she would not have sufficient time with her patients to gain necessary experience (In Standard Hours — Nursing Staff in Hospitals 1934:318, cited in Johnstone 1994:77).

Implicit in any discussion about Australian work experience and conditions is the in-built assumption that the nurse benefited from these experiences because they provided her with the opportunity to learn.

In Australia from the 1960s onwards nurses were not so complacent in accepting either their poor work conditions or low wages, and they expressed their dissatisfaction
through increased militancy over industrial issues (Russell 1988:38). During the same
time period there was an increase in social and technological changes in hospitals and
nurses roles became more complex. Russell suggested that these changes resulted in
hospitals becoming more complex in organisation and operation. As a consequence the
need for nurses to develop managerial and educational skills was seen as a pressing
need by some members of the nursing profession.

*Line of Authority*

The establishment of the Nightingale model of nursing led to different lines of control
within the hospital. Where doctors had control over knowledge, the matron of the
hospital exercised considerable authority over the life of nurses, both within the hospital
workplace and outside the ward, to include control over their social life in the nurses’
home. For example, nurses were expected to return to the nurses’ home by a certain
time each night.

The matron always played a major role in the selection of nursing students. As such,
they were influential in determining “who” and “what” made a “good nurse”. For
instance, Miss Luckes, one time matron at the London Hospital in 1886, wanted women
who would develop certain characteristics and become a nursing stereotype who:

was a tender hearted woman, who from practical experience, is
skilled in the services and attention which sick people require,
and whose devotion to work is inspired by genuine love of, and
satisfaction in helping, those who are in need of what she has to
give (Maggs 1983:33).

Reinforcement of the nurse’s relationship to the system was evident in the behaviour
expected of the student nurses. Some attributes, such as complaining, were not
acceptable. Critical thought was not encouraged but unquestioning submission (even to
the point of absurdity) was commanded. As one matron remarked:
One thing I do most heartily deprecate is the habit many hospital nurses have of grumbling, never satisfied, work too hard, hours too long, food not all that they desire... Loyalty to their own training schools is, I am afraid, lacking in many nurses, and yet what happier time have we had than when eagerly learning all that is to be learned in theory, and doing all that can be done in practice for the relief of those suffering ones under our care, without anxiety or responsibility when off duty, busy and perhaps hard worked when on duty... Beware of that captious spirit of finding wrong everywhere (Maclean 1903:34 in Johnstone 1994:42).

These sentiments regarding attitudes, practices and expectations were replicated in Australia until the transfer of nursing education into the tertiary sector. The degree of discipline and rigour visited on student nurses depended on the personality of the individual matron. Nurses who were brave enough to complain about their experiences were portrayed as “failed women” (selfish, disloyal, disobedient and uncaring), and therefore deserving of reprimand, scorn and rejection (Johnstone 1994: 42).

Baly (1987:40) reported that complaints about the authoritarian attitudes of the British matrons were widespread. In Australia, some matrons continued to be influential persecutors of student nurses. In 1929 Farquharson, a matron of an Australian hospital, wrote about the nurses’ most important responsibility, which she regarded as obedience:

Obedience is better than sacrifice. Obedience. It is necessary for peace that we should all learn obedience. There are two kinds, loyal and disloyal, but whichever it is, no hospital can be carried on without it. Loyal, willing obedience brings happiness with it. Unwilling obedience the reverse (Farquharson 1929:340, cited in Johnstone 1994:134).

The practice of working with someone more senior meant that the pupil nurse was constantly being socialised into attitudes, values and appropriate modes of behaviour such as learning through repetition, developing an unquestioning approach, and caring. Student nurses were expected to submit to all regulations unquestioningly. These aspects are now considered to reflect a high degree of social control, but it is obvious that they had many benefits as well as negative implications for trainee student nurses.
From the time of Nightingale employment conditions and the opinions of matrons have been influential in how the nurse was positioned within the work place. Gradually work conditions have improved. The role of the matron, now called the Director of Nursing has also undergone considerable evolution, and the nature of their responsibility towards and for nurses has altered. In addition, the development of hospital management and organisational practices in theory mean that more open lines of communication exist within hospital and community work environment.

3.6 Developments on the Nightingale Model

In both Canada and the United States reforms to the Nightingale apprenticeship model of nursing education, specifically the transfer to the tertiary education sector, were implemented at a much earlier time than in other western countries. The earliest shift to tertiary education occurred in the United States in 1893, when a short-lived attempt was made to establish a University School of Nursing at Howard University in Washington DC. In 1909 a university nursing program was re-established on the same site as the earlier university program. Over the next 50 years more than 350 college and university schools of nursing were established throughout the United States (Bevis 1989:22).

In Great Britain, the first university education for nurses became available in 1956, with the creation of the Faculty of Nursing at Edinburgh University, which later became the Faculty of Nursing with a chair of Nursing Studies in 1973 (Perry & Jolley 1987). In England and Wales efforts by the General Nursing Council contributed to inquiries and modifications of the apprenticeship model of training. However, widespread suspicion surrounded the notion of an academic nurse. On the other hand, the “clever doctor” and lawyer were spoken of with awe, while the “clever nurse” was usually the subject of sneers and considered unlikely to be any good practically. Perry and Jolley (1987:7) have suggested that one obstacle to the development of university education for nurses can be attributed to those nurses who themselves denied that there was an academic
content to nursing. Such nurses emphasised the importance of practical skills and the value of ‘experience’ as opposed to basic theoretical knowledge (Perry & Jolley 1987).

In England, the proponents of nurse education asserted that a change to university education for nurses would result in improved professional status (Perry & Jolley 1987). The Dean of the Hammersmith Postgraduate School, Charles Newman, in 1958 claimed that if nursing were a university discipline more research would be done on nursing and nursing would be in a much more progressive state (Perry & Jolley 1987).

3.6.1 Tertiary Education of Nurses in Australia: Nightingale Influences

In Australia, a series of reports highlighted the continuing tensions which have characterised what it means to become a nurse, learning to nurse and nurse education. The first major report into nurse education was the Kelly Report of 1943. The primary purpose of this report was to improve the “status and training of the nurse” through a reorganisation of the profession. The report, however, was not really concerned with the intellectual development of nurses, or with changes that would enable the nurse to constructively contribute to the reform of the health care system. Its intention was to increase the number of nurses in the workforce by recruiting women into nursing at a younger age. It proposed to achieve this by lowering the entrance age from twenty one years to seventeen years in order to catch young girls before they got married (Kelly 1943).

Between 1950 and 1968 five reports on nursing education in Australia were published by the World Health Organisation Expert Committee on Nursing. Significant amongst these reports is the Chittick Report of 1968 which linked nursing education with general education for the first time (Chittick 1968). This was an interesting connection which had not previously been explicitly recognised and it had broad implications. Such a link suggests that learning to nurse must be more than learning how to do what is necessary in the wards. Chittick criticised nursing education up until 1968 as an apprenticeship system which was too restrictive and did not prepare the students for broader involvement in decision-making within their own discipline or the healthcare system.
Rather, it was training where it was assumed that knowledge would develop and accrue through continuous contact with a "master" nurse. Chittick also argued that the apprenticeship style of nurse education did not prepare nurses for life and the wider society.

At the age of seventeen, the entrance age to schools of nursing, students are cut off from any educational program that would enlarge their vision, develop their potential resources and make them aware of the social, political and cultural problems they must face as citizens. Nursing education at the basic level remains a trade which students learn over a period of three or four years (Chittick 1968:11).

Further into her report she stated:

Most students practising in the hospitals learn from each other since there is no one else to teach them. The ward sister is too busy to teach and there are very few clinical teachers (Chittick 1968:14).

One is forced to conclude that nursing in Australia, as was the case elsewhere, was based on a situation which perpetuated assumptions about learning as a kind of mechanical process taking place, in the main, through the experience of carrying out the work. Perry & Jolley (1987:3) suggest that habits of discipline and unquestioning obedience which were part of the nurses' learning context must have led to an acceptance of conditions which might have been improved had they been criticised.

The Institute of Hospital Matrons' Report (1969) discussed the quality and level of nursing education and urged that a high level of professional education ought to be provided. It argued that nursing students needed to be taught to understand underlying principles, not just technical skills and that students should be expected to understand nursing procedures and their performance before being required to carry them out. Moreover, it stated that the aim of nursing education should be to produce a mature citizen as well as a nurse and that a fully competent practitioner should be produced on the day of graduation.
Another Committee (1979) inquiring into nursing education suggested that:

apart from knowledge related to the rapid growth of technology there is a need for knowledge in behavioural science. This derives from a growing understanding of the importance of relations between nurses and patients, including interventions in crisis situations. Skilled help can prevent breakdown of the individual and family at times of bereavement, loss of a limb or organ or body function, and during major disruptions in patterns of living. The nurse is often immediately involved at such times (Committee on Nurse Education and Training, Report 21, 1979).

Although this report still focuses on what might be described as nursing practice, it seems to acknowledge that the nurse needs to learn about broader issues. Bruni (1991:184) suggests that practice is primarily related to an interpersonal context—in other words the occupation of nursing occurs in a situation which involves an interpersonal nexus in which the nurse and the client are the main actors. Although the language is different, in this contemporary analysis of nursing, the nurse/patient relationship is essentially unchanged since the implementation of Nightingale’s reforms; that is, the nature of her work mostly involves a close level of physical contact and mental communication with the patient. It makes little mention of other aspects of the nursing relationship. For instance, given the advances in the medical and physical sciences that have occurred this century it would seem to be appropriate that nurses access this knowledge, in order to adequately fulfil the work required of a close patient-nurse relationship.

Excerpts and recommendations from the preceding and all subsequent New South Wales inquiries have influenced the findings of other committees in Australia. In summary they all recommended changes to the Nightingale model of nurse education and aimed to produce nurses who could function in a broader capacity within the health care system. A consequence of these reports was that senior nurses in New South Wales actively and politically pursued a move to the tertiary sector. Continual reporting of the need for more formalised education for nurses resulted in the commencement, within the New South Wales Technical and Further Education System, of the Newcastle
Regional School of Nursing in 1972 (Punton Butler 1993) as an interim or trial project. This was discontinued along with several other pilot programs when the transfer into the university sector occurred in 1985.

From the 1970s the beliefs and assumptions once considered to be satisfactory for the basis of nursing practice have been redefined (Miller 1985). In addition, research into "traditional nursing practices" have described them as unsatisfactory and wanting (Hamilton-Smith 1972, Lelean 1973, Wells 1980, Bolton 1981, Bennett 1981, Chapman 1983, Parkes 1984, Miller 1985, Lublin 1985). Australian nurses endorsed these and Chittick's sentiments, with Bolton reiterating Chittick's argument that:

Nursing education is the focus for the future of nursing practice. An adaptive, flexible and imaginative nurse does not emerge from a training based on service and discipline. A sound, broad-based education will go a long way towards preparing a nurse who is capable of contributing to social change (Bolton 1981:35).

Two distinct messages conveyed by these writings, in keeping with the Nightingale claims, are that nursing education is important for improving nursing practice, and that nurses have a responsibility for contributing to social change. The nature of that change is not apparent from Bolton's statement but the original reference focused on the need for nursing education to transcend the hospital environment and prepare a practitioner who can also function effectively within a wider community setting. Although community nursing existed at the time of Nightingale and was also practiced in Australia, Chittick's report suggested a broader training than that provided by hospitals.

Prior to 1985 the training of nurses was directed primarily towards providing hospital health care needs, also known as providing service needs, which generally meant that student learning was behaviourally orientated. In 1985, in New South Wales, political acceptance of the 1979 Sax Report resulted in the transfer of nursing education to the university sector of tertiary education. The Sax Report suggested that the professional functions of nurses would be enhanced if nursing were transferred to the universities.
University academics claimed that tertiary education, unlike hospital-based training, would produce more broadly functioning nurses (Chittick 1968), and "improve the professional status and autonomy of nursing" (Perry & Jolley 1987:7, Bolton 1981) which state registration had failed to achieve (Johnstone 1994). From the hospital service perspective, Parry, then Chairman of the Higher Education Board, argued that a tertiary education would, amongst other things, "improve the quality of care by having a much more efficient, stable workforce" (1984:14). Both nurses and patients were supposed to benefit from the transfer of nursing education into the tertiary sector.

From an educational perspective it has already been noted that the move into university education was expected to bring about a change in the meaning of experience for student nurses, an expectation that is being investigated in this thesis (see Chapter One). White (1975, 1985) argued that education should prepare the nurse for role changes. Education in the tertiary sector should allow the learner to construct knowledge from a conceptual approach to learning. This approach would also serve to provide a general educational foundation, as the basis for becoming a registered nurse, capable of working more effectively in a wider range of contexts. This change also reflects an extension of the curricular shift towards a basic general nursing program from the previously specialised basic programs. As a consequence, specialisation in nursing would occur at a post basic level rather than at the pre-registration level.

For some nurses, particularly those involved with teaching nurses, the transfer of nursing education into the tertiary sector positions nursing "as approaching its own age of enlightenment, its age of emancipation from the stranglehold of unquestioned tradition" (Gerebits 1985:75). From another perspective, the move would introduce a change in the nature of learning. On one level the change was seen as a move from a pedagogic approach to learning which existed in the hospital system, to an adult approach in universities. For instance, traditional nursing programs have been criticised as focusing too heavily on content and a rote learning approach to knowledge
development (Chittick 1968, Sax 1978, Sax 1979, Creighton & Lopez 1982, Parry 1984, Russell 1990), without enough attention to the wider issue of learning. In contrast, an appropriate pedagogy for university nurse teaching claims to be centred on “ensuring that graduate nurses are self-reliant, efficient professionals who are capable of researching and examining problems within the work place” (Creedy & Hand 1992:222).

With the State Registration Board no longer responsible for the nursing syllabus, university nursing programs were developed in an attempt to produce a nurse who would fulfil the preceding expectations. For instance, one curriculum's statement about its tertiary nursing program includes the following:

> While a knowledge of facts is important, a significant function of a basic program is to ensure that students develop analytical and evaluative skills fundamental to independent thought and objective decision making (The University of Wollongong Diploma of Applied Science [Nursing] Course Document June 1986:4).

The transfer into tertiary institutions has not been uncontested or uncriticised by nurses within the workplace. For instance, Hattenfels (1990), in a conference paper on her personal reflections as a new graduate nurse describes how gaining a tertiary education served to label her as having all theory and no practical ability, with the result that she learned to refrain from discussing nursing practice. Shorten (1990), and Norris (1990), at the same conference, presented papers expressing similar perceptions. Within the first twelve months, however, they felt more comfortable and confident about their performance within the hospital setting.

The transfer of nursing education into the tertiary sector is important firstly because nurses can now have a general education, which hopefully will equip them with educational skills and abilities not permitted by the previous system of education. Despite the increased number of men now entering nursing, “it remains a woman's’
profession and retains all the accompanying issues that relate to the value of women's work, women's contributions and the relationship between nursing and other health related professions" (Melias 1991:135).

Various stakeholders have argued that the transfer of nurse education into the tertiary sector would improve the educational experience of nurses because it would have an increased formal component and that the teaching of theory and practice of nursing would be better correlated. Tertiary education would thus be an avenue for improving the professional status of nurses (Davis 1991, Bolton 1981, Parry 1984). However, these assumptions need further examination because the move to the tertiary sector has not overcome all of the inadequacies of the former system, and has produced new problems which need to be understood.

3.7 Conclusion

This chapter has highlighted movements that have occurred for nurses since the establishment of the Nightingale School of Nursing. It was believed that nursing practice could be improved through nursing education. This assumption continues in the education of nurses today. This historical account and the distinctions made between the notions of "education" and "experience" lay the groundwork for exploring nurses' perceptions of the educational process.
CHAPTER 4

LEARNING THEORY, EXPERIENCE AND NURSE EDUCATION

4.1 Introduction

The transfer of nursing education from the hospital system into tertiary institutions was a departure from a system where the provision of service needs took priority over the educational needs of nurses. The traditional approach to nurse education has been seen to have had its own set of implicit assumptions in the sense that it took, as given, that women learned to become nurses through practical experience.

Students were trained in (and received demonstrations on) what they needed to know in order to carry out their duties with only limited provision for a formal theoretical component. Teaching methods consisted of instruction (and demonstration) in the classroom, with the same methods being repeated within the ward environment. The content of instruction was both descriptive and prescriptive: to learn how to nurse the student nurse listened, observed and performed nursing practice under direction. This mode of training nurses was underpinned by the assumption that practical on-the-job experience was the most valid way to learn to nurse.

This chapter discusses how learning theories have used the concept of “experience” in order to promote student learning. In the process, changes in the nature of “experience” are traced as they relate to how the student is positioned as learner and nurse.

4.2 The Meaning of Experience

This section will discuss some of the ways in which “experience” has been used to account for how learning occurs within nursing education.
According to many learning theorists, “experience” is the most basic method of learning and is reinforced by failure as much as by success. The Australian Concise Oxford Dictionary (1987) defines experience as an actual observation or an actual acquaintance with facts or events and the knowledge or skill resulting from this. In an educational context the concept “experience” is used to describe the phenomena that a person gains from direct encounters with a person, subject or thing (Burnard 1991).

There are however a number of theories of “experience” which provide some insights into developments in nurse education. Influences from theorists such as Dewey (1916), Vygotsky (1986), Freire (1972), Knowles (1975), Schón (1983) and Novak & Gowin (1984), are discussed directly in this chapter. Others, such as Polanyi (1958), are useful in providing interpretations of “experience” which enable a critique of implicit and explicit assumptions about "experience" where it relates to nurse education.

As an educational concept, experience has received recognition in both general and nursing education. John Dewey (1858-1952) was an early and significant proponent of the importance of life experience as a basis for the learning process. In this context experience is defined as the interaction of the individual with the environment (Dewey 1932). This notion is also fundamental to the school of humanistic psychologists and includes the contributions of Carl Rogers (1949, 1969), Abraham Maslow (1954, 1970) and Liz Raichura (1987).

Historically, the term “experience” has been used to describe how nurses learn. The development of knowledge was expected to occur as a result of classroom teaching and carrying out nursing practice. Dewey (1916, 1932) would regard this view of the place of experience in learning as one based on trial and error, which leads to rule of thumb decisions. Dewey, however, adopted a broader perspective of experience in which the individual was encouraged to reflect on connections between different aspects of an experience, as a participator, in relationship to a democratic society. He suggested that
“reflection turns experience into learning” (Boud, Keogh & Walker 1985:11), so that, for Dewey, observation and reflection on experience are the essential features of learning.

A similar notion of experience is adopted with the concept of “experiential learning”, a technical concept found in the context of adult learning and influential in contemporary nursing education. Experiential learning, in this context, attempts to encourage the link between theory and practice, by providing students with the opportunity to take an active part in the learning experience. However, as the term is used in the literature, it means different things to different theorists.

The theoretical basis of experiential learning is frequently linked with the work of John Dewey (Kolb 1984, Boud, Keogh & Walker, 1985, Burnard 1990, Burnard 1991). However, Boydell (1976 cited in Merchant 1989:308) described three types of experiential learning, each one stemming from a different psychological foundation and applicable for teaching. Briefly, these relate to Gestalt theories as applied to experiential learning, experiential learning based on autonomous learning theory, and experiential learning from everyday experience.

Different definitions of experiential learning have been used in the nursing education literature. These include that used by Walter and Marks (1981) who considered that experiential learning is comprised of a sequence of events with one or more identified

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1Experiential learning occurs when a student who is faced with a problem restructures their perceptions in order to make sense of them to solve the problem. The teacher's role is one of facilitation and focuses the learner's attentions on the goals (which are set by the teacher).

Experiential learning based on autonomous learning theory stems from a phenomenological position and emphasises the way the individual restructures perceptions due to experience. This is the "most socially useful learning in the modern world" and is a characteristic feature of a "fully functioning person" Rogers (1969, cited in Merchant 1989).

Experiential learning from everyday "experience" is how learning occurs for the majority of people and has in some ways become equated with knowledge. Four components identified as comprising everyday experience include: the individual; formal learning structure(e.g. job descriptions); opportunities to learn (e.g. the work experience itself); the learning climate itself (the general psychological, sociological and political environment.) Boydell 1976 cited in Merchant 1989).
learning objectives requiring active involvement by the participants at one or more points in the activity or experience. On the other hand, Heron (1981) defined an experiential learning technique as one which involves the whole person and his/her experiences to a greater or lesser degree. This very general statement presents personal involvement and human experience as the essential characteristics of experiential learning. According to Heron (1981), the sharing of these experiences through discussion can constitute personal involvement.

Like Boydel, Burnard (1990), has classified experiential learning into three main areas. These relate to personal experience, reflection and the transformation of knowledge and meaning. When personal experience refers to the involvement of the individual and to his or her life experiences, the process of reflection allows the student the opportunity to explore previous experiences, feelings and thoughts. This leads to a re-evaluation of what the student knows and understands. In turn, the learner acquires new meanings, new ideas and a deeper understanding, which Burnard has referred to as the transformation of knowledge. Student nurses' perceptions, on the other hand, sometimes consider experiential learning to be learning which occurs mostly within the clinically based ward environment and is connected to real life situations (Burnard 1990).

According to Sheahan, experiential learning occurs when experience is followed by reflection, discussion, analysis and evaluation of the experience (Sheahan 1980, cited in Merchant 1989: 308). However, with the transfer of nurse education into the university, students' learning experiences are taken up as simulated experiences; this in turn defines “experiential learning” in a particular technical way (Raichura 1987, Burnard 1990). This type of experiential learning takes learning away from a real life setting and places learning in a safe, neutral, environment where procedures such as simulations, and role plays can be rehearsed before they are used on the patient/client. Learning in this way is considered to be valuable to nursing students as they get to
practise nursing procedures before they visit the wards for clinical practice, then limiting the consequences of trial and error for learners (Raichura 1987, Janes & Cooper 1990).

4.3 Experience as an Educational Concept

Experience as an educational concept has historical and philosophical origins and has been influenced by wide ranging ideological and theoretical constructs. This section will discuss several approaches which signify the types of influences different theorists have had on the development of “experience” as a concept.

*Kantian Influence*

An early essay on the relationship between the concept of experience and knowledge can be traced back to Immanual Kant's *Critique of Pure Reason*. Kant, an 18th century German philosopher, proposed that knowledge begins with experience, but the mind supplies the form in which it is known. The part of experience, which precedes knowledge, is the raw material from the outside world acting on our senses. The other part of experience is supplied by the pure faculty of knowledge. Knowing from experience is, therefore, a combination of knowing from direct concrete experience and knowing supplied from cognitive activities primed by experience but independent of it (Taylor 1990). Kant describes the two modes of knowing as 1) *a priori*, which exists prior to the experience, is independent of the experience, and remains unchanged throughout the experience, and 2) *a posteriori* knowledge, derived from experience (Taylor 1990:80). In summary, experience serves as a teacher and needs a student with an inherent ability to attain knowledge.

From Kant's explanation of how knowledge developed, it can be suggested that for nurses, the everyday work experience led to knowing which resulted in part from the sensory input experience of carrying out tasks together with some theoretical input. The nurse found herself in a position where she had to rely on “intuition” to promote her learning.
The Influence of “Progressive” Educational Theory: Dewey

John Dewey (1916/1966), an early philosopher and educator who informed both general and nursing education patterns in the United States, argued that experience was important to the promotion of learning. Nurse academics, like Abdellah (1959) believe that his theory was adapted by curriculum developers in order to change how the nurse thought about and practised nursing.

Dewey claimed “knowledge is always a matter of the use that is made of the experience of natural events”, and could be experienced at different times under different conditions (1917:413). Dewey stated that learning is gauged by problem-solving or intelligent action in which the person continually evaluates experience in the light of foreseen and experienced consequences.

“Interest” serves as the basic motivational construct of the Dewey system. Interest was further seen as a critical link between the pupils' stage of growth and where the teacher hoped they would be. For Dewey, learning was group and individually orientated. His approach to teaching and learning led to the concept (fostered by the progressive education movement) of encouraging growth of the individual through independence and self control. Education was also viewed as preparation for active participation as a citizen in a democratic society (1916). This position seems to considers knowledge to be “relative” with what people know being bound up with who they are and how they view things (Burnard 1992:34).

Dewey (1916) considered that thinking was synonymous with the process of inquiry; thinking occurs only when things are uncertain or problematic. Acquiring knowledge, therefore, would always be secondary and instrumental to the act of inquiry. For Dewey, thinking originates in situations where the course of thinking is itself part of the event. Yuen (1990) suggested that this definition of thinking demonstrates the reflective principle of the problematic method; reality is located within the situational context.
(thinking turns inwards to find meaning). Dewey felt that the reflective experience and
the basis of problem solving consists of the following characteristics:

- perplexity, in which one is implicated in an incomplete situation;
- conjectural anticipation, that is, the tentative interpretation of the situation;
- careful survey and exploration;
- exploration of a tentative hypothesis; and
- taking a stand on a hypothesis as a plan of action for testing (Dewey, 1916, 1938).

Dewey has pointed out that reflective experience differs from methods involving trial
and error. Rather than being transmitted from one to another, knowledge is developed
by the individual. Andersen who has contributed to the development of nurse education
curricula in New South Wales, suggested that Dewey's theories have influenced
curriculum by shifting "the definition of knowing from a product to a process and
method approach" (1991:98). In the United States where nurses firstly incorporated his
ideas into the curriculum it was thought that a different approach to learning would
change how the nurse thought about and conducted nursing practice. Curricular
changes were designed to construct the nurse as a problem solver, rather than a
traditional non-thinking follower of instruction.

Dewey's theory represents a significant departure from the traditional approach to
teaching nurses which was didactic and did not encourage questioning. According to
Gordon and Poze (1978) Dewey, like other learning theorists, realised the importance of
association as the basis for learning. They have argued that other teaching and learning
theorists failed to include the explicit skills that produce purposeful learning
connections. In ignoring the perceptions or ideas that grow from experience, it was
likely that theory would continue to remain at an implicit level. It has also been claimed
that if students are unable to make connections between what they are trying to learn and
the validity of their own experience, a learning short circuit is likely to occur. This they
have pointed out has possible implications for tertiary education, where a heavy emphasis is given to learning abstract knowledge in the form of theoretical propositions (Gordon & Poze 1978).

*Influence of an Approach to Knowledge Development: Polanyi.*

More recently American nursing theorists have utilised aspects of Michael Polanyi’s theory of knowledge development in different, and in fact, opposite ways to account for the place of “experience” in the development of nurses (Rogers 1970, Benner 1984). Polanyi was a 20th century English chemist and philosopher who believed that thinking involved making constant judgements. Judgements could take the form of reflection on the nature of knowledge, or reflection on how knowledge is acquired in the process of teaching and learning (Brownhill 1983).

In keeping with Dewey’s theory, "experience" contributes to the development of an expert practitioner, but unlike Dewey, Polanyi considered that the expert knowledge was embedded in practice. Polanyi (1958) takes up experience in relation to the concepts of tacit knowledge, maxims and connoisseurship. These three concepts are considered to be developed through practical experience.

Polanyi (1958, 1962) argued that tacit knowledge, also known as inarticulate intelligence, or implied knowledge, is demonstrated when experienced practitioners are able to act appropriately but are often unable to explain the theoretical basis for their action. Maxims are rules and their correct application relates to the part of the art of nursing which they govern. Whilst maxims are applied to improve performance, they can, however, only be applied when a practitioner possesses a good practical knowledge of the art or practice of nursing. Connoisseurship is something that can only be developed by experience and is communicated by example.

Polanyi’s use of experience in relation to these three concepts suggests that it not always possible for practical knowledge to be underpinned by theoretical knowledge. Expert
practice which is governed by these three concepts requires practice and experience to develop, and in fact, connoisseurship according to Polanyi can be communicated only by example.

One nurse academic, Martha Rogers (1970), adopted aspects of Polanyi's theory to argue for an improved theoretical basis for nurse education. She focused on that aspect of his theory which asserts that learners have a responsibility to gain knowledge objectively. In contrast to Rogers, Patricia Benner (1984) adopted aspects of Polanyi's theory which focus on the knowledge held by the expert practitioner. This knowledge which develops from experience is embedded in actual nursing practice and is made explicit through the process of reflection. Benner's focus might be seen to have a slight parallel with that aspect of knowledge development which Nightingale also regarded to be important. For instance both Benner and Nightingale seemed to believe that practical experience represents the teacher or primer for the nurse's knowledge development. Benner, however, clearly adopted a view of the nurse as a whole person, and not just a pair of hands and a bit of muscle.

However Benner's propositions for nurse education are less straightforward than Nightingale's, and might even be regarded as somewhat convoluted. This is in part explained by her selective use of Polanyi's theory. Benner, unlike Rogers, emphasised that aspect of the theory related to experience. Where Benner argued for the use of reflection on practice to help registered nurses develop their knowledge of nursing, Polanyi claimed reflection is an inappropriate path to follow because it is more likely to lead to the defending of one's position and actions rather than the generation or transformation of knowledge. He claimed that while the personal participation of the knower occurs in all acts of understanding, the personal component of knowledge which shapes all perceptions of truth links the subjective and the objective (Polanyi 1962). However, nursing education in Australia and overseas has taken up Benner's and others' approach to critical reflection as an approach to knowledge development
(National Health & Medical Research Council 1991, Andersen, 1991, McMillan & Dwyer, 1991, Bachelor of Nursing Curriculum Document Wollongong University 1991, Jarvis 1992). The intentions of Benner and others seemed to represent a shift in perceptions about knowledge associated with nursing practice. This is a shift from the classical view of knowledge whereby it was considered that information taught was "truth" to be applied in practice, to a more relative view of knowledge.

The Influence of Critical Thinking: Freire

One of the tenets of Polanyi's philosophical position on learning is that the learner, not the teacher, is central to the learning process. This is a position explicitly adopted by Paulo Freire (1972) and some other psychologists including George Kelly (1955), Jean Piaget (1968) and Malcolm Knowles (1975), to name but a few who have been influential in the development of curriculum and pedagogical practices in nurse education.

The transfer of nurse education from the hospital based training schemes to the university education system in New South Wales seemed like a good opportunity to adopt a more learner centred, and critical approach to nurse education, than the highly controlled narrowly focused, non-questioning training to which nurses had previously been subjected.

Freire (1972) recognised from his literacy programs with peasant workers that learners have a personal perception of the world which is culturally induced. He argued that the "banking" approach to learning whereby the learner merely stored, or banked, increasing amounts of knowledge in the mind without linking the knowledge in any way to experience did not change the person. He argued that personal meanings or constructs need to be comprehended in each social and political context (Boud, Keogh & Walker 1985:23).
Learning which facilitates awareness raising (conscientisation) through the contextualised learning of concepts, and the development of problem posing in learning, leads to the empowerment of learners (Freire 1972). Such an approach to nurse education would enable nurses to view their learning in the context of the power relationships existing between teacher and learner (hospital, doctors and the positioning of nurses). In this way nurses would be able to critique a social system that they knew experientially was riddled by untenable power relations.

**Behaviourism as an Influence on Nurse Education**

Implicitly and explicitly the principal assumptions drawn from behaviourism have informed traditional nurse education practice. The main theorists associated with behaviourism are Ivan Pavlov, John Watson, Edward Thorndike and most recently Burrhus Skinner (Marx & Hillix 1973). These theorists, among others, have argued that learning is a process of making connections through associations. They demonstrated that behaviour can be shaped through the guided use of stimuli, and the reinforcement of a correct response to such stimuli (Conley 1973). Reinforcement is the term used to describe the rewards and punishments for correct and incorrect responses.

Operant conditioning is an aspect of behaviourism that has been influential in nursing education. It is used to shape human behaviour through reinforcement. Its use was prevalent for nursing students in the classroom and ward environment. Teachers used reinforcement techniques to create a learning environment designed to bring about desirable behavioural changes in the learner. Praise is one of the ways in which human beings are rewarded for successful performance. The notion of the “good nurse” can be seen to have its origins in these practices. Approval and assessment results reflect the measures of success achieved and as such are an incentives to learning. The meanings of reinforcement however can not be taken to be necessarily shared, that is, nurses decide whether or not the behavioural change is meaningful to him or her (Lindberg et al. 1983).
In the context of nurse education, behaviourist concepts seem to be of most relevance to the notion of learning through observation and repeated practice. Students are expected to be able to demonstrate knowledge at the end of the lesson (for example, to be able to take a blood pressure reading). At the most basic level with this approach to learning, emphasis is placed on the demonstration followed by imitation of appropriate behaviour. There is little room for thinking, reflection or problem solving. Behaviourist principles require students to observe and perform. Reinforcement is given if the activity is performed appropriately (positive) or inappropriately (negative) (Marx & Hillix 1973).

Much of nursing education can be seen to have followed an approach to teaching which emphasised that learning occurred in this way. Such an approach contrasts markedly with the more progressive approach employed by Dewey (1938/1971) whereby learning was taken to occur as the result of observation and reflection on experience. In this sense, he is aligned with the following group of psychologists who, in different ways, consider experience to be important for promoting learning.

Cognitive/Constructivist Influences on Approaches to Learning

Cognitive psychologists counter behaviouralist theory by arguing that learning involves mental activity and events. Knowing occurs in the form of insights and is holistically centred. A number of different theories are subsumed under the title of Cognitive Psychology. Some of these which relate to both the cognitive and social-cognitive development have been taken up by nurses in different ways. The link to nurse education can be seen in some cases to have occurred where nurse education was transferred into university institutions. However, constructivist ideas can be recognised in certificate nursing programs from about the 1950s with the introduction of the concepts “nursing process”, and psycho-social factors of patient care. While these concepts were introduced in formal learning, the suggestion is that learning about these theoretical concepts made no difference to the performance of nursing practice in the wards (Creighton & Lopez 1982).
The cognitive approach to learning attempts to go beyond the experience of specific stimuli and responses, to bring the person to understand and develop a conceptual approach to learning. One underlying assumption of cognitive learning is that stimuli in the environment act on the individual in the sense that they cause change to occur at the level of feelings, interests, attitudes, values and perceptions (Chandler 1991). Since the incorporation of the progressive education ideas into nursing education, educational efforts have continued to pursue an approach to learning which will also develop abilities such "as concept development, problem solving, decision making, critical thinking, and clinical judgement" (Reilly & Oermann 1992:148). The shift from relying mainly on practical experience to develop knowledge was intended to have nurses develop skills that would allow them on one hand to validate both nursing and borrowed knowledge, in keeping with other professional groups. Although cognitive psychology was originally taken up in the context of school education, its concepts are still considered valid for nursing education, because they might shed some light on how experience is used.

Nurse educators have adopted aspects of the structural view of the developmental psychologists such as Piaget for curriculum development within Australia. The structuralists' movement in cognitive psychology is a "reaction against the behaviouristic position of the person as a passive receiver of stimuli from the environment (Benner & Wrubel 1989:38). Piaget, for instance, argued that the mind develops through interaction with the environment and that particular factors influence this development. There is a continuity between behaviour and cognition, where thinking develops by internalisation.

To understand is to discover... a student who achieves a certain knowledge through free investigation and spontaneous effort will later be able to retain it: they will have acquired a methodology that can serve them for the rest of their life. The goal of intellectual education is not to know how to retain or repeat ready made truths. It is in learning to master the truth by oneself at the risk of losing a lot of time and of going through all the roundabout ways that are inherent in real activity (Piaget 1973, cited in Blais 1988:3).
Experience is integral to the learning process with Piaget's approach. Gaining knowledge from experience means gaining expertise through practice. However, in this model, in contrast to the role of experience in behaviourism, practical experience enables the development of cognitive processing to either modify information, or change the existing cognitive structure that leads to the achievement of concrete operations. Piaget identified equilibration as the process which regulates thinking. It is a self regulating process by which the individual adapts to their experiences of the environment. This balance is maintained by means of two other processes which he calls assimilation and accommodation (Piaget 1973).

Piaget's theory allows that learners have some responsibility for their own knowledge construction, but also that teacher responsibilities are important in ensuring that the appropriate exercises are designed for practical experience. The aim of problem-based learning, as taken up by nurse education, is to enable students to become self-directed responsible graduates, independent in nursing practice and capable of solving problems through reflective evaluation. Learning is said to be organised around problems which arise in practice, rather than around traditional academic subjects (McMillan & Dwyer 1989).

Piaget's theory has been useful in helping to make a shift from the traditional approach to teaching nursing to a problem-based approach, in which the student is required to adopt a more self-directed learning role. Aspects of the problem-based, self-directed learning approach, however, might be problematic for nursing students whose traditional schooling has been based on what Freire described as the “banking”, concept of learning, where students own schooling has done little to prepare them to be active self-directed learners (Little & Ryan 1988:34).

Another branch of cognitive psychology uses the analogy of the “computer” model of the mind to account for human performance (Benner & Wrubel 1989). It considers that
the brain is the hardware, and the "mind" is the software and human experiences are the neural bits of data (stored in the memory). This view relies on experience to provide the data from which knowledge results. Experience is talked about in relation to mental activities. Nurses borrow knowledge from other disciplines such as the sciences, psychology and medicine which use this theoretical approach, and so traces of this way of thinking actually filter into nurse education. Benner and Wrubel (1989), amongst other researchers, are critical of this approach in that it retains the Cartesian dualism position which sees a split between the mind and body.

Benner and Wrubel (1989) claimed that the computer model of the person cannot account for some of the most important human activities such as emotions, embodied knowledge, and skilled behaviour. The computer model cannot account for shared meanings, the role of the situation in shaping meaning or the way people use context to grasp meaning and hence is limited as an approach for the theoretical development of nurses who require a holistic approach to education (Benner & Wrubel 1989:30).²

Novak and Gowin (1984) proposed a cognitively based view of learning which is a departure from the behaviourist and mechanistic approaches to learning, to incorporate the affective component of learning which other areas of cognitive science have neglected. Such an approach:

should provide learners with the basis for understanding why and how new knowledge is related to what they already know and give them the affective assurance that they have the capability to use new knowledge in new contexts (Novak & Gowin, 1984, p.xi).

² An extreme position adopted by the "computer" model is the "thinking-makes it so" concept of human involvement in any situation (Wrubel and Benner, 1989:39). For example, with health, the person’s way of thinking is seen as the reason for his or her own illness. The judgmental position adopted is that illness is the person's own fault. The danger of this thinking is highlighted by Booth's (1948, cited in Wrubel and Benner, 1989:40) example which explains that before the neurologic cause for Parkinson's disease was discovered, it was considered that the disease was the result of suppressed hostility. Similar examples must be relevant when talking about student learning which is, after all, the purpose of this descriptive exposition of psychological theories.
Novak and Gowin (1984) have suggested that learning occurs on a continuum from rote (memorisation) through to meaningful learning. Meaningful learning is defined as a process of consciously integrating new knowledge with one's previous knowledge in ways that strongly link the two (Novak & Gowin 1984). This approach to learning provides the learner with the capability to construct knowledge from concepts enlarging and extending on them through experience and knowledge growth (White 1985). The particular cognitive ability necessary for students to develop this approach is known as concept mapping, where, the student is able to identify concepts from a lecture or body of literature which are meaningful to the development of their knowledge.

Novak and Gowin's (1984) approach to learning claims students can take responsibility for their own learning development; a theoretical approach to learning representing a major departure from the regimented learning experience that occurred within the Nightingale model. The use of concept mapping is not, however, limited to a problem based approach to learning alone; it is applicable to identifying concepts and restructuring ideas, and is also an approach used to help students learn how to deal with textual or lecture information.

Novak and Gowin's approach is considered appropriate for the learning of theory, and represented a new approach to learning for nurses. The ability to think theoretically was believed to assist in the development of broader personal and professional knowledge. Its development emphasised an ability to use theory to solve problems of care delivery. The adoption of such an approach to formal learning represented a change in student nurse involvement in the formal learning experience (Smith 1992).

The preceding three approaches to cognitive psychology, whilst attributing a different value to experience are, however, primarily concerned with the development of intellectual skills, and to a large extent the learning of "objective" knowledge. One criticism of their focus would be that the theories ignore the social and cultural arena in
which people function, an important consideration for nursing where nurses' ability to communicate with staff and patients is paramount.

The work of Vygotsky (1962) goes some way towards addressing these criticisms by shifting the emphasis to the social context of learning. Vygotsky employed a social-cognitive developmental approach which emphasised that language and social interaction were important in the development of higher mental functions — that is, that capacities of attending, perceiving, thinking and remembering occur in the course of using language in social situations. Vygotsky defined a person's sphere of capabilities as the zone of proximal growth. It is the expansion of this zone that accounts for intellectual development. Social interaction through completing tasks and activities particularly through interaction with others provides for the next development of this zone.

His theory has significance for nursing education because, historically, nurses were immersed in particular social environments where they were instructed in work practices by working with seniors. Vygotsky argued that social processes form the foundation for cognitive processes. For nurses, this meant the practical experience of working on the ward with more experienced nurses provided the opportunity for both skill development and conceptual development. The potential for learning relied on the quality of the interactions and the starting place for the nurse as learner. Where social interactions were limited to experienced nurses on the wards, there was the potential for a closed system, rather than opportunities for reflection through interaction with a wide diversity of sources. Thus replication of knowledge both practical and social was likely to be perpetuated.

The influence of cognitive learning models has been important to nurse education because they can be seen as an attempt to redress the limits of behaviourism and the traditional apprenticeship approach to nursing. Cognitive models of learning reflect an attempt to redefine the learner. They allow students the opportunity to access that
knowledge which is considered to be objective and theoretically important. However, any attempt to split the person into a “cognitive” element and an “emotional” element creates a false dichotomy (Burnard 1992:34). Moreover, most cognitive models tend to ignore the social aspects of learning, and to decontextualise learning.

The recognition by learning theorists and by nurse educators that learners were not socially and culturally homogenous, together with a concern that learners needed to become more active decision makers in the learning process, led to the adoption of an adult learning theory designed to meet these needs.

4.4 Adult Learning: Andragogy

Adult learning theory or andragogy rests on the argument that adults constitute a specific group of learners with their own particular needs, which differ in many ways from the needs of children in a school setting. Andragogy has been influential in nurse education because of its emphasis on the place of experience in learning. Some students involved in tertiary nurse education are already experienced and qualified nurses who are upgrading their qualifications. Other students, the majority, are school leavers engaging in professional education for the first time, which means that their breadth of experience and the degree of dependency on their instructors, can vary from group to group.

Adult learning theory became very popular amongst some nurse educators from the 1970s with the work of Malcolm Knowles (Chambers Clark 1979). Expanding on the earlier work of other psychologists, Eduard Lindeman (1926, cited in Knowles 1984), Carl Rogers (1949, 1969) and Abraham Maslow (1954, 1970), Knowles described adult learning as:

a process in which individuals take the initiative, with or without the help of others in diagnosing their learning needs, formulating learning goals, identifying human material resources for learning, choosing and implementing appropriate learning strategies, and evaluating learning outcomes. This actually takes place not in
isolation, but in association with various kinds of resources, ie. teachers, mentors, peers and other human resources (Knowles 1975:15).

Knowles (1975) differentiated andragogy from pedagogy. The principles underlying the difference relate to changes in self-concept, the role of experience, readiness to learn, and orientation to learning. These principles will be reported in some detail because they have been taken up by nurse educators as useful tools in promoting formal learning for nurse education.

Knowles claimed that as a person grows and matures his or her self-concept moves from one of total dependence (as is the reality for an infant) to one of increasing self-directedness. Andragogy assumes that the point at which an individual achieves a self-concept or self-direction is the point at which one becomes adult. When this occurs, the individual develops a deep psychological need to be perceived by others as being self-directing. Consequently, when an individual finds himself or herself in a situation in which self-direction is not allowed, a tension is experienced between the situation and the individual's self-concept, which makes learning difficult.

According to Knowles, students who enter the workforce or those who begin professional learning have made a significant step towards seeing themselves as essentially self-directing. They have largely resolved their identity-formation issues; they now identify with an adult role. Any experience that puts them in the position of being treated as children is likely to inhibit their learning.

With regard to the role of experience in adult learning, Knowles believed that, as an individual matures, he or she accumulates an expanding reservoir of experience which causes one to become increasingly attuned for learning and at the same time provides the individual with a broadening base around which new learning may be associated. Consequently, the approach of andragogy emphasises teaching techniques which tap the
experience of the learner and involves them in analysing their experience. The use of lectures, audio-visual presentation and assigned reading tends to fade in favour of discussion, laboratory, simulation, field experience, team projects, and other practical action techniques.

Knowles suggested that young children identify themselves in terms of external definers, such as who their parents, brothers and sisters are, where they live and to what church and school they go. As children mature, they can increasingly define themselves in terms of their own experience. For Knowles, children’s experiences are something that happens to them whereas for adults experience is who they are. Therefore, in any situation where an adult's experience is being devalued or ignored, he/she perceives this as a rejection of themselves as well as their experience.

Concerning readiness to learn, Knowles suggested that as individuals mature, their readiness to learn is decreasingly the product of biological development and academic pressure and is increasingly the product of the developmental tasks required for the performance of an evolving social role. In a sense, pedagogy assumes that children are ready to learn those things they ought to, because of their biological and academic development, whereas andragogy assumes that learners are ready to learn those things they need because of the developmental phases they are approaching (in their roles as worker, spouse, parents, organisational members and leaders, leisure time users and the like).

The use of adult education theory as an approach for nurses’ undergraduate education, marks a major shift from the Nightingale model of learning through work experience plus formal lectures, where the two were often not immediately connected. It also represents a significant departure from the master-craftsman apprenticeship model of learning through experience on the wards. However, in keeping with the apprenticeship notion, it recognises a wider range of practical experience as being important. An adult
education approach plus life experience is a foundation for ongoing and higher order learning. In keeping with the shift to formal learning at university, student nurses education includes practices such as lectures, laboratory, simulation exercises, tutorials, seminars and other forms of group work. In this context, students are expected to be self-directed in their own learning. For this reason, the adoption of an adult education approach to learning seemed appropriate as part of the development of a self-directed health professional.

The assumption surrounding adult learning theory is that it promotes an active approach to learning. As a consequence, learning theory carries with it the opportunity for personal learning development. For Knowles, the underlying assumption is that, because learners have past experience with learning, they will be able to employ appropriate and personal strategies to proceed with their learning. This will shift the focus of nurses from working as small parts of an overall function towards learning how to be better informed about health service practices and become better prepared for their more sophisticated and complex role in the twenty-first century.

The systematic learning of nursing procedures in this way represents a departure from the certificate program of nursing where most practical learning occurred in the ward, through working with a more senior nurse, and is an aspect of experiential learning common in university nurse education. Knowles would claim that the modes of delivery offered within a university environment would be considered fitting opportunities to accommodate his active experience-based approach to adult learning.

An extension on Knowles' andragogical position in which experience as important to learning, are those theories which propose an andragogical approach with a more explicit emphasis on reflection on/in action. The reflective educational movement is evident in both general and nursing education and is viewed in part as an attempt to reduce the gap between formal learning and clinical practice. For some of these theorists
knowledge is seen as having a different view of what constitutes knowledge. Schön (1987) claimed that professional education such as that which occurs in universities, privileges "scientific" knowledge which is often of marginal relevance to practice. In order to rectify this imbalance, Schön suggested that reflection in action and reflection on practice, are activities that practitioners need to develop. Current university approaches to studying nursing have included reflective practice as an essential aspect of clinical learning.

For nurses the move to include reflection as a component of intellectual activity represents a departure from the traditional learning through practical experience in certificate nursing programs. The contemporary emphasis on reflection so as to involve a critical component is intended to allow for the identification of knowledge that is historically embedded, action-orientated, shaped by society, shape society and is political, ideological and transformative (Street 1990). However, anecdotally, as a nurse educator in a hospital and within the university system, it is my experience that despite the rhetoric about reflection, nurses do not have the strategies in place to accommodate separate reflection as talked about by the theorists.

4.5 Tensions Between Theory and Practice With the Move Into the Tertiary System

Early debates about the place of theory in nurse education have been discussed in Chapter Three. The debate and tensions have not been lessened by the shift into the tertiary sector. An increase in the formal component of nursing education has been accompanied by debate about the balance between theoretical and practical components of the learning experience. This section will visit some of the arguments underlying either side of this debate as it relates to nurse education.

One influential American critic of the role of experience in the certificate model or hospital model of nursing is Martha Rogers (1970). She claimed that professional
education is not intended to prepare a skilled practitioner (1970:80). Rather the purpose of professional education is to provide the knowledge and skills whereby an individual may become an artist in his/her field. Rogers has been somewhat disparaging of the concept of practical experience as the sole basis for nurse education, arguing that practical experience should not be regarded as a substitute for formal education. In support, she has cited Campbell who states:

No popular saying is more misleading than that we learn from experience; really the capacity for learning from experience is one of the rarest gifts of genius, attained by humble folk only by way of arduous training. When we have established how little worthy of confidence is “practical knowledge” we shall be in a position to see the value of theory (Rogers 1970:121).

Rogers also drew on Polanyi to argue that to simply leave learning to experience is naive and possibly works against productive learning:

Almost every major systematic error which has deluded men for thousands of years relied on practical experience (cited in Rogers 1970:121).

From this point of view, experience needs to be theory driven. Rogers (1970) and others for example Bevis and Watson (1989) have argued that

...professional nursing practice should be creative and imaginative, grounded in abstract knowledge, intellectual judgement, and human compassion. There are no set formulae by which action is determined, neither are there rules of thumb which can be subject to memorisation and unquestioning application. The tools of practice are numerous, but their appropriate selection according to the needs of an individual, a family or a society is dependent upon intellectual skill (Rogers 1970: 121).

In contrast to a traditional position which assumed that nurses learnt how to be nurses through the engagement of their intellect with their practical experience, that is, that work practice encounters served as a primer for the attaining of theoretical knowledge, Rogers’ perception of professional nursing practice implied a more analytical position in
relation to the concept of experience. It is this latter position which influenced the move toward tertiary nurse education as the emphasis shifted towards intellectual formal learning, rather than continuing to rely on the practical experiences given on the wards.

Long before nurse education was transferred to the tertiary sector in Australia, Julia Wong (1979) in a Canadian study, claimed that the disparity between theory and practice in nursing resulted from a learning problem experienced by students who were unable to transfer classroom learning to a clinical situation. The outcome was one in which students experienced inflexibility and frustration with clinical practice, and viewed classroom instruction as "right" and hospital practice as "wrong". She suggested that teachers had the responsibility to ensure that they facilitated students' learning to translate theory into practice. This meant assisting students to make the connections between theory of their formal learning and clinical practice.

Bendall (1976) in an early study of English nurses also talked about theory and practice. She found that the way student nurses were taught, often meant they looked good on paper, but (through no fault of their own) were woefully lacking in many of the skills they needed in the workplace. She urged that unless there was a change in the approach to teaching nurses, a change to what she terms learning for reality, the gap between "theory" and "practice" would draw further apart. Her research suggested that although nurse education's syllabus may be patient-centred, practical nursing is job centred. Nurses were rarely involved in clinical practice that approaches total patient care. Furthermore her study showed a negative relationship between the degree of idealism of the tutors' philosophy, and the students' acceptance of that philosophy (Bendall 1976:5).

Since the move to tertiary nurse education the criticisms of the discontinuities between theory and practice have become more pronounced. For instance:
the outcome of theory may be perceived as vaguely useful, or the unintelligible mutterings of those in ivory towers. On the other hand practice is sometimes viewed as routine and mechanical, while learning theory is considered a higher undertaking (Speedy 1989:12).

Nursing education in New South Wales has been conducted within university institutions since 1985. Formal learning in the university is considered to include more theoretical learning, more classroom learning, more opportunity for the development of intellectual skills, and more structured assessment of students' knowledge, and less practical experience of nursing. However, research findings have suggested different reasons for why the learning of theory within a university is problematic for many students including those in nursing (Eisenberg 1990, Candy 1990, Evans 1990). In particular, Evans (1990) from the findings of her study warned that nurse education as conducted within the tertiary sector runs the risk of being described as encouraging rote or surface learning, rather than encouraging deep learning, which can account for one reason as to why students experience difficult in learning theory.

With the move into the university and the adoption of an approach which emphasises self-responsibility for learning, the difference some argue has been exacerbated. For instance, Perry (1985:31) suggested that students taught from a humanistic, individualistic conceptual model in the classroom, (such as that which occurs with experiential learning, or the adoption of an adult education approach, or even from a heavily theorised formal university program), may find in the clinical environment that they come into conflict with nursing practice which stems from a medical technology conceptual framework.

The problem with this is that tensions are created for the individual. A psychological perspective of education assumes that the individual is an autonomous human being, in rational control of his/her choices and follows developmental patterns of growth. It assumes that every individual will have the same experience in established situations.
Bell (1993:22) has suggested that such a "view of the individual decontextualises behaviour, in a search for generic knowledge". A learning process which fosters self sufficiency and directedness in learning has the potential to create conflict in a health system which has traditionally relied on the interdependency of patients and staff.

For some nurse educators and theorists the move into the tertiary setting has seen a devaluing of the learning developed from practical experience. For instance, Jocelyn Lawler (1991) an Australian nurse academic has offered a different perspective on the nurses' development of knowledge. She has claimed that nurses accumulate knowledge through the experience of dealing interactively and intimately with people, a position which has parallels with Vygotsky's emphasis on social interaction as important to the promotion of learning (1962). Lawler (1991:58) suggested that the knowledge that the nurse develops from carrying out the work of nursing, is "not abstract knowledge but contains elements of being in both a reactive and pro-active position in relation to objective reality". She argued that nursing performance focuses on objective reality, which in some ways is similar to scientific enquiry. However, nursing is not universally regarded as having the same authoritative basis as the sciences. Implicit in Lawler's interpretation of how nurses develop knowledge is that it is work and practice centred, and that learning occurs through the experience of working in close physical contact with people, and through communication to do with their mental health. Her interpretation of nursing work and practice carries a realistic sense of the value and difficulties associated with learning how to perform nurses' work.

Patricia Benner (1984) has argued that nursing theory has not been adequately shaped by nursing practice (Benner & Wrubel 1989), a view which has implications for the way in which experience, or personal knowledge, is considered important for the development of nursing knowledge. Benner's adopted a phenomenological approach in which seeks a fuller understanding through description, reflection and direct awareness (Ray 1990). Benner's "phenomenological view of the person" (Benner & Wrubel
1989) traced the role of personal knowledge in the development of clinical knowledge and says that as a nurse gains “experience”, clinical knowledge (that is the hybrid between naive personal knowledge and unrefined theoretical knowledge) develops (1984:8). According to Benner “experience”, as a development, occurs when preconceived notions and expectations are challenged, refined, or not confirmed by an actual situation (1984). Benner like many of the learning theorists discussed in this chapter argued that interaction with the learner's prior knowledge creates experience, which brings about the refinement or turning around of preconceptions and prior understanding. Clinical actions and decisions are due to a transaction between personal knowledge and the particular clinical situation (Benner 1984) occurring as a result of intuition. At the same time, Benner also argues that this changing of perceptions and the development of expert knowledge requires interaction with other expert clinicians to model how they combine their personal knowledge with the clinical situation (Benner, 1984). Benner is an advocate of an approach to the development of knowledge which includes all phenomena of experience, in particular, practical experience. Her approach places greater emphasis on the practical element of nursing knowledge than on theoretical information. This notion has been criticised in the past and in this thesis for its limited contribution to nursing's intellectual and professional development.

In the certificate system, the behaviouristic approach ensured that reinforcement of learning in the workplace occurred. This meant that student nurses developed a sense of their own competence which was constantly reinforced in the process of being given more opportunity to undertake nursing practice. With the shift to university the challenge was to teach students about nursing by incorporating nursing practices into the university environment. Even though they may perform adequately in the University learning environment, they will most likely be viewed by the hospital nurses as not being “finished”. They may have inadequate practical skills and be too inexperienced to operate, without close supervision, as registered nurses.
There are, however, those theorists who employ a more balanced and measured approach to nursing education. Much earlier, Ashley and Labelle (1976) claimed that for nursing (as for other practice professions) a need existed to relate theory to practice without either restricting the growth of the other. They argued that exploration of the unknown in nursing education requires a high degree of responsibility on the part of the teachers. Access to issues such as health teaching, health management and maintenance, health promotion and education and the prevention of illness is essential. They suggest that "the ability to think productively assumes that one can eliminate patterns of non productive thought" (1976:60) which is a basic motivation for the move into tertiary nurse education. Despite the transfer of nursing education into University institutions, "experience" resulting from practical experience is still emphasised as being important in helping nurses and nursing students make sound clinical judgements. Experience is also important because on graduation nurses pick up a full work load on entering the workforce.

In summary, part of the tension surrounding the theory/practice debate stems in part from different perceptions of what constitutes knowledge, what constitutes experience and what constitutes learning. Arguments for transferring nursing education into the university sector related to nurses inadequate knowledge base; this was taken to mean inadequate objective knowledge. Educators who emphasise reflection on experience adopt a view of knowledge which is closely bound up with what we do, and includes the domains of feelings, perceptions, beliefs, and values (Burnard 1992a:34). Those who adopt a more measured approach than either the theory proponents or the experience proponents, are less rejecting of so called "objective" knowledge, and give more recognition to approaches to learning in keeping with workplace practices.
4.6 Research Related to Current Learning Approaches in Nurse Education

The research findings in this section are intended to provide an understanding of some of the approaches used in nurse education as they relate to the preceding discussion in this chapter. This section focuses on research which addresses changes for student nurses as learners in the light of how adult education and experiential learning have been taken up by nurse education. In particular, different theoretical approaches to nurse education are examined. Some of the directions which adult education have taken in university nursing education are firstly discussed. Secondly, research into the effectiveness of changes in approaches to teaching nursing undergraduates is examined.

Research Findings for Descriptions of Educational Practice

With the emergence of the North American adult education movement of the 1960s and 1970s nursing education, which was already established within the tertiary sector, adopted adult education principles for teaching. Self-directed and student-centred learning is a feature of North American nursing programs. One of the perceived benefits of such an approach relates to teaching nurses as adults so they can in turn use these approaches when assisting patients to assume more responsibility for their health care. This constitutes an increasingly emphasised aspect of the nurses' role (Gessner 1989).

Dear and Bartol (1984) surveyed nursing staff in forty baccalaureate programs on the use and faculty perception of independent study in the United States. The results of the survey showed that the concept of adult education has been incorporated into nursing education in different ways. These include the use of individualised student objectives, student-directed learning, clinically orientated independent study, and self-directed learning activities. These findings showed that ninety-five per cent of the 219 respondents indicated use of independent study in their nursing programs. This represents a marked change from approaches to teaching in certificate programs.
There is also evidence in British literature that adult education and experiential learning approaches to nurse education are being adopted. The aspects of adult education incorporated within undergraduate nursing programs include student centred learning programs, self directed learning and contract learning (Knowles 1975, Burnard 1987, Merchant 1989, Jarvis 1992 and Mander 1992).

In Australia the theory of adult education has not been taken up formally to the degree of the USA and Britain except in institutions where curricula are framed around a problem-solving approach to learning. However, many nurse educators would argue that they take notice of adult learning theory in everyday practice.

A number of nursing academics have been influential in arguing for a shift from the very traditional approach to nurses' education which is seen also to have been influenced by, and suffered from, the negative impact of a high level of formal educational practices which mitigate against curiosity and questioning (Emden 1988). The move to an educational approach which nurtures autonomy and collaboration, as well as redirecting resources to a positive health focus, has been strongly advocated (Emden 1988). This change in focus is considered to be achievable by adopting aspects of Knowles' approach to adult education.

Emden (1988) recommended that nursing knowledge be placed within a broader historical and philosophical context, with learning opportunities to be shared between disciplines. The examination of distinctive aspects of teaching and learning applicable to experiential or problem-based learning was recommended. The study recommended the implementation of innovative pilot education programs specifically designed to complement current trends in health care, primary care and independent practice. It also implied a need for creative and reflective thinking in nursing education.
Other changes to the nature of nurse education programs in Australia were influenced by Lublin (1985). She undertook an evaluative assignment for the Commonwealth Tertiary Education Commission to discuss four reports which the commission had funded. Lublin claimed that these reports attempted to evaluate the differences in performance between hospital and college graduates which indicated no significant difference in performance between the groups. She suggested that often the conclusions of these reports were invalid owing to methodological flaws. She suggested that tertiary education, if based on a regard for intellectual inquiry, and if it encouraged independence and the cultivation of critical analytical skills would be very effective in preparing nurses to deal with the increasing complexity of their roles.

One university curriculum program in New South Wales which has encouraged the use of a self-directed learning approach to nurse education and is underpinned by the theories of Piaget and Novak & Gowin has been extensively discussed in the literature (McMillan & Dwyer 1989, White 1985, Little & Ryan 1988, McMillan & Dwyer 1989, Creedy & Hand 1992). In addition, this approach to tertiary nurse education emphasises the development of a problem-based approach to nursing and the development of reflective practice. As such it represents a departure from the traditional approach to nurse education.

_How Effective are Changes in Teaching Nurses Within the University Institutions?_  

The research findings in this section are concerned with the perceived effectiveness of changes in approaches to nurse education in relation to formal tertiary education. Some of the themes discussed relate to student-centred learning, and the difficulties associated with applying learning theories in practice.

After a search of the research literature failed to produce any findings which demonstrated unequivocally that andragogy principles were being translated into practice, Burnard (1990) suggested that perhaps nurse educators simply liked to write
and talk about self-directed learning. Sweeney (1990) also suggested that some educators have difficulty in adapting to learner-centred education because of their own educational experience which has left them unprepared for a more facilitative role. How one “thinks nursing” and “thinks teaching” is, therefore, likely to be influenced by individual socialisation. Therefore educators who have been educated within formal hospital-based environments may be less likely to select new approaches to teaching, and may not be likely to be disposed towards innovative ideas.

Thompson (1992) for instance conducted an investigation into the ability of new graduates and preceptors to identify how the principles of adult learning were applied to helping the new graduate settle in and adjust to clinical practice. Amongst other things, she found that a fragmentation of learning principles existed in the workplace. Reasons for these findings relate to the lack of relevant education given to preceptors prior to their assuming the role, and in part, to the fact that most hospital nurses have been trained and socialised in a hospital-based nursing program, with an underlying behaviouristic approach to learning and development. Most of the preceptors in the study found it difficult to incorporate the principles of adult education into their clinical teaching. The consideration of nurses as learners with self interests, needs and responsibilities within the workplace environment, does represent a shift from how nurses have traditionally been regarded.

Hart and Rotem (1994) identified a difference between student and teacher perceptions in regard to the value of reflective practice used in clinical debriefing sessions. The introduction of the systematic teaching of reflective practice in tertiary nursing programs represents an additional educational shift for nurses from the hospital based programs. Theoretically, clinical practicum debriefing sessions offer an important opportunity for students to discuss their clinical experiences with peers and critically evaluate their own performance. Hart and Rotem (1994) found, however, that debriefing sessions were not considered by tertiary students to be of much value as learning experiences. There
may be a range of explanations to account for their findings, but the lack of value attributed to critical reflection in the hospital environment may well have made some contribution towards these findings. Within the hospital environment nurses are busy “doing” and as such do not have time for organised systematic reflection. As previously pointed out by Sweeney (1990), the application of theory to teaching can be problematic when the teacher’s socialisation has been influenced from within a hospital based program. Whilst some nurse educators do a lot of talking about reflective practice, others say nothing or remain confused about what it all means.

Students have limited clinical practice, and may not see evidence of reflective practice being part of the way existing registered nurses conduct their work. What the researchers Hart and Rotem (1994) did find was that the culture of the workplace rated highly when determining the success of a learning experience. Many tertiary students felt that they benefited from the opportunity of working side by side with a sympathetic skilled practitioner. These findings could be supported by Bendall’s claim (1976) that the more idealistic the philosophy of teachers, the less likely it is that students connect with the ideals, and where the philosophy of teachers more closely reflects the perceived reality the more students connect with the ideas. On the other hand, the findings could also be supported by Benner’s (1984) claim that learning within the workplace environment allows an opportunity for learning to occur through interaction and using Polanyi’s notion of connoisseurship. Hart and Rotem’s findings are supported both anecdotally and by my own experiences in conducting debriefing sessions, and in reading students reflective journals.

In another study Sweeney found that despite the intention of educators, students may see a situation rather differently. Using a conceptual framework designed by a group of adult educators known as the Nottingham Andragogy Group, Sweeney investigated the degree of perceived learner-centredness in two first level courses in general nursing and two in psychiatric nursing (Sweeney 1990:1208). Results indicated that the so-called
learner-centred first level nursing courses were perceived by the students to be highly teacher-centred in terms of planning, direction, sequence, pace and evaluation of learning. In these same courses the learning climate was perceived to be moderately learner-centred though teacher student relationships were perceived as formal. Students perceived the variety of learning approaches to be limited, with a tendency towards positivism rather than a relativism of knowledge, that is, students knowing of "scientific knowledge" and "facts" as opposed to the making of connections between concepts or knowledge was important.

Sweeney found that dialogue between teacher and student provided a beneficial learning experience and contributed towards students progress with learning to nurse. Students and teachers of nursing expressed a slight preference for teacher-centred courses despite student dissatisfaction with their lack of participation in determining learning objectives. In the psychiatric courses a significantly greater learner-centredness was perceived. This was attributed to psychiatric teachers' philosophy of learning being different from that of general nurse teachers, rather than to the psychiatric course per se.

Other studies have shown that students have demonstrated more satisfaction with a student-centred rather than teacher-centred approaches to learning. For example, Mackie (1973) conducted an early British research project which also investigated learner centred programs. The study compared a traditional course with a learner-centred program in relation to the level of satisfaction arising from active student participation in the educational process. Nursing students were taught either by traditional lecture or a student-centred teaching model, in which the students were asked to define their own learning goals that were congruent with the course. They participated with peers in selecting content and teaching methods; assisted in directing discussions; selected, with teacher input, their own resources for learning and evaluated their own learning in co-operation with the teacher. Findings showed a significant relationship between the teaching model and degree of satisfaction with the educational experience. Subjects who
participated in student-centred model reported a higher degree of satisfaction than did the group using traditional lecture methods. The idea of taking student satisfaction into account represents a huge shift in the approach to nursing education, a shift towards seeing nursing students as having needs, interests and rights as well as responsibilities.

Student satisfaction, or more specifically in this case independent study contracts were investigated by Richardson (1988:315). His findings supported the use of independent study contracts in fostering the acquisition of self-directed and self-initiated learning skills. The short term successful results, as perceived by both teacher and student, depended on the quality of the relationship and dialogue between them. Richardson argued that more permanent gains might be achieved as students continue to develop their basic competencies within an educational climate that values, supports nurtures and facilitates professional development.

The research findings discussed in this section so far suggest that some of the problems of the effective translation of adult learning theory into practice lie with inexperience and perhaps resistance by some of those involved in nurse education. The need to balance a more student centred approach to learning with an adequate practical component has also been highlighted. Moreover, student satisfaction is more likely to occur when there is congruence between the ideals of the teacher and student.

However, Herdman (1992) offers a more serious indictment of the move to tertiary education when she reported on what it means to be a nurse and on changes in the workplace conditions of nursing. During the period 1970-1990 Herdman undertook an empirical analysis of the transformation of nursing work in a New South Wales hospital. Her focus was not so much on learning but on the restructuring of the workplace and redefinition of what it means to be a nurse. In contrast to claims of tertiary nurse education that a university education would produce a more autonomous reflective and empowered nurse, she argued that the experience for registered nurses
working in the hospital environment is that tertiary qualified nurses promote the
deskilling of nurses by destabilising the hierarchy.

Herdman has shown that registered nurses are forced to carry out the duties previously
allotted to student nurses, who now remain in tertiary institutions until graduation, when
they themselves become registered nurses. This causes one level of nurses to drop from
the hospital hierarchy. Registered nurses have become engaged in work that is also
carried out by workers without formal qualifications. Work previously carried out by
registered nurses has been taken over by other health workers such as occupational
therapists, dietitians and specialist nurses. She is concerned that a separation between
the conception and execution of nursing work now exists. Also, in contradiction to
original expectations, many registered nurses are still experiencing a lack of autonomy
and decision-making ability.

She concludes that there has been a departure from the practical enskilling of registered
nurses in New South Wales, and suggests that dominant groups which include nurse
academics and researchers, nurse educators and nursing administrators have obscured
the reality of practical nursing as it is experienced by the majority of nurses. This is a
provocative finding but, what Herdman does that other researchers fail to do, is to go
beyond exploring the effectiveness of particular approaches to questioning what it means
to be a nurse in the current climate.

4.7 Conclusion

This chapter has provided an overview of how a shift in the concept of “experience” has
occurred in nurse education from the certificate program where the emphasis in learning
focused on everyday learning and practical experience, to university nurse education's
emphasis on a conceptual learning experience.
The original perceptions of the suitability of Knowles' theory to nurse education has been challenged. One difficulty in accommodating Knowles' theory is that university nurse education remains prescriptive with a heavier emphasis on conceptual knowing with less opportunity for practical experience. The underlying philosophy of Knowles' approach to adult education positions the learner as an autonomous learner, a position which is a different psychological position from the traditionally formal approach to learning. At the same time the approach encouraged by Knowles' theory seems to parallel the approach to learning where learning occurred through the senses. It accommodates subjectivity in learning and is concerned with negotiation of goals. Formal university undergraduate nursing does not operate in this way. The research discussion in the chapter should not be interpreted as a claim that either the theory side of the debate or the practice side of the debate is right or wrong. Part of the dilemma relates to a shift from an approach to learning which was previously based on experience (in which conceptualisation often arose from practical experience) and an approach to learning in which a conceptualisation occurs prior to practical experience, when in reality, the concepts do not fit neatly with the practice.
CHAPTER FIVE

ANALYSIS AND FINDINGS

5.1 Introduction

This chapter focuses on the analysis of data arising from interviews conducted with registered nurses. It describes the method of analysis and discusses emerging themes. In the earlier chapters connections between “experience” and learning how to nurse and learning to be a nurse were drawn from historical and other literature and a review of learning theories. In this chapter, findings are presented from interviews which were held with nurses to explore how these connections were made and expressed from a nursing perspective.

Eighteen registered nurses were interviewed, twelve had certificate level nursing qualifications, and six had tertiary nursing qualifications. The similarities and differences of the perceptions of nurses with and without tertiary qualifications will be presented in detail. The issues arising from the interviews will be discussed in the concluding chapter.

Aspects of Knowles' adult education theory were used to code the interviews. His categories of “experience”, a central feature of his theory, were used as an aid both to framing the questions (see Table 2.1 in Chapter Two) and in interpreting the participants’ responses in terms of the nature and purposes of learning.

The categories of experience accommodated within Knowles' learning theory can be summarised as:

- Past learning;
- Collegial support;
- Experience of nursing;
- Professionalism; and
- Present learning (Knowles 1975).
It became evident early in the analysis (when linkages and discontinuities between concepts were being mapped and categorised), that the initial categories were problematic or inadequate. Problems in applying Knowles' theory relate primarily to a basic premise: that adults are responsible for their own self-directed learning (see Chapter Four). The interviews indicated that the experience of most of respondents did not always reflect this premise. Although the interview responses did not always agree with Knowles' theory, this was, in itself, not a good reason for rejecting his assumptions. It was apparent that, as an emerging theme, self-directed learning was not a major concern for respondents. Nevertheless, some of the tertiary respondents favoured taking responsibility for their own learning.

A form of modified discourse analysis, in conjunction with the concept mapping technique, was chosen to enable a more critical analysis of the data (see Chapter Two). While some interesting differences in experience were established, it became clearer that the concept of “experience” is more complex and problematic than Knowles' notion of the term conveys.

Three main themes, which are applicable to both groups, emerged from the interviews. They were: nurses’ sense of knowing, nurses' duties, and nurses' sense of self. Each of these themes is discussed in detail in ensuing sections of the chapter.

5.2 The Interviewees

Nurses were grouped according to whether or not they had tertiary qualifications, on the assumption that their sense of learning to nurse, of being a nurse, and of self, would vary according to the type of nurse education experienced.

- The first group (certificate nurses) comprised of twelve women whose held certificate level nursing qualifications.
- The second group (tertiary nurses) consisted of six respondents with tertiary nursing qualifications; four of whom hold certificate and tertiary qualifications and two respondents hold tertiary qualifications only.
The interviewee with the longest work record began nursing in 1957, and the shortest employment time was five months, the respondent having recently completed the Diploma of Applied Science (Nursing). All but two of the interviewees held certificate level qualification as their basic nursing qualification. The range of educational qualifications mainly covered and included general, midwifery, and psychiatric nursing. Ten respondents held two certificates, two held three certificates, and four held tertiary nursing qualifications at the time of the interviews. Since the interviews were conducted, five respondents have upgraded their certificates by undertaking tertiary nursing studies, and four of those holding tertiary qualifications have continued with tertiary studies to degree level, while two have undertaken postgraduate studies. Table 5.1 provides details of the respondents according to their years of experience and qualifications. Names have been changed to ensure anonymity.

Table 5.1 Years of Experience and Qualifications of Interview Respondents

<table>
<thead>
<tr>
<th>NAME</th>
<th>YRS EXP</th>
<th>QUALIFICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karen</td>
<td>0.42</td>
<td>Diploma of Applied Science (Nursing)</td>
</tr>
<tr>
<td>David</td>
<td>5</td>
<td>Dip Applied Science (Nursing) + degree Conversion</td>
</tr>
<tr>
<td>Kirsty</td>
<td>7</td>
<td>General Nursing Certificate + Assoc Dip Community Health</td>
</tr>
<tr>
<td>Elaine</td>
<td>8</td>
<td>General Nursing Certificate</td>
</tr>
<tr>
<td>Janice</td>
<td>10</td>
<td>General Nursing Certificate</td>
</tr>
<tr>
<td>Irena</td>
<td>11</td>
<td>General Nursing Certificate</td>
</tr>
<tr>
<td>Nancy</td>
<td>12</td>
<td>General Nursing /Midwifery/ Theatre Certificates + Dip Applied Science (Nursing)</td>
</tr>
<tr>
<td>Tania</td>
<td>13</td>
<td>General Nursing/Psychiatric/Midwifery Certificates</td>
</tr>
<tr>
<td>Denise</td>
<td>13</td>
<td>General Nursing /Midwifery Certificates</td>
</tr>
<tr>
<td>Barbara</td>
<td>15</td>
<td>General Nursing/Accident and Emergency Certificate</td>
</tr>
<tr>
<td>Lorraine</td>
<td>15</td>
<td>General Nursing/Midwifery Certificates + BA</td>
</tr>
<tr>
<td>Leanne</td>
<td>20</td>
<td>General Nursing Certificate</td>
</tr>
<tr>
<td>Sandra</td>
<td>20</td>
<td>General Nursing/Psychiatric Certificates + Dip Applied Science (Nursing)</td>
</tr>
<tr>
<td>Iris</td>
<td>25</td>
<td>General Nursing/Midwifery(Part 1) Certificate</td>
</tr>
<tr>
<td>Mary</td>
<td>25</td>
<td>General Nursing/Fever Certificate</td>
</tr>
<tr>
<td>Kathy</td>
<td>25</td>
<td>General Nursing/Midwifery/Mothercraft Certificates</td>
</tr>
<tr>
<td>Marianne</td>
<td>31</td>
<td>General Nursing Certificate</td>
</tr>
<tr>
<td>Monica</td>
<td>32</td>
<td>General Nursing/Midwifery/Continence Promotion Certificates</td>
</tr>
</tbody>
</table>
5.2.1 The Certificate Nurses

The certificate group of respondents held between one and three nursing qualifications, and their work experience as nurses ranged from ten to thirty-five years. Their basic general, qualification involved three or four years of hospital-based training. Further training was required for specialisation. Most periods of training were hospital-based and used the same approach to teaching as general nursing programs. The courses were of varying duration, from six weeks to one year. The short courses were more likely to be conducted outside the hospital. However, most of the post-basic certificates undertaken by these respondents were of twelve months' duration.

Formal tuition was limited to a restricted program which rarely coincided with clinical experience. Learning to nurse emphasised one's place within the system. Nurses were expected to be able to carry out set tasks efficiently without questioning established practices. For these nurses “knowing” is mostly directed towards a pragmatic outcome, and is often identified with “knowing what” and “knowing how”. These were the features of their education which these women most valued. Regimes of obedience and social control were embedded firmly in the discourse of learning how to be a nurse.

5.2.2 The Nurses with Tertiary Qualifications

This group comprised one man and five women. All held tertiary qualifications but four of the group also had certificate nursing qualifications. They held between one and three certificates which were upgraded through tertiary study and had additional qualifications (Bachelor of Arts, Diploma of Applied Science Nursing and an Associate Diploma of Community Health). Three women undertook their tertiary qualifications while working full time as registered nurses, and one completed a year of full time study for her associate diploma qualification. The other two nurses had, as their first qualification, the Diploma in Applied Science Nursing; with one respondent having undertaken further tertiary level nursing studies.
There were some interesting commonalities about learning to nurse in both the tertiary and certificate groups. This is not surprising given the shared experiences of early learning in the wards and hospital classrooms. For instance, themes common to both groups were the values attributed to practical experience and the locality of the ward environment as a place for learning and nursing. However, it was expected that nurses with tertiary qualifications would express slightly different perceptions because of their additional study. This indeed was the case, although it is acknowledged that some of the nurses chose to take on tertiary study and this, in itself, makes them a self-selecting group. The greater value they placed on formal learning may be as much a reason for their having done tertiary study as it was an outcome of it. The following analysis of the interviews has been organised primarily around where nurses were educated. This allows those with both certificate and tertiary qualifications to throw light on their varying experiences.

5.3 Nurses’ Sense of Knowing: Learning to Nurse

This section will describe the influence of three different aspects of gaining knowledge in the process of learning to nurse—formal learning, practical learning and experiential learning.

5.3.1 Formal Learning

For the purposes of this study formal learning is the gaining of knowledge that takes place according to syllabus guidelines. Formal learning for the certificate program involved lectures, laboratory sessions and examinations, and as such is about learning that occurs primarily in the classroom. The formal component for university students varied between institutions. It included a wider range of teaching and learning strategies that include, lecture, tutorial and seminar presentation by students, simulation and laboratory exercises, written assignments and examinations, and a varying number of hours of clinically based experience over three years.
Formal Learning for Certificate Nurses

Certificate nurses gained their qualifications from the hospital-based model of training and they considered their formal learning often came into conflict with their own experience as learners. The respondents often felt that the information given in formal learning was difficult to understand, inadequate or irrelevant. They all mentioned discrepancies between formal classroom and ward learning to the extent of appearing dismissive of formal learning.

One certificate respondent described an apparent lack of connection between nursing theory and practice. While she enjoyed learning theory, she felt that the classroom was a limiting environment for learning nursing procedures. She valued the experience of learning to nurse in the ward because she was taught by other nurses who were familiar with the wider context. She felt nurse educators operated from a less valid knowledge base.

We were given our theoretical information in blocks in the college, which would be about six to eight weeks, which was great, especially anatomy and physiology. That was great because you were learning: It was easy knowing how to inject into an orange, but it was totally different doing it in the wards, so that was the difference. People you were working with in the wards were nurses who had been trained in the hospitals; they weren't the nurse educators who were not working in the wards. A lot of things they were teaching in the college were old fashioned. They were different because they hadn't caught up with what was going on in the wards.

Differences between nurse educators who taught in the nursing schools and ward teachers (who were not nurse educators) have been a source of tension since the time of Nightingale. This is not surprising, because nurses were required to work long hours and the trainees' educational needs always came second to the requirements of the hospital (Russell 1990).

The same respondent touched on an issue which continues to exist in formal learning today. She distinguished between learning in college or "block", where the information
was often not remembered because of the delay in applying it to practice, and learning in the ward, where memory is reinforced through constantly having to carry out the procedure. She felt that the experience gained from carrying out a procedure was a more important way of learning than trying to remember "all" that was told in the lecture:

If you are being taught something in college that was six weeks ago, you are not going to remember it the same as it's happening there and then—with a dead body in the ward—and the next time you go to a body you think: "that's how you felt then, you know..." You don't remember all they talked about in college.

Even though certificate trained nurses spent less time in a classroom situation than university educated nurses, the former were still confronted with a certain amount of theory. Most of the certificate respondents described a feeling of dissatisfaction with processing lecture or seminar information (which was not usually presented in an easily understood format) in relation to knowledge gained from ward experience.

Formal teaching as provided by doctors who lectured students was perceived to be more complex and difficult to understand than explanations provided by nurse educators. Janice felt that information delivered by doctors was at a more complex level than was necessary, as compared to the simplicity and clarity of information given by most nurse educators. She also described how self-initiated learning from textbooks occurred if interest in a topic developed, either in connection with lecturers or from wanting to understand real life:

Our lecturers were doctors, and I used to find that they would go way over my head. They were very geared towards doctors, and we used to leave those lecture rooms and look into books and do our own ground work. So I didn't really learn anything from the block. I mean I did learn when they were the nurse tutors, but not when they were doctor based lectures. A lot of them were at that stage. On the ward—if there were interesting cases—I used to look them up: like in intensive care you saw so much there that you would relate to a lot of what you were doing.
Comments that teaching by doctors is too complex might reflect the respondents' lack of theoretical background, on the other hand it may be a realistic reflection of doctors being out of touch with what students need to be informed about in lectures. Instruction given by nurse educators was also sometimes considered to contain too much information for practical implementation. This contrasts with the on-the-job instruction given by ward nurses who were perceived to have both practical information and knowledge of the social context to guide instruction.

Not only was there a disjunction between formal classroom learning and ward practice, but also between "basic" and "technical" nursing. Respondents became aware of the responsibility expected of them by ward staff and hospital administrators when, as trainees, they were often forced to work in situations where they had inadequate knowledge. For example Leanne described how:

We were frightened a bit because one of the girls in my class and I were in a medical ward when somebody had a heart attack and we were only in our second block and we were quite frightened because we didn't know what to do. There was only one senior nurse on the whole floor and us two feeding. She was putting out the meals which was her job in those days. We kicked up and said this is not fair, we shouldn't be in these wards and carrying all this responsibility and not really knowing what we were doing.

Tania felt that the system often did not prepare her adequately for some procedures:

There were a lot of times doing different procedures when I really felt uncomfortable.—like say, doing a liver biopsy. That was really a big thing, to have a liver biopsy on the ward. It was such a big thing and I've got to set up for it. It was sort of like a big drama, but maybe we didn't have enough academic knowledge behind us. It seemed like a big procedure...

Nancy, who held both certificate and tertiary qualifications, remembered her experiences within the certificate program in which disparities occurred between the content of lectures and the nurses' rostered work areas:
... being able to acquire that information with practice helps, but it was a little bit of a nuisance if I'd learnt about maternity in first year and I actually worked on the Obstetric Ward in second year.

Giving nurses lecture information which did not coincide with the work required of them was a source of tension, frustration, and lack of adequate closure, due to hazy memories of a set of instructions delivered many months earlier. Nurses were required to have a large amount of practical knowledge, even though this was often an unreasonable expectation. The respondents' impressions was that much of their work involved procedural activity. Performing their nursing practice competently was important to them and they felt they required theory that explained nursing practice. Instruction to guide nursing practice (as discussed in these interviews) emanated from the traditional medical and biological sciences theories and was taught to students as “truths”, often by doctors whose interest and purpose were closely tied to their self-directed professional interests which differed from nurses' intentions and professional purpose.

*Learning Skills of Observation: Using the Senses*

Some of the certificate nurses felt that the engaging of a number of the senses, such as touch, smell, sight and sound, was an important aspect of processing information and compensated for their lack of “theory” or formal learning. The respondents explained how they integrated their formal learning on return to the ward environment. Elaine felt that senses-driven “direct” learning in the workplace was sometimes valued over formal learning because:

... you didn't really learn something, or it didn't really sink in or become significant until you saw it in real life. Although you still needed all the other stuff, (information presented in lectures) and you could base it on that.

And for Barbara the use of the senses in learning were valued because:

I would say, for me, I'm a tangible sort of person, and [I need] to be able to touch and see and absorb more concepts than I would get in a class-room.
Whilst Iris considered that she was:

... the sort of person that if I am able to go through a situation I remember it: it stays with me, and I have no trouble remembering it—but if I just learn the theory, I find it difficult to put the theory into practice—unless I have been through it.

The respondents felt more confident about remembering and being able to apply "theory" when they had been engaged in a real life situation. Theory was important, but taking on board a set of instructions, or a list of concepts was not enough to achieve a competent level of practical performance. These respondents seemed to prefer a learning process in which competency is acquired as a consequence of direct exposure to the rigours of practical nursing in a hospital environment. The nature of the certificate system meant that after lectures in the practical situation nursing students sought counsel with the ward staff to develop a balance between nursing concepts and instructions given in formal learning—practical experience which allowed for reasoning and the provision of a service. There was, however, no room for them to recreate their own ideas.

Traditionally, nurses have been taught in both their formal and ward learning that "observation makes a nurse" (Lawler 1991:65). The development of observational skills which occurs through the use of the senses cannot be learnt totally through formal teaching, but is learnt through practical experience. An aspect of observation which forms the basis of nursing practice and is taught in the classroom is in the performance of tasks such as the measurement of temperature, pulse and respiration. Within the tertiary sector these tasks are compositely known as assessment. None the less the abilities required for making different types of observation continue to exist.

Some of the certificate qualified nurses support Lawler's assertion that the use of the senses are crucial to performing nursing care, and it is acknowledged that all nurses must develop these skills. Leanne spoke about two types of observational ability: the
first were the obvious practical things that nurses are taught in formal learning, and the
second was observation of the client, where she was relying on her senses and
experience to make an assessment of the patient's condition. Some might be tempted to
consider that this insight comes from intuition. Leanne took this up in relation to her
nursing work:

I think that nurses generally have them, skills of observation, I
mean... There are other little extra things that you need to know,
like how sneaky some of the clients can be, and the tricks they get
up to. All nurses have very good observation skills. I don't think
I have ever met a nurse who doesn't have very good observation
skills. Some may be better than others, and when ever there is a
slight change in even one client here they will pick it up. Even
our secretary picks it up, she is so used to it now, having been
living with nurses for two years. I think those skills just become
more acute with experience.

The duty of care presented here is embedded in a theory of the need to observe. As a
principle of practice, observation remains fundamental to contemporary nursing.
Observation is an aspect of the overall assessment, and is an important adjunct to
providing nursing practice. In addition, this observational ability can be learned by lay­
staff who are repeatedly exposed to these situations. If the secretary can pick it up,
clearly observation is something that develops over time through exposure to the ward
environment. Sunberg (1989) has claimed that nursing observation occurs through the
use of all five senses in gathering data about a patient's health status.

Lawler (1991:65) has suggested that nursing, like medicine, became concerned with
surveillance in the sense of making observations of patients for changes in body
functions and behaviour. She argued that the history of modern nursing is as much
founded on observation of the patient as anything else and cites Florence Nightingale's
text, Notes on Nursing (1850s), which laid down the basic tenets of nursing and
devoted more space to observation than any other subject.
Observational ability also incorporates the use of techniques of examination and measurement of features like temperature, pulse and respiration, known as “doing the obs” and is taught in the classroom. Traditionally these procedural skills and others form the basis of routine tasks performed by nurses. In conjunction with the tool used to perform the procedure, these skills also include the use of the senses. Observation techniques necessary for assessment were learned as opposed to occurring intuitively (see Chapter Three). Mostly certificate students were introduced to them in formal learning and mastered them in the ward. The certificate respondents felt that practical experience provided an opportunity to develop practical observational abilities and aided in refining performance, competence and learning.

Certificate respondents perceived theory delivered in lectures should be applicable to nursing practice but lecture theory seldom matched ward practice. Perry and Jolley (1987) saw such a description as a layman’s interpretation of theory, and as inappropriate for nursing education. They would see these perspectives as being an underdevelopment of the profession. The respondents did not regard the abstract conceptualisation of theory-building as important, nor as contributing to problem-solving even though theory is supposed to have a practical value to be applied while carrying out nursing procedures. Regardless of how nursing theorists view theory, respondents perceived a separation between theory and practice.

The traditional relationship between formal nursing education and ward learning was considered by the certificate respondents to be prone to dissonance and conflicting expectations in an environment in which informed and systematic reflection was unlikely to occur. These respondents’ experiences reflect a sometimes incongruous relationship between formal learning and ward practice. While formal learning may be systematically designed and hierarchically driven or integrated, the practice in the ward was and is subject to considerable uncertainty and chaos.
Formal Learning for Tertiary Nurses

The tertiary nurses held university qualifications and seemed to have a stronger sense of knowing as a consequence of their formal learning. They described enjoying formal education and, while theory and practice continued to be seen as separate entities, they found theory helpful in performing nursing practice, provided they had the opportunity to apply it to their work in the immediate future. When this did not occur, theory became problematic. Most of these respondents valued continuing formal education as a means of improving their professional status and individual development more strongly than did the certificate nurses. The tertiary nurses found that the method of instruction (including the teaching of the medical model and disease process) also helped to teach them their place within the system.

Four women with tertiary qualifications, held certificate qualifications as their initial nursing experience, and when they spoke about their past learning it was often from experiences in the certificate programs. Sandra spoke about her tertiary experience as if, for her, it was a logical extension to her professional development. However, it is significant that in comparison with most other respondents' reflections on past learning experiences, that she identified that her first nursing program in psychiatric nursing instilled in her a pleasure in learning, which was nurtured, developed and encouraged by nurse educators. Discrepancies between formal learning and practical experience were not so evident here as with her subsequent certificate course:

We were spoilt at (the Psychiatric Hospital) I trained at. We had everything handed to us on a silver platter in regard to education. We were educated by nurses. We had very few lecturers who were not nurses. I can remember getting some psychiatric type illness lectures from psychiatrists but predominantly the lectures were by nurses. The programs seemed to be set by nurses, provided by nurses and everything was clearly spelt out in regard to what was expected of us as students. When we went to do our final exams we were very well prepared—if we were prepared to do our part: certainly the course itself was well organised—we just had to participate in it.
This is not an uncommon experience as the philosophy for teaching and learning in psychiatric nursing programs is intrinsically different from general nursing courses (Sweeney 1990, see Chapter Four).

Sandra described a different experience when she went through her general nursing course, which was a modified version of the general nursing program. Although Sandra felt that a disjointed learning and nursing experience occurred in this phase, she did not see herself as a victim but recognised the need for some self-directed learning to assist her progress:

I found that for General [nursing] it was very different. That was probably because I was a conversion student and the first conversion student they had at that hospital, so they floundered—they didn't know what I should have. It seemed to take them ages before they got any information from the Nurses Registration Board or wherever. I was put in with one group of nurses and did a few lectures here and there. I did another block somewhere else and everything seemed to be very fragmented compared with my psych training. I had to do a lot self-learning. I had to get a couple of good books for the theoretical part of the course. I felt that a lot of it was up to me, to be truthful.

Kirsty claimed that her personal background and life experiences were valuable motivators in her taking responsibility for her own learning in a certificate program organised within a regional school experiment, where the formal learning was conducted in classrooms rented from the university, instead of the hospital classrooms.

I was sixteen when I left school and I was twenty-one when I started nursing. I think that was a big advantage to me being twenty-one, in the learning aspect, because I was a bit older, and it was something that again, I wanted to do. It was my decision.

For Kirsty an important feature of the formal learning experience related to the environment in which her learning occurred, rather than to any particular learning experiences she identified:

... being in the university atmosphere—I think that helped promote it. I don't know what it was like learning in the hospitals, but I felt that being in the university, promoted it—it is a learning institute, and so you are there to learn and to study.
Like the certificate nurses, those nurses with tertiary qualifications also viewed theory and practice as different entities. Libby, who held both certificate and tertiary qualifications, spoke of a shift in emphasis regarding theory and its value for ward practice. Unlike the view of some of the certificate nurses, her view was that theory can be a useful problem-solving tool.

... then again the academic learning and lecture situation—and being at ward level, are two different types of situations with different types of information and I see them as being different, one would help the other. Information given in a lecture situation would help you deal with the information that you are getting at ward level and help you solve it.

Nancy spoke of a shift to research as a base for understanding, in comparison to traditional practical experience:

Theoretically... no... well, we went right into it almost down to cell level... and I don't think their theory training is quite at the level that mine would have been for two reasons: it's more recent, and secondly, I had a lot more hours of a lot of theory of education than they would have had when they did it, so mine has to be a little bit higher than those. What they've learnt in the interim has been through practical experience, but a lot of it is not based on the actual theory that has been brought about through research.

On the other hand, Karen's tertiary experience was that some components of what might be seen as formal, or perhaps more accurately “factual” learning, were learnt more easily in the ward than in the classroom. For example, aspects of pharmacological information were very satisfactorily learnt in the ward:

... last year I put everything into perspective and then this year I put more of it into perspective... plus you don't get enough lectures on certain projects at uni... and you learn about it here [in the hospital]... especially pharmacological stuff.

In contrast to earlier comments on formal learning, the male respondent in the tertiary group suggested that the analytic aspect of university learning was what he valued most. David felt that the formal learning environment exposed him to the experiences of other
nurses, academic lecturers, and to a meta-discourse which valued university education. He told how the value system surrounding university nurse education was important and empowering:

I have always been encouraged to not think of it as training, to think of it as being educated rather than trained... I think that it’s given me probably a better perspective... with the new system, being educated in the university environment, you were exposed to a lot more different faculties and subjects and points of view, so it helped me to understand the world in which I was to work a lot better.

David's university experience was about learning how to think about health issues. This is in contrast to the hospital training experience where the nurse is taught what to do and how to do it without question; ward learning experiences are factual and relate specifically to the topic at hand.

Unlike most of the respondents from the certificate group, who expressed difficulty in specialist factual knowledge from lectures, David valued formal learning because it was analytical and complex, a shift from the transfer of knowledge to a more critical reflective approach to formal learning:

... a lecturer who taught physiology, and physiology, by itself, wasn’t the essence of it. It was the way he taught and he made us think about what we were learning and analyse the reasons behind why things worked and not just to accept the superficial reasons.

The lecturer required the student to “not just accept the superficial reasons”, and by implication, to question and look for deeper or hidden issues when learning. Studying in a system where students now have the opportunity to interact with other disciplines creates, from David's point of view, a more open learning system. Students can develop perspectives on nursing using the knowledge gained from other disciplines which lead towards critical, reflective thinking.
the course gave me the ability to problem-solve. I think it is probably the best thing it gave me; the ability to have this body of knowledge. It wasn't specific but you could adapt it to use in solving various problems. I think that's the most important thing; so it gives you a bit more confidence to be able to go into the unknown and function (David).

Some certificate nurses expressed reservations about fitting into the workplace environment and this was also very much the case for those who learned within the university environment. David experienced difficulties with fitting in and learning how to survive on entering the university system. He described the difficulty inherent in learning to identify the educational discourse in order to ensure his survival as a student:

... not knowing what was expected of you in particular, so you were given assignments and you didn't know what sort of standard that had to be met to pass; so that was a learning experience in itself. Probably the main thing was that the hidden curriculum of knowing the sorts of ways to present your work that would get you through...

The discussion of problem-solving is evidence of a shift from the emphasis on practical experience and Freire's notion of a "banking" approach to learning, to emphasis on problem-solving and experiential learning. Phrases from the interviews such as "the ability to problem-solve" reflect the language used by some of the learning theory psychologists such as Dewey, Freire, Piaget and Knowles, as discussed in Chapter Four. This might indicate that learning and functioning is becoming more theory driven and open to inquiry, as opposed to being driven only by practical experience. The phrase "to have this body of knowledge" is more in keeping with the certificate sense that knowledge is learnt and used. This point is more strongly made by Karen, who believed that her initial education at Diploma level provided her with a finite knowledge base. She left her tertiary training feeling that she knew that all there was to know. Karen commented that:

... the diploma should be made a degree—but we've got to go back and do our degree—we've done that amount of work; we should have that degree—we should be upgraded without having to go back and do two years part time or one year full time....
because I really don't think that the course will change that much; really it can't. I mean we've done all the work that a degree course does. People who do arts do three years—we've done three years and only popped out a diploma!

Her attitude contrasts with that of David who keenly took on additional study. Karen's position is similar to anecdotal comments of certificate nurses about upgrading their certificate training to tertiary level qualifications. These comments imply that there is a finite body of knowledge required for nursing practice and that once a nurse achieves this level, there will be nothing left to learn of any importance to nursing.

In summary, the tertiary respondents were generally more appreciative of their formal learning experience and had a sense of being responsible for their own learning. Unlike the certificate respondents, who stressed remembering information from classroom as being important, this feature did not appear to be a concern for the tertiary qualified respondents. The tertiary respondents continued to see theory and practice as separate entities. As was the case for the certificate respondents, the purpose of learning remained directed towards academic or pragmatic work related purposes, particularly in the provision of patient care. The notion that one undertakes formal learning and acquires a body of knowledge which is then applied to different situations continues to exist but has expanded to include an approach to problem-solving. For one respondent, however, problem solving is presented as a way of thinking about issues.

David, who adopted this perspective, suggested that a gap exists between problem-solving as an approach to thinking and the way it is used in the workplace environment. If this is so, then this is one area of theory-practice gap and a source of tension between the formal learning expectations of the university which carries over into the hospital system. The theory-practice gap still exists, but no longer are years of practical experience the sole criteria for development. Paradoxically, the nexus between formal learning and practice in the hospital system has widened in the area of curricula, the conceptual development of independent personnel, patient advocacy and so on. The
nursing education curriculum is now influenced by a wider range of theories, which includes biomedical, psychological, educational and management theory, together with research findings from studies of nursing. Hospital practice, however, is still hierarchical in its valuing of traditional nursing practices.

It can be said that educational settings and employing organisations represent different subcultures. It is claimed that norms, values and behavioural expectations differ more between educational settings and the workplace than they do between different work settings (Kramer 1976). From a traditional perspective, nurses have moved relatively easily from formal learning to the workplace because classroom learning was specific in the sets of instructions and expectations delivered to students (unlike Karen's perception in which classroom learning did not always provide information that could be used in practice). Nurses could move easily from one workplace environment to another, because their knowledge base, which was largely the result of practical experience, was a practical skill and ability that was transferable from one hospital to another.

5.3.2 Practical learning

Practical learning relates to how the respondents talk about learning to nurse within the ward environment.

Practical Learning for Certificate Nurses

Certificate nurses described the practical aspect of nursing as being important in learning how to nurse. This is not surprising because their education emphasised practical duties over other aspects of professional performance. As mentioned in Chapter four, learning has been based on observation and practical experience since the time of Nightingale.

For all of these respondents the nexus between learning and knowing was facilitated through the practical experience of nursing. Practical learning occurred through experience and incidental teaching which commenced as soon as the trainees arrived in
the ward. They learnt rapidly in order to survive. However, this learning was also
accompanied by a feeling of barely coping. Student nurses were shown as early as
possible how to carry out their duties. Irena described some of the procedures she was
encouraged to learn on arrival in the ward. She also indicated that she and her fellow
student nurses had no choice other than to learn what was required in order to do the
work:

We were forced, well encouraged to get right into it from the first
day, into doing injections and doing everything....

On the other hand, Tania felt that learning through the repetition and routine of doing the
work gave her some confidence about her abilities, even though she felt that her level of
knowledge for some procedures was inadequate:

I guess it is the practical work, the continuity that you were
around a lot, that you only had small breaks for education, so I
guess practically we did gain a fair bit of confidence, but then
sometimes we didn't have the knowledge to go with the practical.

Their practical experience of the relationship between learning and knowing allowed the
respondents to feel competent. A sense of competence in action is important for nurses.
Without it they feel unable to convey adequately that sense of being in control, which is
needed in dealing with patients and working with other staff in the ward (Lawler

Denise felt that her learning crystallised while acting in senior nurse positions while in
her second and third year. The senior nurses’ work involved the responsibility for
teaching and supervision of junior nurses, and the performance of preferred activities
such as “-pills” and “dressings” as opposed to more general and often unpleasant
nursing tasks. While a senior nurse did not totally miss out on having to carry out
“basic” or general nursing care, it was often done while assisting or teaching junior
nurses. As she recalled:
I think that I learnt most in my second to third year. In those days as you became a second and a third year nurse you often ran the wards [assumed responsibility for ward management and organising staff and treatment when the registered nurse was unavailable]. I mean you did the pill rounds—and did the dressings... you were given some responsibility. I'm sure that it was second and third year that I learnt the most because it was all coming together then.

Denise’s experience reflects similar findings reported by Lawler and other nurses (Bolton 1981, Lawler 1991:31, and Russell 1991) who observed how, in the apprenticeship system, the work of nursing was organised according to a hierarchy of tasks; these were structured in such a way that as the nurse became more senior, she assumed responsibility for more complex tasks.

Practical experiences were perceived as helpful in ways other than mere opportunities for carrying out work. The repetition of practical work, connected to real life situations, and real patients, was seen to be more easily remembered than classroom learning.

... you can go to many lectures, and you can find that unless you are putting that new skill into practice that you lose it (Marianne).

Mary considered practical experience helped her remember information when being formally assessed:

I think one of the things that I found, especially when I came to exams, was that if you got a question on a particular thing (that you had dealt with in the ward) you could immediately relate it to a patient, and you could work through the nursing care of that patient.

Practical Learning for Tertiary Nurses

Like the certificate group of respondents most of the respondents in the tertiary group considered that practical work and experience were important in the relationship between learning and knowing. Some of these respondents felt that the notion of practical experience had expanded to incorporate the practical experience of learning
within the university system. Two respondents, neither of whom had prior hospital training, felt that they were not concerned about remembering practices and that practical experience was more likely to be connected with the development of knowledge. Karen and David took up this issue in different ways.

Karen considered that practical experience contributed to a sense of professional confidence. Her practical experiences with drug administration meant that she accumulated a lot of knowledge which was not acquired within the formal University environment. Repeated practical work experience enabled her to feel confident in adapting to each different ward situation.

... there's still a lot of pharmacy I don't know—tablets and things like that... what they are for, I suppose.... and not knowing the generic name and their trade name... that's probably basically what I don't know, but I think that'll just come in time, really... and being down on medical ward I learn hundreds that way. While I was down in the ward there I learnt more than when I was at uni... and I think if I was to walk into intensive care, adult intensive care, I'd be a bit lost for a while, but I'm sure I can do that as well... It's like walking into any new area... It's just hard for the first month or so to pick up on everything when you haven't done it for ages...

David, however, felt that the practical experience of learning tasks and procedures was not anywhere near as important as the broader theoretical nursing issues. Unlike all of the other respondents (certificate and tertiary trained), he was quite dismissive of procedural learning in practical laboratories:

The task business was a fairly easy learning thing—how to stick thermometers in people's mouths—that wasn't a problem, but I think the wider area of nursing, the interaction—not just with individuals—but society, and the coming to grips with problems and having to think about ethics and the sociological reasons behind actions that we do was very valuable...

The respondent who held both certificate and tertiary qualifications described nursing practice in a way which suggests that performing nursing practice is more than just a practical skill. Embedded in her reflections of observations, made while carrying out
nursing practice, was an awareness of issues that relate to responsibilities, decision-making ability, and autonomy to guide performance. Nancy perceived a need to employ measurable observations of the patient's progress outside the allocated routine:

I can't see something that's not done, or meant to be done, and walk away. I can't think that this lady doesn't really need her temperature done, or she doesn't really need her dressing taken down until tomorrow... I just can't do it... I know that they may get an infection... I know that she may not have a temperature... but she doesn't look all that well to me so I'd better check her out...

5.3.3 Experiential Learning

When the respondents talked about experiential learning it seemed to have two characteristics: the first involved the situation being attended to and the second involved doing an activity with an experienced other. None of the nurses' responses fits perfectly with the descriptions of experiential learning as has been described in different ways by learning theorists (discussed in Chapter four). The way these respondents talked about experiential learning is, however, similar to that of other student nurses' talk about experiential learning; they considered it to be learning which occurs within the clinically based ward environment (Burnard 1990). The learning may be incidental or specifically conducted within the workplace environment, and appears to be the learning most highly valued by these respondents, because it is real life experience.

Experiential Learning for Certificate Nurses

Responses by the certificate respondents indicate that experiential learning occurred in the ward. It was accompanied by the development of a particular body of knowledge for learners. It differed from practical routines in the ward in which respondents focused on the routine of activity with emphasis on the task at hand.

Some certificate respondents valued the ward as an area for learning because they were able to learn practical procedures from working with other nurses, rather than learning theory in the classroom. It allowed the nurse to internalise the cognitive behavioural and
affective components of learning holistically. For Irena this learning experience allowed for a more holistic partnership between learning and knowing:

In the hospital [other nurses] were doing it along with you—for example, if you were laying out a body, they had done it before and they knew how to do it. It was different from what you learnt in college and they would go through it with you. You’ve got a dead body in front of you... I mean, you've got to deal with all your feelings. If you are with somebody who has done it before they say something like “look, I know how you are feeling...” You have no idea what these feelings are going to be like because you have never seen a dead body before. You don't know how to put on a shroud... or something different to what the college training would tell you.

These words highlight the importance of a context for learning and the importance of teaching by seniors which allows student development in ways which both accommodate the students feelings and needs, as well as addressing the task at hand. In contrast, Lawler (1991) has described teaching in the classroom as a situation in which nurse educators often promote and teach nursing procedures in ways that do not reflect clinical reality or knowledge derived from clinical experience.

*Experiential Learning for Tertiary Nurses*

Nurses with certificate and tertiary educational experiences exhibited differences of opinion about the value of experiential learning. One tertiary respondent valued hospital training over her tertiary experience. Karen, who held a Diploma of Nursing qualification, portrayed the learning experience in the workplace context as being generally more important. For her, the hospital and its staff provided a complete learning environment. She spoke very positively about medical and nursing staff facilitating her learning. When asked what degree of help she received, she replied:

... 100 per cent ... and if I don't know anything I just have to ask them and they'll tell me. [Question: Are there other people who help?] There's the pharmacist, and the doctors are pretty good... dietitians... everyone really, everyone who works in the hospital is educating me...
On the other hand David found collegial support from staff within the University and did not perceive his learning experience within the hospital as being as helpful:

... from the university I’ve had a great deal of help and assistance for research projects etc, but I don’t have a great deal of support from my colleagues in the hospital system... That’s fine for my colleagues in the hospital system, the acute system, who were trained in the old ways...

David’s comments often reflected a tension between the old hospital approach to nursing practice and the new more global university approach of nursing education. David’s application for assistance in order to conduct a research project relating to nurses was rejected on the basis of the senior nurse’s opinion:

I support investigating a particular task that’s done—why do we do it?... It can be: ‘Why registered nurses have a lot of back problems?’ I wanted to investigate that but I needed assistance from my other colleagues in the hospital to do this, answer questions, and I didn’t get any. My superior in that area said that it wasn’t a problem so don’t worry about it... that’s been my experience.

David’s senior colleague may have failed to support his investigation for any number of reasons. It is surprising, however, that her response to his request was turned down on the basis that his area of interest was of little value. Perhaps the overly high incidence of back problems in the nursing profession is a condition that most practical nurses have decided to live with. David’s research area would have to rest heavily in the academic area and may have been devalued because of this.

The tensions that come with change are picked up by Sandra in relation to community nursing. She is critical of nurses who believe that extending the already overcrowded workload to other areas of responsibility is foolish. As she explained:

To be perfectly truthful I think that my learning has been prevented by my nursing colleagues. I think that nurses are a little bit frightened or threatened by change and new things—maybe like all people are... I’ll just go back to that family intervention program. A lot of my colleagues think I’m a fool
working with families extending my case-load by working with families. I only work with the identified client. I don't have anything to do with the rest of those family members left at home.

Knowing how to carry out work in the workplace continues to be valued by practising nurses. Nancy, who held both certificate and tertiary qualifications, prized those learning experiences where she learned in co-operation with other registered nurses:

... and I didn't come back into a labour ward until I came to this hospital... so I had forgotten a lot of my theory, and I had that to revise... and also certain things that happened in a clinical situation... even where you're senior, permission for others to come in and say it's all right.... don't worry, you do it this way... or just help support you and help you to get the baby out with practical experience that they've used before [that] they've found work... so I need to practically have them to teach me some of the little tricks of the trade... things that I wouldn't really get out of a textbook.

Experiential learning for these respondents has more diverse dimensions than for the certificate group. Unlike the certificate respondents, most of the tertiary group enjoyed both the formal and practical aspects of education. From their comments they imply that professionalism and individual development depend on further education. Some of the tertiary group felt that learning was the result of the accumulation of facts, information or knowledge, that could be applied to some practical situation. The two respondents who held tertiary qualifications as their initial nursing qualification, conveyed different impressions of how they were involved in practical nursing experiences. Overall, despite their varied perspectives, tertiary respondents seemed to have a stronger sense of responsibility for their own learning, and involvement in work practice. This is understandable when three of these respondents completed their tertiary qualifications while working full time.

In summary, the formal component of learning, for those nurses whose sole form of training was in the hospital system, reflects a fairly passive experience. These respondents demonstrated some ambivalence towards theoretical learning. The
respondents with some tertiary qualifications, however, while suggesting that a shift from workplace experience towards tertiary education may be detrimental in the short term from a purely practical point of view, believed that gains are to be made in the longer term in producing a nurse with a broader education. The tertiary group of respondents described a more active participation and self-directedness with their formal learning. In some ways both groups can be seen to have picked up their teachers' beliefs about the aspects of knowledge considered to be important.

The site of ward learning was highly valued by those nurses for whom it was a major component of their training, in particular for the learning of practical skills and routines. Nursing practices were learnt through the experience of carrying out the procedure, mostly without assistance, but often under the surveillance of more senior nurses. Those nurses trained in the hospital environment emphasised the primacy of practical, everyday work-experience to learning and developing competence. They valued observation of nursing practices in promoting learning. Learning was considered to happen when necessary information was imposed on students from above. Experience and knowledge were in some ways inseparable, which meant that little consideration was given to reflection or problem solving. However, disjunctions between formal learning and the knowledge needed to perform procedures contributed to a lack of confidence for some respondents. They were aware of the need to be seen as a clinically competent practitioner and the expectation for them to function within a hierarchical relationship, where the patient was an object of routines, observation and scrutiny.

There were similarities in practical experience for the tertiary respondents to the certificate group, in that the notion of learning from experience and working with a more experienced person continued to be important when working in the hospital. A more extreme position, held by one respondent, found practical work to be fairly straightforward, but assimilation into the workplace to be more problematic. This same
respondent felt that there was a shift towards valuing working with an academic "master".

Observation and practical experience provided the opportunity to learn a pattern of skills which were used in many different areas within a hospital. In this way the cultural tradition of nursing was preserved. The ability to competently perform practical activities, without the assistance of a senior person was considered an indicator of efficacious learning.

5.4 Learning How to be a Nurse: Service Needs, Obedience, Surveillance and Professionalism

In the previous section learning to nurse was concerned with gaining the necessary theory and knowledge to function as a nurse. In this section the focus shifts to learning how to be a nurse. The first aspect of learning how to be a nurse relates to how nurses are formed as subjects within a hospital or tertiary system. The second aspect relates to learning how to be a nurse from these respondents' professional perspectives. Learning how to be a nurse is an attempt to find a balance between the need to acquire nursing concepts and reasoning and the need to provide a service. The themes were taken up in different ways by the two groups of respondents.

For the certificate respondents, learning to be a nurse and to provide nursing care has traditionally been viewed as fulfilling explicitly stated service needs in relation to hierarchical relationships within the workplace. Within the apprenticeship system knowing and performing one's duties was closely linked to aspects of social relationships. In the process of learning practical nursing skills, respondents were also conditioned to be responsive to authority and to accept the place of routine within the hospital.
Some certificate respondents described their training in a way that indicated that obedience and social control were integral to their learning process. This contrasts with the expectations of an adult education approach where nurses are encouraged to take some responsibility for their own learning and to question when they needed clarification. As Irena said:

We were forced... well, encouraged, to get right into it from the first day... into doing injections and doing everything... even if you were only standing observing you were really pushed by everybody to do that... We were forced... you were pushed to do it [the work]... you were short staffed and had to do it [the work]...

The mode of control in the ward was both overt and subtle as Kathie pointed out:

You performed at your absolute optimum level the whole time, and you didn’t ask questions because that wasn’t part of it...

The demands of the ward situation required the nurse to operate as a service to meet the hospital's purpose and maintain a duty of care towards the patients.

As pointed out in Section 5.2 on learning to nurse, the responsibility for instructing nurses about general and particular responsibilities for patient care resided with more senior staff. Carrying out instructions required obedience from every nurse. Information passed on from senior staff was designed to ensure that the trainee knew what her responsibility of care towards the patient entailed rather than as part of the teaching process. Learning resulted from these encounters, unsystematic and incidental as they might have been. Mary, for instance, was aware of the need to get the instructions right, because failure to do so would create chaos for the ward and the patient.

A lot of the older sisters had so much information they used to pass on... They used to talk to you... they used to talk at you maybe sometimes... they always made sure that you knew what was going on probably more for the benefit of the patient than the student nurse... but they always made sure that you knew what you were doing so that you didn't knock off the patients...
In this excerpt the nurse has positioned herself as an uncertain performer and one to be supervised, because of the harm she could cause to the patient. In the apprenticeship system where teaching came most frequently from a senior nurse, the responsibility seemed to be double edged and directed towards the primary goal of getting the work done for the patient, while simultaneously reminding the nurse about her “duty of care” to the patient.

Emphasis on learning from others and their experiences was important to learning how to be a nurse. In contrast to the obedience previously demonstrated, learning how to perform a duty of care for some students occurred with less tension. Tania was happy when being taught by senior registered nurses, particularly when uncertain. She felt that senior nurses were a valuable resource for demonstrating how to do whatever was necessary.

...there was always someone who knew more than you did, but you could still say: “look, I don't know what to do,” — and they would then show you... people were always very keen to show you.

When students went into “block” it meant that they were attending lectures only and not working in the hospital. In some institutions nursing administrators continued to resist the total removal of students from the work situation. Leanne as a student in “block” experienced was rostered to work in the wards before attending lectures.

... we had a system of blocks [a number of weeks where students attended lectures] but we still had to work prior to it [lecture]. We used to work from six in the morning until breakfast, because they were short staffed; then go into class all day. We were too tired to learn at times...

Student nurses were often exploited. Leanne was aware that the industrial union discouraged these rostering practices at that time, but it was powerless to enforce change in some hospital regimes. The incident mentioned by Leanne occurred at a time of curriculum and industrial change. Both certificate and tertiary group nurses mentioned that physical tiredness often interfered with their ability to learn.
Subservience to hierarchical requirements was reinforced in the classroom learning environment. As Leanne explained:

... we did try to do something about [working in the wards before going into lectures all day]... but we were all stood up singly in class and asked why did we go into nursing?... and did we want to stay there?... and kind of heavied a bit.... so we decided we wouldn’t complain any more... We had to keep doing the morning shift before block...

Rather than seeing justification in the students complaints, the nurse educators saw their behaviour as disloyalty to the hospital, doctors and nurse educators. Despite the recommendations of the Nurses Association that students be released from ward work whilst in block, nurses had very little status, and the daily exercise of power by administrators and educators, often in the form of humiliating rituals, reinforced this.

The implied messages to the students were several:

- Obey because you are a nurse;
- Nurses do not disturb the peace;
- Nurses must put themselves out to help others;
- Nurses must ensure that all that is needed to be done gets done; and
- Angering the hospital administration is not a good thing to do.

The powerlessness of student nurses is further highlighted by Johnstone (1994) who argues that the nurse was morally obligated “to obey” in order to preserve the peace of the hospital; that is, to maintain the status quo where the hospital hierarchy was dominated by administrators and doctors. Aspects of the requirement “to obey” continue to-day but are manifest in different ways.

5.4.1 Surveillance

A theory of observation and surveillance has been explained by Foucault in *Discipline and Punish* (1985, cited Lawler 1991:62). He has suggested that one means through
which surveillance was achieved, particularly in prisons, was the Panopticon, an architectural structure which allowed uninterrupted observation of inmates without their knowing they were being observed. Traditional hospital wards were structured to allow continuous observation of the patients and staff. Lawler (1991) has suggested that, as a design concept, it is still a highly functional means of observation within the hospital especially in adult and child intensive care units. This view suggests that this system operates as a means of keeping patients under observation. It also allows for control and surveillance of junior nurses by their seniors. Foucault saw surveillance essentially as a means of maintaining power over people, both structurally and socially.

The Panopticon is a type of location of bodies in space, of distribution of individuals in relation to one another, of hierarchical organisation, of disposition of centres and channels of power, of definition of the instruments and modes of intervention of power, which can be implemented in hospitals, workshops, school, prisons (Foucault 1985, cited in Lawler 1991:62).

Lawler's study focuses primarily on the nurses' observation of patients and gives less attention to the surveillance of nurses themselves. However, Foucault's notion of surveillance can be used to describe the close constant observation by the charge sister or a more senior nurse, of a junior nurse and is a way in which a person learns to comply with the practices and requirements of the dominant groups.

**Surveillance for Certificate Nurses**

Among the certificate trained respondents there are a number of statements which refer to some form of surveillance of the nurse by more senior staff. In the following account the language used by the respondent, suggests intense observation:

In the hospital that we were at we were fairly well regimented, because we were known very well in the district—because our parents all lived there. Because our parents were important people in the district we were watched very closely and people had extremely high expectations of us which did or didn't do us much good. You were really under scrutiny—so you performed at your absolute optimum level the whole time and you didn't question because that wasn't part of it...
Surveillance of dress regulations was another means of positioning the nurse to act in a subordinate way towards senior staff. Obedience in meeting dress requirements comprised part of hospital etiquette. For some respondents, particularly Irena, this was a memorable experience:

In Scottish Hospitals, you were very much treated as, sort of, not second class citizens, but you were there to serve them, especially as a student nurse—as a sister you weren't. It was like the old fashioned training; you stood up and took your cardigan off when somebody who was more senior than you—even if it was only a block in front of you—came into the room.

This resonates with my own experience as a nurse. Our cuffs were removed and the sleeves rolled up for certain activities. Generally sleeves were up for doing work such as bathing, toileting, dressings and down when doing rounds with more senior people, when one left the ward, when feeding people, or interacting with visitors. At the time this was not seen as a problem, because of certain perceived practicalities of the actions. On the other hand, strict regulations about dress also provided a site for close control where any divergences, no matter how minor, could be considered as disobedience or resistance. They were punished, as one of the respondents (Nancy) explained about her hospital training experience. Surveillance and discipline were tools used by nursing administrators to reinforce the often rigid educational experience of student nurses.

Nancy demonstrated disobedience to the establishment's dress requirements, argued with a nurse administrator and threatened to further disrupt events. She was driven by a desire to serve the system on her own terms. She chose to attend work because the system expected a measure of self sacrifice and, to some degree, she had become indoctrinated:

I started questioning patients' rights and my rights, too. I had an incident with myself—it was the middle of winter in second year and I had the flu. And back then you couldn't wear capes on the ward and certain things like cardigans, or vests... so I was on duty one day and it had been very wet for about a week and half and I managed to keep going to work even with this very bad flu. A senior sister came up to me because this day I had a T shirt on
under my uniform. The hospital wasn't warm, and we were not allowed to wear anything else at all except for the uniform and the duty shoes and the duty stockings. She told me to take the T shirt off... I was coughing and blowing my nose and obviously to any nurse I looked unwell, and I said, “No! That's all I've got to keep me warm.”... And she said: “it's not regulation—you can see it above your button—take it off!” And I said: “No, I have the flu and I am not taking it off. I am not allowed to wear a cape on duty; I'm not allowed to wear a cardigan or a jumper on duty... I am cold and I am sick and I have a fever.” And we still had sick parade in those days...no point to go down there, they just give you two paracetamol and tell you to go back to work. So I said: “No, I refuse to take it off; it's the only thing that's keeping my chest warm and my chest is really hurting and I still don't feel well. I'm probably one step off having bronchitis.” Anyway, she told me to take it off, ordered me to take it off again, so I started to take my uniform off in the middle of the corridor in the large medical ward, and she said you can’t do that, and I said if you want me to take this T shirt off the whole lot is coming off now. And I continued undoing my buttons until she really got scared and said stop. And I said the tee shirt stays on. And she said you report to the Director of Nursing on Monday, which was the Matron, and I said: “I certainly will!” You know I went and saw the Director of Nursing on the Monday, and I just stood there and said: ”You wanted to see me?” And she said I believe you wanted to see me. “well, not really,” I said: “I don’t want to see you—I was ordered to see you.” And she said: “...I think the situation got a bit out of hand.” I said that I think the situation was ridiculous. And I'm sure it was only because she knew me—knew my work—and she herself really thought that senior sister was really, over doing the old role and the old system—that she really didn't want to know about it, but had to sort of support her senior member of staff, and that's how she supported it, she said I think the situation was, like, out of hand. And that's all she said. And I continued to wear T shirts—above my uniform! I have rights, and they can not take them all away from me. And that's what I believe nursing is trying to do.

Disobeying uniform regulations was a situation in which the nurse could be “justly” (Johnstone 1994:149) punished. One cannot help feeling that at times the “duty to obey” was more important than a “duty of care” within the apprenticeship system of nursing. These findings are in keeping with the notions of obedience expressed by the certificate respondents. Nancy who now holds tertiary nursing qualifications, gained her first certificate within the apprenticeship system of nursing. She has, however, been able to move beyond the more restrictive elements of behaviour encouraged within that system.
An aspect of learning how to perform surveillance of those junior to yourself involved moving up the hierarchy. Denise explained how, after graduating, she was informed that she was now going to "start learning" how to establish her place in the policing system:

She also said to me: always check up on everything that you do; always check up on everything that everybody else does; never assume that anyone does anything for you. That's what I remember most—it's about responsibility, and checking on your work and everything that you've done; and never assume that anyone does anything for you because you can't rely on people.

Learning how to perform supervision of other nurses was often uncomfortable. Conflict, unease and tension accompanied the responsibility of observing other nurses. The respondents reported feeling tense about fulfilling the role of surveillance of other nurses, who also felt unhappy. Some of these concerns were taken up by Denise:

You also have to check on your junior staff and they don't like that. They feel threatened, because now that they are registered nurses they don't see why you should be checking on them.

Barbara was often uncomfortable with her management responsibilities when there was an expectation that she should question the practices of junior staff:

... where you find that you are out there sticking your nose in where it is not wanted...

On another level Denise identified that stress was evident in terms of her position as a registered nurse. She felt that there was:

... a lot of stress on people in charge and senior people to try and make sure that things are done that should be done for the patients, and also that you have to check... that everything is being done.

Surveillance can be a positive process which improves the quality of patient care and nurse education. Unfortunately it all too often reinforces one's own quiescent position
within the hierarchy. Learning to nurse within the apprenticeship system involved the
development of a proficient handmaiden, driven by a duty to obey and to support the
status quo within the hierarchical structure. Johnstone (1994) labelled this process
"subordination of the nurse".

Surveillance for Tertiary Nurses

Those nurses who had tertiary qualifications placed less emphasis on feelings of
oppressive surveillance, than did the respondents with only certificate qualifications.
However, the tertiary group expressed subtle variations in their feelings about this
practice. Dissatisfaction was more overt in the interviews with the four respondents
who gained certificate qualifications before they upgraded to tertiary level nursing
studies. This could well reflect their reaction to hospital training which seems to have
had a greater impact on this aspect of their work than their subsequent tertiary
experience. Their feelings about surveillance were characterised largely by a sense of
constraint.

For Kirsty, the hospital environment carried an imposition of time constraints in
conducting nursing work which was task-orientated, exhausting, and non-conducive to
encouraging study afterwards:

In the hospital situation you were really pushed for time and it
(the work) was task-orientated... you were so exhausted that you
just wanted to leave nursing behind and get on with your life
when you left work. You didn't have a frame of mind to study at
all—well I didn't—and I felt like that most of the time.

In reflecting on her hospital experience, Kirsty contrasted hospital nursing with
community nursing to demonstrate the different levels of autonomy available to her:

I think you were just told to do things — not told — but you had
to do things... I guess it was lack of autonomy in the hospital,
whereas I very much make my own decisions here in the
community... You are also pushed for time in the community,
but you are the manager of your own time, so you organise your
own day — so that you can actually fit everything in — and give
the clients a reasonable amount of time...
She described a sense of constantly being pushed for time when working in the ward:

I found the big problem with that was that you didn't have time to really communicate with the client as a real person, who has a family, and things going on at home that they are worried about...

For Kirsty the hospital environment involved a significant lack of decision-making opportunities.

I think it was pretty much dictated about what you did for a client, and also just in reference to doctors — you virtually did what they ordered. Not that you don't to a certain extent out here, but I think you have more respect for your judgement out here, whereas, as a hospital nurse you did what they said, and if you questioned it was out of line...

Whereas she believed that she was better positioned to make decisions about patient management within the community.

I make decisions about my clients' care. I go out and assess the clients for their needs and come to some agreement with them about what sort of care and resources we are going to provide. Then I decide on the type of care that I am going to give...

Her experience of the hospital environment highlights a social control which operates under the guise of obedience, time constraints, responsibility and surveillance.

These differences between hospital and community nursing are long-standing and a source of tension between nurses, with both sides seeing the other negatively. Other respondents from both groups also made distinctions between hospital and community environments. While these accounts have not been presented in detail, the comparisons mainly related to an issue of difference in social control perceived between the hospital and community workplaces.

Nancy highlighted a constraint on nurses' professional development and practice which related directly to patient care. Reflection on her certificate experiences of nursing
terminally ill patients caused her to consider the right of patients to make decisions about their treatment. She was also aware that a patient's personal wishes were often ignored. Nancy experienced a conflict of loyalty to the hierarchy in the development of her perceptions of ethics and justice:

... a few patients I nursed over three years... finally died in my third year. I now have a dark feeling that I wished they had died when I was in first year... there was about three patients that this happened to... I was still there when two of them died, in third year, from cancer. I watched them die and they were not elderly people... One was in his early thirties... the other lady was in her late forties, and the other chap was in his mid fifties. The chap that died left two young children behind and I watched that man suffer for three years... I thought where is this person's rights—to say I don't want this treatment. Where is this person's rights to say: “I want to be home with my family; I want to die at home.”... And he wanted all those things—and they were all taken away from him... He had no choice... I mean early 80s is not long ago... and that's why I realised human beings had rights and I had a lot of rights...

She was critical of the fact that nurses have been taught to “observe” and “report” and “see” and never to “diagnose” or “treat” (Johnstone 1994:160). Another dimension of traditional nurse education with which she was in conflict was with the nurses' “duty to obey”. One aspect of this law, “the medical construction of the nurses' duty to obey” (Johnstone 1994) says that the nurse cannot under any circumstance talk to the patient about the doctor providing treatment (for fear that she will speak ill of him), and neither must the nurse give the patient information about other specialists who practise in the same field (in case the patient seeks treatment elsewhere) (Johnstone 1994).

Nancy in the above scenario was not permitted to speak openly to the patient about the treatment, even though she was aware of their concerns. On first reading, Nancy's excerpt seems to contain all the ingredients of thinking that the traditional apprenticeship system of nursing actively worked to discourage. It contains all the items that some doctors have actively sought to discourage and prevent nurses thinking and speaking about. It is in keeping with Johnstone's thesis about the medical subordination of nurses being an archaic construct which claimed that the nurse's duty was “not to reason
why”, but to loyally carry out the doctor's instructions. In the 1900s this medically constructed “duty to obey” was legitimated and reinforced by the law (Johnstone 1994:149).

Johnstone emphasised that nurses’ “duty to obey” was not just sanctioned by the medical profession but adopted by the leaders of the nursing profession as well. The construct evolved to include different types of obedience, one of these incorporating acts of “disloyalty” as punishable offences. Disloyal acts are those acts which “disturbed the peace”, and also means “questioning or failing to loyally carry out a superiors orders” (Johnstone 1994:149).

Social control was not discussed as overtly by the tertiary nurses, and when they did it was for some of them from their earlier hospital experiences. In some instances the responses reflect the respondents primary socialisation into nursing through the certificate programs. The tertiary only qualified respondents did not convey any sense of surveillance from their clinical experiences, and it may reflect their socialisation in which they spent less time in the hospitals. It was not surprising to find that these accounts of learning how to be a nurse contained less vivid accounts about obedience and surveillance. There have, however, also been shifts in hospital institutions in the way that some practices such as discipline and supervision are now conducted.

5.4.2 Nurses Sense of Professionalism

Nurses’ awareness of their place within the hierarchical structure was not only influenced by the duties they were required to perform. The respondents linked their experience of nursing duties with professionalism. Nurses were not merely subject to a hierarchical model in learning to perform nursing care. From their experience of learning how to be a nurse, they discover what nursing means to them. The respondents did not view nursing as simply the performance of skills, procedures and routines. They had fewer subservient attitudes about their place in the hierarchy, than
was evidenced in the previous section. They were less likely to accept unquestioning subservience to the medical profession than was the case on the reflections of earlier experiences.

This discussion was relevant because nurses have been historically involved in providing a service to society which was not offered by any other group (Conley 1973:113). The positioning of nursing as a profession has been ongoing since the time of Florence Nightingale. The politicisation of nursing has influenced how nurses talk about their role and their place within the system.

Professionalism for Certificate Nurses

Eight certificate nurses unequivocally described nursing as a profession. Others were less certain in distinguishing an occupation from a profession. This distinction, in academic terms, occurs according to classically accepted definitions of a profession where a degree qualification is required and the practitioner exercises autonomy over that practice.

Two respondents did not agree that nursing was a profession and their differing positions resulted from their experience of nursing. Janice who had only ever worked in a hospital was not sure of the distinction between an occupation and a profession. She experienced some difficulty in seeing nursing as a profession because she associated nursing with demeaning, unglamorous work. Further, nursing seemed to be associated with responsiveness to clients. Being responsive to clients meant providing a service which was not autonomous:

I guess that it has just been inbuilt in me... when I started it was just an occupation, and it is hard for me to adjust that it will become a profession... I guess it's just change and I will have to change in myself—the way I think—I think nursing is just something that you do... It's just a job... It wouldn't be compared to being a lawyer or a social worker or anything like that.... There's no glamour in it... It's still a bit demeaning really... I guess the ultimate aim is the patient and doing things for them.... To be perfectly honest with you I don't know what
the difference is between an occupation and a profession so it's very hard...

Elaine felt that the important issues were those of autonomy, interaction and responsibility:

... I think it is what you make it. I think that for some people it is a profession and for some people it is an occupation... I think a lot of it boils down to the attitude of the individual nurses. A lot of times we just do whatever we are told, and if the doctor says do this we jump and do that... I think the more input we can have into a patient's or a client's care, that the more it is going to be regarded as a profession. We have got to have an identity of our own as nurses and an important identity, rather than people looking at us and thinking: "aren't they wonderful people... they are so dedicated... they look after all these sick people... and aren't they compassionate..." They have got to look at it and think: "well they are very clever and they do a good job... and it is a very useful purpose out there..." so I think a lot of it comes down to what we ourselves make of it.

Those certificate nurses who were more convinced that nursing was a profession, identified various characteristics in support of this. These respondents attributed to nursing qualities associated with knowledge, perceptions about the level and complexity of their knowledge, skill and training, and levels of responsibility for providing patient care. These qualities, in conjunction with their years of experience, constituted their perceptions of nursing as a profession.

From one point of view nursing was described as a profession because it allowed for the basic accumulation of new knowledge, which allowed for greater work options. Tania perceived nursing to be a profession because it went beyond learning a limited range of tasks to include new knowledge and adaptation to changing work situations:

... nursing is a profession... to me an occupation is something that you learn ... you know you might learn a trade and that becomes what you do for the rest of your days... what you've learnt with nursing you can choose to have it as an occupation ....where you are... or stay in one place... or you can actually extend onto it, so that makes it a profession... I mean it's a profession anyway but the fact that you can add to the knowledge that you have—the basic knowledge that you have—makes it a profession... when I'm dealing with people I behave as a professional....
Iris considered that nursing was a profession because it had incorporated an identity and responsibility designed to maintain standards of professionalism. She compared nursing, as a profession, with engineers who are practically orientated professionals. The professional features of nursing, in turn, have implications in terms of personal responsibility of how the nurse functions within hierarchical structures.

Iris seemed to accept her position in a hierarchy where management had responsibility for maintaining standards, while Mary described the challenges of the nurse/doctor professional relationship as being important:

... nursing is a profession, and I think, as such, it should be treated as a profession... for too long nurses have been seen as the handmaiden of the doctors... our training — our attitude to people — are important... What we do in caring for people is quite different from what other people do... even in other occupations... the actual caring for people that nurses do... there is nobody else who looks after patients who can do that ...

Some respondents felt that qualifications were not the only mark of a professional. Barbara believed that a high level of skill, rather than qualifications, made her a professional:

... I think it is a calling... I think that we are highly skilled... We may not have the formal education that most people would consider make us professionals, but I think that the skills that we do develop are extremely important...
Barbara, Marcia, and Irena all gave considerable importance to qualifications. They recognised that, in the main, professions are dependent on their educational basis. Degree status for nurses is accompanied by an expectation that the nurse may now have greater autonomy and responsibility. However, Marcia expressed concern about nurses who have lots of qualifications but relatively little practical experience. She did not believe that tertiary qualifications necessarily provided students with all the skills that define modern nursing, though she did acknowledge that neither is sufficient alone:

... but in the past nursing hasn't been seen as a profession maybe... but I think there's more opportunity these days for people to aspire to higher heights... but there's definitely further to go for the girls if they wanted to these days — if they're willing to work and study.... that doesn't always make them a good nurse — the study, the bit of paper doesn't... They like to think that the more studies they do, the better the nurse, but without the practice they aren't...

Irena, on the other hand, considered that recognition from others, both inside and outside the work context, was important to her:

...[nursing] is a profession... here the nurse is the person who deals with the patient the whole time... it is only you there... you only call in assistance when it is required... you only call the doctor to come and see the patient if you are worried about him... You are the one who is in charge of the patient... I am in charge of all my thirty clients here, and that is a pretty professional thing... I think it is becoming more of a profession, now that nurses are being taught in the university... but before that—no, you had to have somebody to empty the bed pan...

The certificate group saw their work as professional in the context of the quality of skills and patient care that they provided. For them nursing was more than just doing a job and forgetting it. They suggested that concern with the work of nursing is ongoing, or, as one respondent said: “it is always with you”. Competency was important. Many of these respondents were keenly aware of their place within the hierarchical structure. While the nurse's sense of duty was inculcated by their profession's requirement for obedience, these same respondents notion of professionalism was also clearly identified as being related to responsibility and autonomy.
Professionalism for Tertiary Nurses

The responses from the tertiary group about the occupational status of nursing were divided. Four of the respondents perceived nursing as a profession, while two other respondents viewed it as an occupation. Nancy rejected the mechanistic perception of nursing, evident from current work experience in the hospital where nurses in the ward are often treated with indifference by administration. Her changed perceptions of nursing's occupational status stemmed from her knowledge of the experience of the changing dynamics in her work environment:

...I used to think it was a very good profession. Now I think it's an occupation... as I got older, I realised that nobody ever really says 'thank you' for what you did do... You weren't acknowledged by administration, who are meant to instruct you... You were just another number or a human resource... You weren't plant machinery resources so you had to be a human resource... Now they've got to meet their budget: now they've got their levels to satisfy: I am now a resource, and I am not noted for being good, bad or indifferent as a resource... so I come to work to earn money so I can live the way I want to live; I don't live to work; I work to live. I don't think administration know about human worth and feelings... they really have stopped seeing nurses as human beings... They did for a while ten years ago... they really improved, but I really feel it's going backwards now... I have stepped back in my professional world coming here...

David explained his own feelings about nursing's status, based on his experience in the tertiary sector:

...I think at the moment it is an occupation, given the true definition of a professional... when you have a distinct body of knowledge... you have the autonomy of practice... you have the control over that autonomy. I don't think nurses have that at the moment... I think the other thing that is occurring now is any health care management endeavour is a multi-disciplinary thing... but you need to have somebody who has an overall concept of how it should turn out at the other end... and I think nurses are in a good position to fill that role...

The four remaining tertiary respondents were less equivocal about describing nursing as a profession. For Sandra, who worked as a community nurse, the criteria for the professional status of nursing included recognition of a knowledge base, skills, and making judgements based on that knowledge:
Well, I think there is a definite body of knowledge that we need to have to be a nurse. Not only is there that knowledge; I think that there are the practical skills... the getting out there and doing it, and applying that knowledge to what you are doing... and being able to make judgements on things that the normal run-of-the-mill person — or the patient — isn't able to make for themselves... being able to look at something and being able to see it in a context of the knowledge that you have about the job you are doing — previous experiences and your practical skills are all enmeshed...

Identifying what made nursing an occupation was pushed beyond the well recognised sociological criteria by Libby, when she explained why nursing was a profession. After lengthy probing about why she didn't view nursing as an occupation, she implied that nursing should be regarded as more than doing tasks because of the personal involvement with patients. She suggested that the decision-making aspect of nursing involved two dimensions of activity. Implicit in her account was the knowledge that a wrong decision can easily kill or seriously injure a patient. She considered that organisational practices positioned nurses as carrying the main responsibility for the overall organisation and administration of very personal care, a more responsible activity than might be the case with doing the same job for many different customers in an occupation. With nursing, the giving and doing were on-going until the patient was discharged. This also made the work intense and important:

I think that nurses give more of themselves as a person than one would do, say, in an occupation like someone working a piece of machinery, or gardening... we are required to give more of ourselves. We have to have a discipline in ourselves... we have to be accountable, but that is not really the giving bit... we have to be set in our own minds what we are giving and doing... We are big decision-makers on other people's behalf for their nursing care... we decide their fate more or less... we are the ones who are with the patient most of the time, whereas doctors or physios breeze in and out. The nurse is the one who is with the patient for however many hours a day—three shifts a day... we have very close contact with people... very personal contact with people...
Karen, who held a tertiary level qualification with little nursing experience, felt that nursing was a profession on the basis of the level of qualifications. In contrast to the two previous responses describing nursing as a profession, Karen’s response had a different emphasis. It reflected exposure to a totally different body of understanding from which the “patient care” purpose of nursing was missing:

...[nursing is] a profession... Not everyone can be a nurse... like not everyone can be a doctor and not everyone can be a lawyer... I think you’ve got to be a special sort of a person to be a nurse... I went to uni for three years to do it... that makes you professional... I mean not everyone can go to uni either... you’ve got to get a good mark to go to uni, and I really think that stands you in a class above everyone else really... anyone who goes to uni... you know they've worked hard to get there... I think that stands you above everyone else... and our wages are coming up to professional standards as well (laughs)... can I tuck that one in?

Despite her own experiences at University, she still made the comment: “you’ve got to be a special sort of person to be a nurse”, which suggests that there is an intangible characteristic of nursing proficiency which seems to suggest that good nurses, like good mothers, are born (to be good handmaidens)—not made.

5.5 Nurses’ Sense of Self: Personal Development

Nursing education and working as a nurse allowed some of the respondents to develop a sense of self actualisation which they implied might not have occurred if they had not taken up nursing. This theme was intentionally sought from the interview data for two reasons. The first relates to the theory of adult education as proposed by Malcolm Knowles. Knowles (1975) proposed that, as a person matures, their self concept is believed to move from one of being a dependent personality towards being self-directed. For the purposes of this study then, it was assumed that if maturation results from the process of learning (for children), and continues in adult life in the work environment, then learning to nurse could be a source of reward, confidence, and self fulfilment, and the basis for further learning. Specifically it was assumed that the everyday work
experience contributed to knowledge development, and the experience served as a basis for future learning. All respondents decided to become nurses, which means that some self-motivation existed. This should have provided a positive attitude towards learning from which the student nurses would work to achieve the concepts required for nursing and a level of knowledge on how to perform nursing tasks. The second reason relates to the fact that nurses have often been described as having a low self-esteem. Game and Pringle (1983) and more recently Bowler (1992) have noted that from the first day in the system many student nurses feel they lose their sense of personal power.

The Certificate Nurses

Some of the certificate respondents who trained in the hospital felt that their experience led to their developing personal attributes which they continued to find useful today. They also implied that these developments might not have occurred with any other work experience. They also claimed that a sense of personal development and satisfaction was not encouraged by the system. The following experiences have not necessarily resulted from formal or academic learning. For instance, Marilyn described the experience of living in a nurses’ home as a supportive and enabling experience:

... I suppose because we shared nurses’ homes and that sort of thing it was, I found that very valuable coming from a sheltered background... It was a good introduction to the world if you like... It was a sort of easy introduction into the world...

It should noted that not all of the respondents shared Marilyn's positive impression of living in the nursing home. Leanne for instance described the experience of living in a nurses' home for three years as “a bit alien”.

Janice felt that her nurse education provided her with the opportunity to learn how to interact more confidently with people.

... when I went into nursing I was a very shy, quiet person... going into nursing has helped me to open up. I really know how to communicate with all sorts of people now... because you come
into contact with so many sorts of people... that is probably the greatest thing I remember... I would never have been doing this (the interview) before say, ten years ago... I would have been stuttering and stumbling, but now I am more confident with people...

For Barbara, the experience of nursing provided an opportunity for meeting people, and through meeting people she believed that she became a more tolerant person:

... I think, all round, the lessons in life more than anything—rather than anything actual in nursing... It shows you a very broad outlook on life. I think that I am, probably, more tolerant... by meeting all sorts of people from other sorts of backgrounds which I may never have been exposed to other jobs...

Marcia talked about a similar experience:

... I think I learnt to get along with other people and to relate to patients. You learnt that life out there was different to life in a hospital. I think you become a better person, a more tolerant person...

The nursing characteristics of tolerance, patience, and respect, have been traditionally considered desirable (Kramer 1976). These characteristics were also judged to be useful to nurses outside the work environment, and in particular were regarded by some as very good preparation for marriage and motherhood.

A positive learning experience occurred for another respondent through learning how to do what so-called "natural" nurses do easily. Iris described strategies such as time management and learning skills of observation which she used to promote her general learning:

When I did my training I had to change my whole approach, during my training. I wasn't a natural nurse and I'm still not a natural nurse, although I enjoy nursing... I had to learn to really discipline myself... I had to organise my time, and I had to learn to see things that were out of place—or irregular—that didn't occur to me naturally... I had to school myself in that sort of thing... All the things that a girl who is a natural nurse doesn't have to learn to do... I found the most valuable thing to me in
nursing was learning to organise myself, and I could apply that to all the theoretical things that I learned and all the practical things that I learned... so probably that was of value... maybe it wasn't so much one learning thing as a sort of just learning a pattern...

Iris can be considered to have overcome challenges to learning to nurse and to demonstrate a level of confidence and trust gained from her experience. In spite of the hierarchical control and socialisation experienced by most certificate nurses, some self-directed learning also occurred.

_The Tertiary Nurses_

Respondents with a tertiary qualification considered that their training provided a trust and confidence in their approach to learning and functioning of which they had not previously been aware.

David described how his course of study helped him develop rigorous thinking abilities. The description of his experience differed from respondents of certificate programs who repeatedly recalled that questioning in many situations was not permitted. For David, who entered university as a mature age student, the opportunity to question procedures and instruction was a valuable and enabling experience:

... being mature age students... may influence how we feel about the course... certainly we went into the course having some degree of expertise in another area, and though we were less likely to accept the information given to us without question... I think this particular education system has allowed us to argue better and also to investigate things we find may not be true...

For Sandra, who held both certificate and tertiary qualifications, her learning and thinking abilities have enabled her to feel confident about being able to learn and understand how this can help her maintain interest in her work environment. Her continued learning helped her assess the nurse's role within the larger scheme. In particular, thinking about issues relating to her job prevented boredom which she felt could develop by staying in the one job for many years. Sandra explained:
... personally, I really enjoy the lecture situation. I like the information to be given to me... I can then go away and work it out... I think that if you are given the basic information you can put it together in the practical situation—that's the way it is for me, anyway... I think that the most important information for me now is the latest things that are happening in psychiatry and where a nursing role fits into it... I like to know the direction that psychiatry is going in so that I can pull parts of that out which are appropriate to my role. Not only does it improve my skills in the long run—it helps nursing because it is identifying aspects of my daily work that are getting into that nursing role. Unless we have the information in the first place we are not able to identify it—and develop the role... to perform the role you have done twenty years ago is very boring and not very productive, either. We need to go with the times... when I talk about psychiatry I am talking about mental health in general and not just the medical aspects of psychiatry. I am talking about the total mental health in the psychiatric field...

The development of a personal sense of caring was more important than an emotional feeling, or just a practical activity. Traditionally, nurses have been told to care—that nurses care, and that for some, nursing is caring. Libby talked from a position of both her certificate and tertiary experiences to confidently link social and interactive aspects of caring as being important to how she considered patients:

... caring for others, and being aware of their needs as an individual... mainly those sorts of things... by being aware of people's needs as individuals you became aware of how they were situated in various societies and communities... how they influenced other people... and how we influence them... and how nurses influence them... how they were in a medical situation... what they were like in hospital...

Not all respondents perceived any particular development to their “self” as a consequence of learning to nurse. In fact, this line of questioning may have been a source of confusion for some respondents. For example, Kirsty responded:

... I learnt to communicate with people... I don't think that would be the most valuable thing... I don't think I can really pinpoint what the most valuable thing was... I could communicate with people really well before I went into uni... I don't think I can really pinpoint the most valuable thing... while I was at uni I realised what area I wanted to go into... what areas I liked and what areas I didn't like...
Two items from the preceding excerpt highlight a contrast between this respondent and respondents from the apprenticeship system. Kirsty felt that she had good communication abilities before entering university. Some of the respondents in the certificate program came from sheltered backgrounds and possibly had limited schooling. Taking up nursing allowed them to develop communication abilities not perceived to be present before.

In summary, the tertiary respondents' sense of personal development has a different meaning from that expressed by the certificate respondents. In particular, they conveyed a stronger sense of decision making about their work environment and nursing. Some of the tertiary respondents exhibited a stronger sense of self-worth as a result of their particular learning experiences.

5.6 Discussion

The certificate group described an approach to learning in which observation and practical learning experiences were important to their development as nurses. This is to be expected because hospital demands and their certificate programs offered limited scope for formal learning. What was available was directed towards providing students with information on nursing concepts and tasks which the authorities considered students needed to know in order to do their work.

Nurses were taught and encouraged during certificate programs to use their senses while performing procedures. Nurses relied on their senses at all times while on duty, not only when performing routine activities, but also when walking past the patients' beds. The nurse was expected to notice, for example, if the patient was blue in colour, awake or sitting as he or she had been placed by the nurse. Respondents within both groups described the necessity for being alert to irregularities in the patient's condition. They were constantly made aware of what could happen if an observation were allowed to
remain unchecked, or if they observed through looking or listening that the patient's condition had changed in some way. This explains why the certificate nurses often talked about nursing with emotion and intenseness. The two respondents who held solely tertiary qualifications, did not speak about their assessment of patients in this way at any stage during their interview. The certificate respondents talked about deciding on actions based on the clues they picked up from their patients through the use of their senses and the routine practices which comprised their provision of care. As well as providing routine nursing care, these nurses were constantly anticipating patient outcomes. This was not the case for the two who held tertiary qualifications only.

Although formal learning in the certificate programs was limited to a lecture format, respondents who held certificate qualifications only believed that the information given filled the missing gaps in incidental learning in the ward. Nurses were immersed in the language of medicine, and they learnt this language and how to think about it through the practice of using and hearing it every day, in much the same way as a child learns language.

The other important feature that influenced nursing care during the certificate programs related to hospital regulations imposed by nursing administrators and the medical profession. Obedience to the physician and nursing hierarchy was considered to be the proper role and the "cornerstone of good nursing" (Kramer 1976: 98, Johnstone 1994). The nurse was to follow a physician's orders for patient care explicitly and without question. S/he had no right to suggest alternative care plans or interpret a patient's condition. The "golden ideals" of the nurse were courtesy, patience, and an unfailing common sense (Kramer 1976). The respondents who held certificate qualifications described these attributes with different words but the meaning was the same. The certificate nurses were constantly under observation, both for the overt purpose of assessment of their development and for the shaping of their nursing behaviour throughout their employment in the hospital. White's (1985) expectation that nursing
education in the tertiary sector would move from a model of learning where experience results in a change in behaviour, to a cognitive model where learning results in a change in the meaning of experience, remains problematical. The nature of nursing practices within hospitals has in many ways changed little. They are however more complex and often technologically involved and controlled. The thread of surveillance and observation reflects a bureaucratic line of operation which requires that an organisation functions effectively and without question from its non-executive employees. The development of observation and supervision as goals to assist staff development and functioning within the institution, and not as impositions, might be a more appropriate strategy for future consideration.

5.7 Conclusion

The learning experiences of the respondents in these interviews were limited by the closed system in which they were employed. Despite the developments over one hundred years, these nurses still described situations in which their primary functions were similar to nursing experience in the Nightingale era. They were encouraged to behave as “ministering angels” and “handmaidens” to the physician or health system, while being required to take on more responsibility which increased concomitantly with the developments of medical science and technology. They were not encouraged to question their superiors or doctors. This was evidenced in the authoritarian non-questioning relationships described between different levels of nursing staff and between nurses and doctors. From the analysis of these interviews it seemed that nurses within the apprenticeship system were expected to function as an extension of someone else’s thinking and to develop drive and obedience and temperament that enabled them to endure and operate without complaint.

Six respondents held tertiary qualifications which were gained at different points in their careers. For two, their tertiary experience was the basic qualification which enabled
them to practise as registered nurses. It is clear from the interviews that these two respondents evaluated initial nursing differently from the other four respondents in the group; of the two, the female respondent leaned more towards the perspectives expressed by the certificate trained respondents which emphasised the value of real practical experience to promote knowledge development, while the male nurse's responses, were much more reflective of the theoretical discourses which have informed the tertiary curriculum. Both of their accounts lack the emotional intensity of those by respondents who hold certificates as their initial qualification. Perhaps it is because they have had far less experience.

There was an overall difference in the responses between the certificate group and the four nurses who upgraded their certificate training to tertiary level. The latter expressed a much greater appreciation for theoretical information, as well as an awareness of how further formal learning could be useful to them. Furthermore, these respondents spoke about the theoretical learning component of their initial learning experiences in a more appreciative way than did respondents in the certificate group. Of all the respondents only two omitted to mention the use of observation and the other senses when talking of learning and the performance of nursing care—and these two were trained at the tertiary level only.

One needs to be cognisant of the fact that most staff currently within the hospital system trained within that system and carry the values and beliefs about nursing which relate to the apprenticeship system. In addition, the organisation of work with the hospital system continues to follow the medical model, according to workplace demands. It is not surprising then that tensions emerge with the juxtaposition of this system with the university based expectations of nurse education informed by adult learning theory.

This chapter analysed the interview data as it relates to the experience of nurse education for these eighteen respondents, in conjunction with the notion of experience as used in
Knowles' (1975) adult education theory. The technique of concept mapping was used to identify themes, and a modified form of discourse analysis identified how the respondents were positioned in relation to the dominant groups within their institutions. Analysis of the data has been supported by the use of verbatim data and connections made with the literature and the social and political processes which impacted on nursing. In the following chapter these findings will be considered in the light of the overall thesis.
CHAPTER SIX

CONCLUSION

6.1 Introduction

The aim of this thesis was to gain a greater understanding of what it means to learn to nurse and how to be a nurse with a particular focus on the role of experience. To do this a number of learning theories and historical sources were examined to see what they had to say about the place of experience in learning to be a nurse, and this was then compared with the nurses' perceptions of their experience of learning to nurse.

The thesis traced the development of nurse education from the master-craftsman apprenticeship system of teaching (where learning occurred through instruction, observation and practical experience) to its contemporary location in the tertiary sector. The shift can be characterised conceptually in relation to

- learning to nurse, and
- what it means to be a nurse in relation to others as workers.

There has been a shift from the learning which occurred as a result of practical on the job experience with limited formal instruction, to learning in the university with a predominantly formal component of instruction and limited practical experience. This has had consequences not only for what it means to learn the knowledge and skills associated with nursing practice, but also for the expectations of what it means to be a nurse; that is the nurse's place in the hierarchy of the hospital and the community.

There has been a move from an apprenticeship system, where learning occurred through observation and contingency reinforcement as a consequence of working closely with a more senior workmate, to learning in an environment which encourages conceptual and
theoretical development, promoting growth through independent study. This shift reflects a shift from the behaviouristic approach, where learning occurred through observation and practical experience, to learning which occurs through reflection about theory, and practice.

Nurses trained in the hospital system were socialised into a highly stratified system, where they were, first and foremost, labourers. They acquired basic and fragmented instruction to fit the situation at hand. The nurse was expected to demonstrate obedience to the status quo. Doctors, senior nurses and administrators determined what constituted an adequate level of nurse education.

Subordination had a lot to do with nurses' positioning within the hospital hierarchy. This was evident in the relationship of working class nurses to middle class matrons, which served as the means of keeping juniors in their place. The common sense and practical approach required of the nurse to perform their duties was a contrast to doctors whose education occurred through a university based learning process of esoteric scientific knowledge.

Historically it can be seen that the Nightingale reforms promoted the formal organisation of nursing practice as well as enabling an increase in the economic and social mobility of women. However, the process of learning mainly through working on the job with little opportunity for private study or research meant that nurses were subject to the whims and requirements of the hospital hierarchy. Although the establishment of the New South Wales Nurses' Registration Board in 1925 provided an updated curriculum designed to improve the formal content of nurses' learning, the physically exhausting work conditions meant that students had little opportunity to engage in learning activities.
In 1985 nursing education in New South Wales was transferred into the university sector. This was expected to bring about a number of positive advances for nursing. The decision to provide nurses with a greater theoretical basis for improving the quality of health care in an environment of rapid technological and social change was also accompanied by a shift in the status of nurses and women. Entrance into nursing courses became more selective and based on intellectual ability, measured by matriculation scores. This meant that nursing was an avenue of employment and economic mobility which was no longer so easily accessible to low achieving school leavers. Students also required financial support for their education and many worked to support themselves for the duration of their course.

University learning has been accompanied by a shift in how learning to nurse is undertaken. University education emphasised the importance of theory. Students could no longer rely only on instruction from lectures as an approach to developing ideas and learning principles; they were expected to become self directed learners. The shift to university institutions meant that nurse education no longer placed a dominant emphasis on practical experience. Instead, simulations provided opportunities for developing aspects of practical nursing experience before students visit the wards for clinical practice.

There has also been a change in the role of the newly registered nurse. In essence a university education was intended to produce a nurse able to “provide responsible nursing care at a novice practitioner level in a range of clinical areas” (Bachelor of Nursing Department of Nursing University of Wollongong 1991). Whereas with the certificate program, the registered nurse was expected to be able to run the ward on graduation.

There has been a shift from nursing's traditional non-questioning approach to learning and work towards a university approach to questioning, criticism and argument. These
characteristics are regarded as positive for university students whereas they continue on the whole to be viewed negatively within the nursing profession (Smithers and Bircumhaw 1988).

It is evident that as nurse education has moved from hospital to tertiary institutions, there have been shifts in the way in which the nurse practitioner has been conceived. Such changes have required different approaches to the curriculum and pedagogy of nurse education and to the theories which have been drawn to inform them.

There has been a profound shift from what is arguably a traditional behaviourist approach to learning with an emphasis on observation, practical experience and reinforcement, to a more progressive approach drawing in part on the works of Dewey and Knowles. The examination of current learning theories demonstrates the necessity to re-shape concepts of adult education now that the transfer of formal learning from the hospitals to the tertiary sector has taken place. Malcolm Knowles' theory of adult education was taken up by some nurse educators and considered applicable to contemporary nurse education. His theory includes the use of experience, past and present which could be capitalised on through reflection, and the individual's self concept of being a self-directed learner. However, the use of Knowles' theory as adopted for this research was found to be problematic in the following areas.

Experience is fundamental to Knowles' approach to learning. Traditionally nurse education was learnt mainly through practical experience. The shift into the tertiary institution has reduced the practical experience in the wards and moved it into simulated experiences. This implies that students are less likely to have that depth of clinical experience that was possible in the hospital based system.

Second, Knowles' considers adults to be self-directed learners, who engage in learning because of their own “interest”. Nurses in the workplace however, have never been
permitted to be self-directed. Despite the shift into university institutions there is a limit
to the degree to which nurses in the workplace can be self-directing. In the past nurses
learnt what to do and how to engage in nursing practice, to a significant degree, through
their interaction with other nurses on the ward. Now nurses are expected learn how to
think about nursing and perform practices in an informed way from their university
experience. In the work place, once the nurse has made an assessment a nursing
problem, the procedure that the nurse must then follow is often by the rule. Most
procedures have an element of rule observance about them, and so the nurse cannot be
(in Knowles’ sense) totally self-directing. The new nurse is viewed as one who has
developed problem solving abilities with a heightened conceptual and reasoning ability.

Third, reflection is more implicit in Knowles’ theory than it is explicit. It is implied in
analysing how one thinks about past learning experiences and present learning
experiences. Knowles’ idea of reflection resembles to some extent Dewey’s notion of
reflection on experience, which viewed experience as separate from ideal knowledge
and engaged in by an active individual. Nurses were traditionally taught knowledge as
“truth” to be applied in practice. Current university nursing teaches nurses ideal theory
to inform students knowledge base. Therefore, for nurses, the reflection on experience
that occurs in clinical practice would be directed towards making a link between their
objective and subjective knowledge. It might also involve reflection on social practices
within the clinical environment. There seems to be a tension between these two foci of
reflection.

And lastly, although Knowles and other theorists claimed that learning is important to
allow people to participate more fully in a democratic society, empirical data suggests
that nurses’ relationships within the hospital hierarchy did not encourage democratic
involvement in the workplace. Traditionally, nurses have been controlled by explicit
and implicit rules. Within modern institutions and organisations all people, administrators or professionals—whether doctors or nurses—must still work under these conditions.
From a review of learning theories and how nurses have historically learnt to nurse it is very clear that “experience” is a complex term. A shift in the underlying philosophy of nursing education has occurred which recognises that practical experience alone is inadequate to produce an innovative and questioning approach to nurse education. This shift is accompanied by the necessity to integrate theory, particularly researched based theory, into the practice of patient care as opposed to relying on past practices.

The mapping of changes in nurse education and the learning theories which informed them was empirically investigated by interviewing eighteen registered nurses, twelve certificate qualified nurses with hospital-based training only, and six tertiary qualified nurses, of whom four had both certificate and diploma, degree qualifications, with both hospital based and university experience, and two graduates with diploma, degree university experience only.

The main concern that emerged from the data was that learning to nurse requires a more appropriate blending of theory and practice than has occurred in either system to date. Nurse interview data supported the idea that theory is important in understanding practice. It also suggested that nurses require appropriate experience in order to understand theory. However, for effective learning, experience needs to be practical rather than simulated experience; in that almost all of the informants agreed that the use of the senses was integral to effective practical learning. One way in which the practical component of nursing could be increased is through additional time at the end of the formal program. This is a feature of other professional groups such as teachers and doctors.

The second theme that emerged form the interview data was that, in the process of learning how to be a nurse, the explicit and implicit social and power relationships of the hierarchical structure influenced at all times how nurses performed their duties. The nurses' status was such that duties were performed in an obedient and subservient
manner. However, in contrast to this they retained perceptions of themselves as professional.

From the examination of all the sources of data, historical, interview and educational theory it would appear that the expectations for the student nurse and working nurse are different. This is a potential source of tension when students enter the workplace. The data suggest that the practising nurse experiences this tension.

The academic view of the nurse is one of an autonomous practitioner. Within the workplace environment, however, the work of the nurse follows the same pathway that it has done traditionally, but it is much more technologically sophisticated in the present day. It is clear from this study that learning both theory and practice are important for practising nurses. However, consideration about theory is needed in relation to the amount that is required, how it is taught, and the purpose for which it is learnt. In particular learning theory needs appropriate practical experiences to assist student learning and understanding. From these interviews students were concerned with the quality of theory which related to the basic biological sciences and could be related directly to work practices. However, the nurse in the work environment continues to be positioned as a doer of patient care. The learning of more theory has not helped the nurses to be more valuing of the knowledge which comes from practice. The respondents showed little interest in a large quantity of theory, and were not interested in more abstract theories like nursing theories. This also makes using reflective practice and critical theory somewhat difficult, which many nurse academics and theorists consider to be important.

Psychological theories create an ideal image of the nurse, which seems to operate as some sort of incentive to encourage commitment. From the data nurses do not appear to lack incentive about learning nor about their work, but are constantly viewing knowledge from their particular context. The examination in this thesis has provided a
view to understanding why the transfer of nurse education from the hospital system into university institutions has received so much criticism from many students and practising nurses and from some members of the health profession.

In order to remedy the situation there needs to be a recognition that andragogy needs to be based on clearer conceptions of experience, reflection and knowledge. There is a need for educators to help students develop ways of understanding the difference between the rhetoric of the university and health care system.
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