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Technological change in nurse education as a professionalisation strategy

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Technological Change in Nurse Education as a Professionalisation Strategy

A thesis submitted in fulfilment of the requirements for the award of the degree of

Doctor of Philosophy

from

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by

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1996.
This work has not been submitted for a degree to any other university or institution.

Peter. G. Thomas.
I wish to thank my wife and children for their understanding about the number of weekends and evenings over the years when I could not be with them.

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Abstract

The transfer of basic nurse education to the tertiary sector in New South Wales brought about major changes to the philosophy, content and presentation of the educational preparation of registered nurses. From a simplified biomedical model of illness which promoted the nurse's role as doctor's assistant, a new nursing educational technology has emerged which emphasises a holistic model of wellness, nursing independence and professionalism. While there are valid educational reasons for this transfer of nurse education, a far more important rationale of the nursing leadership of this country for their continued support of this move is their desire to professionalise nursing. This professionalisation of nursing cannot succeed because it is based upon the false premises of a modified trait approach to professions and technological determinism as a mechanism of professionalisation.
### Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declaration</td>
<td>i</td>
</tr>
<tr>
<td>Acknowledgments</td>
<td>ii</td>
</tr>
<tr>
<td>Abstract</td>
<td>iii</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>iv</td>
</tr>
<tr>
<td><strong>Chapter</strong></td>
<td></td>
</tr>
<tr>
<td>1. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>2. What is a Profession?</td>
<td>9</td>
</tr>
<tr>
<td>2.1. Introduction</td>
<td>9</td>
</tr>
<tr>
<td>2.2. Early Trait Approaches to Professions</td>
<td>12</td>
</tr>
<tr>
<td>2.3. The Professionalisation of Medicine</td>
<td>16</td>
</tr>
<tr>
<td>2.4. Other Sociological Perspectives on Professionalism</td>
<td>22</td>
</tr>
<tr>
<td>2.5. Conclusion</td>
<td>33</td>
</tr>
<tr>
<td>3. A History of Nurse Education in New South Wales</td>
<td>35</td>
</tr>
<tr>
<td>3.1. Early Nursing</td>
<td>35</td>
</tr>
<tr>
<td>3.2. The Nightingale Myth and its Problematics</td>
<td>37</td>
</tr>
<tr>
<td>3.3. Nursing in New South Wales</td>
<td>43</td>
</tr>
<tr>
<td>3.4. The Influence of Overseas Changes to Nurse Education</td>
<td>58</td>
</tr>
<tr>
<td>3.5. Conclusion</td>
<td>61</td>
</tr>
<tr>
<td>4. Professionalisation and the Sociology of Nursing</td>
<td>62</td>
</tr>
<tr>
<td>4.1. The Nurse-Doctor Game</td>
<td>62</td>
</tr>
<tr>
<td>4.2. Gender and Subservience</td>
<td>67</td>
</tr>
</tbody>
</table>
6.6. The State Government's Reasons for the Tertiary Transfer 151
6.7. The Role of the C.A.E.s 154
6.8. Opposition to the Tertiary Transfer 155
6.9. Conclusion 157

7. Nursing's Covert Reasons for the Tertiary Transfer 159
7.1. Tertiary Socialisation Reexamined 159
7.2. The Encouragement of Professional Attitudes 161
7.3. Other Professional Traits and Tertiary Education 163
7.4. The Boundaries of Nursing 164
7.5. Increased Status and Increased Remuneration 169
7.6. A Two Tier System of Nursing 173
7.7. Empowering Nursing 176
7.8. Nurse Teacher to Nurse Academic 181
7.9. Conclusion 184

8. The Consequences of the Transfer 186
8.1. A Liberal, Multi-Disciplinary Nurse Education 186
8.2. Integration of Theory and Practice 189
8.3. A "Comprehensive" Educated Graduate Nurse 190
8.4. Clinical Practice 191
8.5. Technology and the Graduate Nurse 193
8.6. Graduate Clinical Competency 195
8.7. Employment Opportunities for Graduates 197
8.8. Entrants into Nursing 199
8.9. Costs of Nurse Education 199
8.10. Problems with Nursing Professionalisation 200
8.11. Nursing Boundaries 204
8.12. Financial and Status Benefits 205
8.13. Nurse Academics 206
8.14. Consequences of an All Trained Workforce 209
8.15. Conclusion 210

9. Analysis of the Transfer 212
  9.1. Technological Determinism 215
  9.2. Technological Determinism and Nurse Education 216
  9.3. Nursing Indeterminacy 225
  9.4. Freidson's Analysis of Paramedical Occupations 229
  9.5. Professionalisation and Patriarchy 233
  9.6. Conclusion 236

Bibliography 239
Chapter 1

Introduction

Since 1985, beginning with New South Wales and subsequently throughout the rest of Australia, there have been dramatic changes in both the basic and the post basic (or postgraduate) education of registered nurses. Prior to 1985 the vast majority of entrants into nursing underwent a three year apprenticeship-style training in general nursing (i.e., medical-surgical nursing) in hospital schools of nursing, leading to the award of a nursing certificate. Post registration or post basic qualifications in nursing specialities involved undertaking either additional certificate training courses in hospitals or short duration academic courses through such institutions as the New South Wales College of Nursing.

With the transfer of nurse education to the tertiary education sector, initially in colleges of advanced education and then as a consequence of amalgamation to universities, nursing students underwent a three year diploma course in a 'comprehensive' range of nursing disciplines. This course was subsequently upgraded to a three year bachelor's degree. Conversion courses were established for hospital trained registered nurses to update their qualifications. Postgraduate courses in nursing specialities, general nursing and research have proliferated. These changes not only involve the acquisition of tertiary credentials but, more importantly, involve fundamental changes in what is taught in nurse education. No longer are nurses taught a simplified biomedical model of illness (cure). Instead they are taught a holistic, nursing model of wellness (care). The technological emphasis and the terminology of nursing education has greatly altered.

Technology means more than the popular conceptualisation of hardware consisting of equipment, tools and machinery. It is far more than a set of physical things, encompassing a complex relationship of knowledge, ways of doing things, equipment and social interactions (MacKenzie and Wajcman, 1985: 3-4). Technology can be defined as "any systematised practical knowledge, based on experimentation and/or scientific theory, which enhances the capability of society to produce goods and services, and which is embodied in productive
skills, organisation, or machinery” (Gendron, 1977: 23). Similarly, Perrow states that "equipment is a tool of technology, but technology rests upon knowledge ... (and) ... hence technology was found to be a unique combination of software, that is, the knowledge and procedures which enabled the hardware to be driven effectively" (Brewer, 1983: 10, 13). The transfer of nurse education to the tertiary sector permitted changes to the technology of nurse education which were not possible within the hospital setting. Changes in nursing knowledge and ways of doing things are aimed at changing the social interactions of nurses with doctors and others. They are aimed at professionalising nursing.

In December 1994 the Federal government released the report Nursing Education in Australian Universities, the Reid Report, which examined the impact of the last decade of changes in nurse education. The report formally acknowledged that one of the major rationales for the tertiary transfer of nurse education was to "enhance both the status of nursing and the career opportunities for women" (Reid, 1994: 2). This is consistent with my argument in this thesis that tertiary based nurse education is a professionalisation strategy aimed at increasing nursing's occupational control over its work. The report also stated that "a culture of higher education and continuing education has come to be one of the features of nursing, providing the basis for deepening professional development" (Reid, 1994: 11). However, it also noted that "the growth of career opportunities has fallen behind the growth in education" so that there was an oversupply of newly graduating comprehensively prepared nurses, while those new graduates who found employment faced a stormy 'rite of passage' (reality shock or a theory-practice gap) (Reid, 1994: 5, 7, 11). Perhaps it might be more appropriate to reverse the emphasis of the above claim to one which argues that the growth of university based nurse education has outstripped the existing work opportunities for registered nurses. This suggests that tertiary based nurse education has its own agenda which is somewhat divorced from the needs and realities of nurses and nursing in the Australian health care context and has resulted from a lack of consultation between university departments of nursing and employers.

While overall the report expressed satisfaction with the state of tertiary based nurse education in Australia, it made several brief comments that illustrate some of the continuing problems of university based nurse education. The report acknowledged a widespread concern
about the insufficient and inappropriate clinical preparation of student nurses, with employers critical of graduates' clinical and generic work organisation skills, and their starting competencies (Reid, 1994: 4). However, I will argue in greater detail later in this thesis that the brevity of these stated concerns grossly de-emphasises their true importance in countering the educational rationales for the transfer of nurse education to the tertiary sector.

The rationale for change to nurse education has been given as the desire to improve the 'skills' and adaptability of registered nurses so that they can deliver better and more effective nursing care to their patients. While there is an element of truth in this, I argue that the principal nursing motivation for such changes to nurse education, which is hoped ultimately to lead to changes in nursing practice, is a continuing desire to professionalise nursing in order to make nursing different from, but equal to, medicine. This thesis examines the motivations behind, the strategies for, the consequences and achievability of such a nursing professionalisation process.

Willis argues that Australian nurses have abandoned professionalisation as an occupational advancement strategy in favour of trade unionism (Willis, 1994: 17-18). This thesis does not support this argument. Since its peak in the late 1970s and early 1980s, nursing union militancy has declined, especially in New South Wales (Dickenson, 1993: 283-284). Nurses do not even call their industrial organisations by that name, but instead name them associations or federations, just as doctors do. Professionalisation through tertiary education has continued to be a major topic in the nursing literature and among the nursing leadership. Patricia Staunton, a former General Secretary of the New South Wales Nurses Association, argues that Australian nurses have probably placed too great a reliance on professionalisation as an occupational advancement strategy, stating that "I had certainly taken the view ... that the Federation had taken too strong an emphasis on professional issues and lost sight of the industrial realities in which nurses work" (Tattam, 1995: 35).

Among bedside registered nurses, clinical nurse specialists and nurse consultants are the groups that have achieved the most occupational advancement, as measured by significant salary increases. Their rewarding position resulted not from union militancy but rather as a consequence of their possession of tertiary nursing qualifications, especially at the
postgraduate level. Hence, trade unionism should be seen as an adjunct to and not an alternative strategy to professionalisation in the promotion of occupational advancement. Doctors are viewed as professionals, yet specialist doctors in public hospitals have undertaken what is, in effect, strike action in order to achieve financial benefits. If doctors can be both professional and militant, then it is not surprising that nurses may copy both strategies for their own benefit.

In order to understand the changes to nurse education in New South Wales it is necessary to define the term profession. An examination of the concept of a profession and the supposed mechanisms of professionalisation demonstrate many different views on these subjects. Nursing's approach to professionalisation is still dominated by the trait approach to professions and is consistent with the early work of sociologists of occupations. The trait approach emphasises a unique body of nursing knowledge, autonomy, professional culture and ethics. Typically, these attributes are depicted as most likely to be attained in the university setting. Such a simplistic approach to professionalisation runs counter to the later work of sociologists such as Freidson, Foucault, Johnson, Collins, Turner and Willis who offer much more complex, interactionist interpretations of professionalisation involving politics, patronage, domination, power and gender. The work of these researchers challenges nursing's approach to professionalism and points up a number of significant flaws in nursing's perspective on the professionalisation process. Yet the nursing literature continues to present the argument that nursing is advancing along the professional-non professional continuum and that continued promotion of nurse education will ultimately lead to a professional nursing.

The motivations of the nursing leadership ¹ for changes to nurse education are partly explained by a historical perspective of nursing involving an examination of its feminine roots, the influences and legacies of Florence Nightingale, the history of nurse training in New South Wales (involving, as it does, significant medical input and regulation), the influence of

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¹ The nursing leadership in Australia and in most other countries consists of the most vocal and active nurse educationalists, union leaders and authors (Wuest, 1994: 359 and 361). This elite derives its voice and power from the fact that "the active members who serve on committees and hold office are a minority of a minority" (Kelly, 1991: 5). This minority both controls nursing journal editorialship and publishes in the nursing journals. The infrequently voiced opposition from within nursing to changes in nurse education and other important nursing issues, speaks out against the elite leadership of nursing which claims to speak for all nurses, but in fact, is concerned more with its own particular needs and agenda (Styles, 1987: 229; Draper, 1990: 361; Salvage, 1988a: 517-518; Salvage, 1988b: 1553).
other Australian states, and the impact of other countries, especially the U.S.A. A discussion of selected aspects of the sociology of nursing as relevant to professionalisation will help to clarify the nursing motivations for change, and the ways in which nurses perceive that tertiary based nurse education will alter important aspects of the social relationships of nursing, especially those related to nurse-doctor relationships. These social aspects include the 'nurse-doctor game', gender and subservience, men in nursing, the image of nursing, hospital socialisation and tertiary based socialisation.

The major strategy aimed at clearly separating the practice of nursing from the practice of medicine is the new technology of nurse education which will, it is hoped, subsequently have a flow on effect on nursing practice. I will argue that the theoretical basis, content, methodology and extent of nurse education have changed as part of a nursing strategy to eliminate or, at least, minimise the influence of medicine on what nurses are taught. The demarcation of medical knowledge from nursing knowledge is expected to eliminate the subservient relations that nurses traditionally tended to develop towards doctors during their training. Rather than teaching a watered down version of medicine which emphasised the nurse's role as a doctor's assistant, university based nurse education could seek to develop a type of nursing that demonstrated the separateness, uniqueness, independence and scientific basis of nursing. In order to achieve this, it was necessary to alter the technology of nurse education. The development of various nursing theories, the nursing process, nursing diagnoses and the promotion of nursing research all attempt to remove nurse education and nursing practice from the control of medicine. The establishment of a uniquely nursing knowledge, it is assumed, will make nurses the equals of doctors in providing health care and will promote the professionalisation of nursing. Nurses want an independent or at the very least interdependent collegial role with doctors rather than their traditional dependent role. Attempts are being made in tertiary based nurse education and research to develop a scientific justification for independent nursing practice and autonomous nursing behaviour.

Prior to 1985 there were many problems with the training of nurses in New South Wales. A number of different remedies could have been tried to overcome these problems, but the nursing leadership instead publicly promoted just one option by giving a plethora of
educational reasons (overt arguments) for the desirability of placing nurse education in the tertiary education sector. However, the nursing literature of this period also gives numerous instances of non-educational reasons (covert arguments) for such a transfer, principally its promotion as a mechanism for advancing nursing professionalisation.

The changes to nurse education have had many consequences. Generally I argue that there is little evidence to support the proposition that it has advanced the capabilities of registered nurses or has helped to professionalise them. For most nurses these changes have had little effect, and what effect that there has been, has been problematic, with some small benefits countered by drawbacks. For instance, tertiary qualifications have led to pay rises for some registered nurses, but it has also made them more expensive to employ and has contributed to reduced employment opportunities for new graduates. Possible beneficiaries of changes to nurse education might be small numbers of nurses in the community setting and in specialised units in hospitals where an expanded nursing role is emerging. The seeming increased independence of these nurses might appear as an important component of professionalisation. To date, the only real winners among nurses have been nurse academics who have achieved professionalisation as a consequence of the transfer of nurse education to the tertiary sector.

My analysis of the reasons for the failure to successfully professionalise nursing through changes to nurse education shows that such an attempt was fundamentally flawed. It was based upon a number of false assumptions, disregard for the practical realities of institutional-based nursing and the observations and experiences of ordinary nurses, and inappropriate strategies. The changes to nurse education reflect a technological determinist perspective by the nursing leadership (MacKenzie and Wajcman, 1985: 4-25; Willis, 1994: 19-20). They have uncritically assumed that the dominant position of medicine in the provision of health care is an inevitable consequence of medical technology which involves medical knowledge, diagnostic techniques, medical interventions, terminology and control of technical equipment. This medical technology is viewed as giving doctors power over patients and other members of the health care team. It is assumed that if nursing can develop its own unique nursing knowledge, diagnostic techniques, nursing determined interventions, terminology and
use of low technology equipment, then nursing can be empowered, escape the domination of medicine and promote itself as a profession equal to, but different from, the medical profession. I argue that such an approach is doomed because it ignores the complex interplay of social, political, economic and gender factors which enabled medicine to professionalise. The work of Freidson and Willis shows that there can only be one true profession in an occupational grouping such as health care delivery and medicine's dominant professional position requires the continued subordination of the semi professions such as nursing.

While it is not possible to professionalise most aspects of nursing work, nevertheless, changes to nurse education will continue to be promoted because it is of benefit to the professionalised nurse academics and it is possible that such emergent nursing elites as independent nurse practitioners might also benefit from such changes. However, there exists the possibility that over time, a distinct division may emerge within nursing with the development of an elite of specialised 'professional' registered nurses possessing higher degree academic qualifications and far more numerous generalist 'occupational' registered nurses with only a minimal basic degree. If this occurred, the transfer of nurse education to the tertiary sector might have done more to fragment and harm nursing than to benefit it.

This thesis involves research and analysis of the relevant literature from both nurses and non nurses in New South Wales, within Australia and from overseas, notably the U.S.A. and England. In the chapters on professionalisation and nursing sociology, which help to set the scene for my analysis of the tertiary transfer of nurse education in New South Wales, it is possible to compare and contrast the written ideas and interpretations of nursing and non nursing authors.

The thesis, examines the causes and effects of this tertiary transfer of nurse education, drawing upon both primary and secondary literature sources. The primary documentation used include the reports, submissions and statements of goals from nursing bodies, associations, unions and special interest groups, from government departments, committees of inquiry, nurse education curricula from schools of nursing and tertiary institutions, and editorials and reports of officials in such major Australian nursing journals as
**The Lamp** and the *Australian Nurses Journal* (the official journals of the two Australian nurses associations).

However, often the information relevant to my arguments in this thesis comprises only a small part of these individual documents, though repetition in a number of documents and over a number of years tends to highlight their true importance. Therefore, it is useful to utilise a number of secondary literature sources where nursing authors, writing in both nursing journals and books, have identified and discussed many of the issues that I bring together in this thesis. It is important to recognise that articles published in nursing journals have passed the scrutiny of editorial boards, which are often made up of members of the nursing leadership. The comments in these articles on tertiary based nurse education are most likely to be seen as acceptable to the nursing leadership and may often represent a more open discussion of the thoughts and motivations of the nursing leadership than was freely expressed in the primary documents, especially the official reports and submissions. With hindsight motivations which were nebulous at the time of a primary document, such as a submission to a committee of inquiry, may have had time to crystallise and be more clearly expressed in the words of a secondary source.

By bringing together these various sources of information into this thesis I intend to develop a comprehensive description and analysis of the tertiary transfer of nurse education in New South Wales with its significant shift in the technology of nurse education.
Chapter 2

What is a Profession?

It is important to address the question, "What is a profession?", because the professionalisation process is the main strategy employed by the nursing leadership for the purpose of occupational advancement and it is central to nursing's demands for ever more university based education at both the undergraduate and postgraduate levels. I will argue that the drive towards nursing professionalisation has been directed by a modified trait approach to professions both because it was the most commonly accepted theory of professions during the critical period of an emerging nursing desire for advancement, and because it was seen by nurses as offering the most likely means of achieving these changes. This approach drove and, it can even be argued, distorted the subsequent direction of nurse education in the tertiary sector. The following sections argue that an uncritical acceptance of technological determinism as a major force in the shaping and reshaping of relationships in the workplace between nurses and doctors underpinned many changes in nurse education.

2.1. Introduction

The issue of the professional status of nursing is not new. It was being argued in the U.S.A. as long ago as 1900 (Robb, 1983: 16). The N.S.W. Nurses' Association has commented upon the irony of the situation in Australia, in that since early this century the various state nurse registration acts have made "provision for educational and registration requirements and disciplinary provisions on the basis of 'professional misconduct'" (emphasis added), while there is still a general perception that nursing is not professional (Staunton, 1989b: 9). However, for most of this century the debate was an obscure one, until the 1960s, when in the U.S.A. and later in Australia, the question of professionalism in nursing became prominent. The issue is still being debated today in nursing circles.

This thesis argues that a major factor in the recent move of basic nurse education into the tertiary education sector in New South Wales, and subsequently the rest of Australia, is the desire of the nation's nursing elite to attempt to emulate the aspirations of the American
nursing leadership to improve the professional status of nursing. Powerful groups of nurses, or at least certain specialties within nursing, want nursing to be seen by nurses, other health care providers and the general public as professional.

Because of the imprecision and confusing nature of the definitions of a profession, various nursing authors make different claims as to the professional status of nursing. American nursing authors most often refer to nursing as a (true) profession (Lynaugh, 1980: 266-270; Mason et al. 1991: 72-77). This is not surprising in a culture which tries to give professional status to such diverse groups as real estate agents and laboratory technicians (Wilensky, 1964: 138). Other nursing authors, especially in Britain and Australia, usually refer to nursing as an occupation which is not yet quite a profession but which with diligent effort over the next ten to twenty years could reach this goal (Chapman and Dickson, 1988: 32-33; Parkes, 1984b: 177-182). Only very infrequently do nursing authors state, or perhaps get the opportunity to publish, the view that nursing is not, nor can ever hope to be a (true) profession (an exception is Frem, 1984: 23-24).

Non nursing authors, notably sociologists concerned with occupations, such as Etzioni and Freidson, perceive nursing as a semi or para profession with some professional qualities but deficient in, and with little hope of ever achieving, a number of important professional attributes (Etzioni, 1969; Freidson, 1970b). Like many other occupational groups, nurses are seen to be seeking to make up these deficiencies in order to improve their status in Western society. Freidson comments that, "Virtually all self-conscious occupational groups apply it [the term professional] to themselves at one time or another either to flatter themselves or to try to persuade others of their importance" (Freidson, 1970a: 3-4).

The root of the word profession can be traced back to the Middle Age words "professio" and "profiteri" referring to a public declaration, an affirmation or an avowal (Styles, 1982: 14). This earliest meaning of the word profession was religious and subsequent adoption of the term by the secular occupations of medicine and law is seen as a deliberate attempt to draw upon the established authority and status of the church (Brown, 1986: 34-35). In the late

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2 The historical context of this desire will emerge in Chapter 3, *A History of Nurse Education in New South Wales*. Further discussion will occur in Chapter 7, *Nursing's Covert Reasons for the Tertiary Transfer*. 
nineteenth century "the title profession was used to establish the status of successful occupations; it became part of the official occupational schema in the United States and England" (Miller, 1985: 22). *The Concise Oxford Dictionary* defines profession as "a public declaration; the occupation one professes to be skilled in and to follow, or a vocation in which a professed knowledge of some department of learning or science is used in its application to the affairs of others or in the practice of an art founded upon it" (*The Concise Oxford Dictionary*, 1990: 952).³

From this working definition of a profession, certain key words and concepts emerge which traditionally many authors, and especially nursing authors, have been quick to seize upon as the essential components of any profession, whether it be an existing one or aspiring one. In particular, the concepts of "skill", "knowledge" and "science" have been critical in shaping arguments for changes to nursing and nurse education.

In looking at the idea of a profession, a difficulty arises in trying to determine which occupations fulfil the definition of a profession. Traditionally, much debate has centred on distinguishing between professions and non professions using sets of discriminating attributes or variables. While more recent commentators on occupations have developed different approaches to professions, the attribute models of professions predominated during the 1960s and 1970s when, in the U.S.A. and to a lesser extent in Australia, there emerged increasing agitation in the nursing literature, at nursing conferences and workshops and amongst the nursing leadership for radical changes to the preparation and role of registered nurses. Over 850 references to describe a profession have been noted by Mok, yet there is little if any consensus amongst the various authors who adopt this approach (Mok, 1973: 107). Perhaps the best way through this confusion is to look at the problem from a historical perspective.

³ The idea of profession encompasses much more than just this concrete description, for it also implies some abstract concepts, in that: "it is an indication of value and prestige" (Chaska, 1978: 104). The word profession is not only descriptive, but is also evaluative (Freidson, 1970b: 3).
2.2. Early Trait Approaches to Professions

In 1915 Dr. Abraham Flexner constructed a set of professional criteria based on his observations in America of the occupations of medicine, law and the clergy.\(^4\) He argued that these three occupations had sufficient public support to be granted special rewards, including reasonably high status and remuneration, for their perceived public services. Superficially, it seemed to be self evident that there were certain common defining characteristics which both united these three professions and served to demonstrate their important differences from other occupations.\(^5\) This trait approach supposes that possession of the traits themselves results in the special position of the professions within society. As new occupations have emerged and developed, or old occupations have changed their activities these criteria have often been used as a basis for judging whether an occupation is a profession. Flexner's six characteristics of a profession were:

1. It is essentially intellectual, carrying high responsibility;
2. It is learned in nature, being based on a body of knowledge;
3. It is both practical and theoretical;
4. It is taught through educational discipline;
5. It is self organised;
6. It is altruistic.

(Flexner, 1915: 576-581).

In 1933 Professor A. M. Carr-Saunders and P. A. Wilson, in their study of British occupations, identified a similar list of characteristics defining a profession. Their most important criterion was a rigorous, lengthy study in the basic sciences and humanities. They

\(^4\) Flexner had issued a report in 1910 on the sorry state of many American medical schools (Dolan, 1978: 260-261). Considering that insufficient time had elapsed for the effects of his recommendations to have permeated throughout American medicine, it could be argued that Flexner's professional criteria reflect his ideal for medicine rather than his observed reality. Early views on professionalism reflect consensus on what professions ought to be, as opposed to what they were (Styles, 1982: 27).

\(^5\) These defining characteristics, in separating these professions from other occupations, both justified their privileged positions in society and helped to restrict competition for the delivery of their services (Pensabene, 1980: 133). Such obvious attributes also meant that it was not necessary to examine further as to whether there were other factors which had led to the existing preferential position of these professions within society.
also included the supply of a skilled service or advice for a fee or salary, the formation of professional associations and a code of ethics governing standards of conduct (Carr-Saunders and Wilson, 1933). In their definition they were inevitably binding the preparation of professionals with universities since it was commonly perceived that it was in such an environment that complex knowledge was imparted, that reasoning skills were developed, that independence was fostered and that enhanced concern for the betterment of society and a sense of belonging to a highly motivated group were inculcated (Styles, 1982: 18-19; Duespohl, 1983: 3-8).

Sociologists have developed their own lists of the desired attributes of a profession, creating a veritable morass of conflicting criteria. In the late 1950s and 1960s a consensus approach emerged with several authors attempting to survey the literature to try to find commonly accepted characteristics. In 1957 Greenwood distinguished five commonly accepted attributes of a profession. In a significant change in emphasis, these attributes were no longer assumed to be distinct to professions but, rather, were evident to a greater degree within professions than in non professions. His five attributes were:

1. A systematic body of theory;
2. Authority acknowledged by the clientele;
3. Broad community sanction;
4. Relations regulated by a code of ethics;
5. Professional associations and culture.

(Greenwood, 1957: 45).

In 1960 W. J. Goode extracted two commonly cited 'core characteristics' of a profession from which he claimed a number of other frequently cited attributes were derived. These core characteristics were "a prolonged specialised training in a body of abstract

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6 Carr-Saunders and Wilson were amongst the first authors to acknowledge the importance of the professional association in professionalisation (Pensabene, 1980: 99). The unity resulting from a single, vocal representative body gave professions considerable leverage in their dealings with the state and other occupations (Cockersham, 1986: 154).
knowledge, and a collectivity or service orientation" (Goode, 1960: 903). Goode typifies a functionalist approach to professions, in which a functional relationship between the professions and the wider society is implied. The superordinate position of the professions is a reward by society for the provision of important services to society, and the ability of the professions to provide these necessary services is a consequence of their possession of such traits as a specialised knowledge base and a service orientation (Johnson, 1972: 23).

An important component of the trait approach to the study of professions is that professional preparation involves considerable duration of study of highly complex and esoteric knowledge. Goode specifically excluded nursing as a profession arguing that its training was no more than a "lower-level medical education" with the bulk of what was taught being specified by medicine (Goode, 1960: 903). There is "an ubiquitous assumption in writings on professions ... that a profession has an essential underpinning of abstract principles which have been organised into a theory, set of theories, or at least a complex web of theoretical considerations" (Jackson, 1970: 26). Both Greenwood and Goode, along with other contemporary authors, blurred the separation of the established professions from a number of other occupations. There was no longer a distinct break between the professions and the non professions. In producing a new set of defining characteristics of a profession, the way was opened for an increasing number of occupations to aspire towards some sort of professional status. Many of the early claims and goals for nursing professionalisation from the 1960s and 1970s draw upon the ideas of Greenwood, Goode and other similar authorities (Duespohl, 1983: 3-13; Moloney, 1986: 5-16). With the increasing availability of university or tertiary education, it seemed possible that some of the widely accepted important defining characteristics of a profession increasingly could be met by nursing.

The above lists share the notion of a trait or characteristic or taxonomic approach to identifying a profession based on the characteristics of the older 'established' professions such as medicine and law. This checklist approach enables sociologists and members of an occupation to determine where on the professional-non professional continuum an occupation lies.
For example:

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Nursing</th>
<th>Labouring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>Continuum</td>
<td>Non Professional</td>
</tr>
</tbody>
</table>

Since "the true difference between a professional and a non professional occupation is not a qualitative but a quantitative one", a list of traits offers a convenient goal for aspiring professions (Greenwood, 1957: 45). The more an occupation fulfils the criteria of a profession, the further it moves along the continuum towards true professionalism.

Nursing has adopted a modified trait approach in its pursuit of professionalisation. I have used the term "modified trait approach" because over time, nursing's drive towards professionalism has come to incorporate, in addition to Greenwood's original list, the important concept of autonomy as an essential requirement of a profession. However, the idea of professional autonomy has been uncritically added to nursing's ideology of professionalisation. Autonomy is seen as both a defining characteristic of a profession and as an important benefit deriving from professionalisation. I argue that nursing has recognised the significance of Freidson's comments on occupational self-regulation, but has ignored the mechanisms by which autonomy is attained (McCoppin and Gardner, 1994: 47). Nursing perceives autonomy as recognition by others, including the state, that an occupation has a special knowledge base which entitles it to self-regulation, while ignoring the complex interplay of factors which led to medical autonomy.

There are obvious problems with the trait approach to professions. It has already been noted that sociologists have been unsuccessful in reaching agreement on a fixed list of attributes. Sociologists claim different occupations as fully professionalised, with one sociologist's list of attributes likely to exclude occupations which are accepted as professions by other sociologists. Of course, for aspiring professions such as nursing, this means that they can be selective in just whose list of traits they choose to emulate. Professionalising occupations would tend to pick attributes which best suit their goals while rejecting unsuitable, but perhaps equally valid, lists of traits.
The major problem with the taxonomic approach to professions is that it is ahistorical, ignoring the actual history of the emergence and consolidation of power and status of the existing professions. The early sociologists of occupations and most professionalising occupations uncritically accepted the professions' own idealistic versions, the hagiographic approach or the 'mythic status', of their early histories (Johnson, 1972: 25; Hicks, 1982: 69-81; Lloyd, 1994: 14-15; Larson, 1990: 24-25; Freidson, 1986: xi; Freidson, 1994: 19-20). Turner wrote that, "Professional bodies, rather like whole societies, legitimize their social power by developing historical accounts of their emergence which emphasise their altruistic contribution to mankind" (Turner, 1987: 12). In order to appreciate why more critical sociologists tend to consider the nature of professions as having more to do with occupational control than with particular attributes or functions it is necessary to examine the professionalisation of medicine.

2.3. The Professionalisation of Medicine

The simplistic and conventional explanation of the professionalisation of medicine presents a direct cause and effect relationship between the development of esoteric medical knowledge and the professionalisation of medicine (Shryock, 1969). It suggests that as medical knowledge expanded and permitted increasingly effective interventions for treating and curing illnesses, so doctors were granted, by the government and general public, increasing prestige, remuneration and autonomy as a just reward for their valuable, public minded services. As medicine grew in sophistication it is depicted as inevitably developing into a profession. The growth of medical knowledge and the maturation of the technology of medicine determined the dominant professional relationship of medicine to the other health occupations and society as a whole. This growth of medical knowledge, with all its consequences, was closely linked to the strong association of medical education with research within the universities.

This conventional story of the professionalisation of medicine, with its elements of technological determinism,7 is important because it reflects the nursing leadership's viewpoint.

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7 In Chapter 9, Analysis of the Transfer I will discuss in much greater detail this relationship between technological determinism and recent changes to nurse education.
from the 1960s onwards of the professionalisation pathway which medicine had already successfully trod, and which presumably nursing could also follow. However, if, as many more recent sociologists of occupations have argued, this conventional story of medicine is deficient, then nursing's existing approach to professionalisation is flawed, and nursing may be prohibited from ever successfully professionalising (Freidson, 1970a: 79-84; Freidson, 1994: 115-117; Johnson, 1972: 89-90; Brutvan, 1985: 3-11). Hence, a brief examination of the more recent critiques of the history of the professionalisation of medicine is required in order to demonstrate both the complex interrelationships of the many factors involved in the professional elevation of medicine and (of particular relevance to nursing) the concurrent and deliberate subordination of other, potentially competing health care occupations to medicine as part of this process. Therefore, it is worthwhile briefly examining the beginnings of the professionalisation of medicine in medieval Europe, followed by events in the U.S.A. around the turn of the century, and, finally, the concurrent emergence of medical dominance in Australia. This discussion can only be a schematic introduction to the issues and does not pretend to be a detailed examination of the historiography of this subject.

The professionalisation of medicine began in the Middle Ages in Europe. Physicians, though not surgeons, had a strong association with universities. Medical care was ineffectual with little to no scientific basis for diagnosis and interventions (Siegal, 1968). While medical care was provided by physicians to the wealthy aristocracy, other male doctors faced strong and effective competition in providing health care services to the other members of society, especially from folk and herbal healers which included many female healers. While unable to provide a coherent argument as to why their services were superior to those of others, nevertheless, doctors were able to utilise the patronage of first the Church and later the State to progressively restrict the provision of services by others (Bullough, 1966; Ehrenreich and English, 1973: 6-20; Gordon, 1980: 166-182; Turner, 1987: 86-88; Derber et al. 1990: 54-55).

The principal mechanism enabling this was to define medical practice in law and to prohibit non-doctors from practising medicine. Politicians who helped to create this monopolisation for doctors gained an area of patronage under their disposal and ensured political support from doctors (Collins, 1979: 179-181). There is a strong degree of
interdependence between the state and professions with recognition of professions and granting of professional autonomy dependent on state sanction. In return the state becomes dependent on the professions to provide the necessary services which are part of its public policies (Johnson, 1982: 189-191; Daniel, 1990: 49-51, 92-94; Crichton, 1990: 11-23). Thus, state support for the medical monopolisation of health care services ensured reciprocal medical support for the provision of increasing amounts of health care dictated by public policy.

Due to the patronage system male doctors were beginning to develop a patriarchal domination of paid health care. In this context patriarchy can be defined as a society wide system of gender relationships, including division of labour, in which males dominate and females subordinate due to the institutionalisation of the exclusionary and segregatory practices of occupational closure (Dale et al. 1981: 197-198; Witz, 1992: 3, 11, 43-46).

Contrary to popular opinion, medicine has not always been granted professional recognition (Cockersham, 1986: 150-151; Pensabene, 1980: 177). One American doctor wrote in 1896 that it was "humiliating to make a comparison of the economic and social positions of our leading physicians and surgeons ... with leading lawyers and other professional men" (quoted in Markowitz and Rosner, 1973: 87). As late as the second half of the nineteenth century there was an oversupply of doctors, who were in competition with a number of other health care providers (Pensabene, 1980: 33). There was considerable disparity in the educational preparation of doctors and by no means was medicine exclusively associated with the universities. Particularly in the U.S.A., a university education was not the only avenue available to achieve a medical qualification. Medical 'schools' abounded\(^8\) and there was often a wide disparity of knowledge and skills amongst medical graduates. Some entrants into the more dubious schools were not even the equivalent of high school graduates (Styles, 1982: 17). It has been suggested that in nineteenth century America anyone with financial resources could obtain a medical degree and practise medicine (Cockersham, 1986:155). Such were the

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\(^8\) At the turn of the century there was a wide variety of forms of medical education; a situation similar to what has existed until much more recently in nurse education in both Australia and the U.S.A. (Kinsey, 1985: 28; Miller, 1985: 23). Medicine early on unified its professional preparation, while nursing is still in the process of doing so. But, if unification of medicine's educational preparation coincided with its increase in status, it is far too simplistic to assume, as many nurses have done, that the two are intimately related.
numbers of doctors being produced from various institutions that many doctors found it difficult to make a living solely from the practice of medicine (Styles, 1982: 17).

Members of the university trained elite did not like this competition, which also had the effect of reducing the public status of medicine because so many of these 'other doctors' appeared little different in social background, language and education from their patients (Rothstein, 1972: 108-109; Markowitz and Rosner, 1973: 83-107). Eventually an investigation was initiated and the Flexner Report of 1910 denigrated the standard of training of medical practitioners in the U.S.A. (Berliner, 1985: 92-127; Miller, 1985: 23). It strongly recommended that all medical training should take place in universities, and, when implemented, it led to much more rigid entry requirements and, it is claimed, a much more consistent and thorough level of training. In the U.S.A. in the 1880s there were approximately 400 medical schools, while by 1980 there were only 126 university based medical schools (Cockersham, 1986: 155-156). The major effects of this move were to greatly restrict the number of entrants into medical training (in a process of social closure), and also to raise the status of medicine in the public's eyes (Bullough and Bullough, 1983: 179). Implementation of the Flexner Report resulted in a significant reduction in the number of medical graduates, thus reducing competition amongst doctors and leading to better remuneration and increased status because doctors were to become a valuable but relatively scarce health care resource (Markowitz and Rosner, 1973: 89-98; Coburn, 1988: 439-440).

The American Medical Association (A.M.A.) was formed in 1847 to promote scientific medicine and, in particular, to agitate for the enacting of licensing laws to restrict medical practice to those deemed suitably qualified by the A.M.A. (Fishbein, 1969: 19-26; Conrad and Kern, 1981: 159-161). The A.M.A. acted as a coercive, unifying voice for doctors, and by promoting the enactment and enforcement of various Medical Acts, virtually eliminated medical competition, and placed its competitors in a subordinate and directed role to

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9 An additional effect was to greatly restrict the educational preparation for medicine to white, middle class males, similar to other university courses at that time and place. Medical schools for Negroes were closed and the proportion of female medical graduates fell even lower than previously (Markowitz and Rosner, 1973: 97; Ehrenreich and English, 1973: 33) Concern has been expressed over the possibility of a similar discrimination resulting from university based nurse education, because it is suggested that it might discourage working class and non white entrants (Salvage, 1988: 515).
medicine (Cockersham, 1986: 154). As a consequence, "Once scientific medicine offered sufficient guarantees of its superior effectiveness in dealing with disease, the state willingly contributed to the creation of a monopoly by means of registration and licensing" (Larson, 1977: 23). This created a "legally supported monopoly over practice" by medicine (Freidson, 1970b: 83). The A.M.A. also gained exclusive control of medical education in the U.S.A. through the Flexner Report (Fishbein, 1969: 893-899; Conrad and Kern, 1981: 162). The A.M.A. represented a powerful and unified voice which successfully promoted the scientific basis and effectiveness of university medicine (Shafer, 1968: 200-240). Medicine's competitors, such as nursing and especially midwifery, were never able to do this because they were not unified and could not provide a scientific legitimation for their work (Fishbein, 1969: 78, 361, 370). As a consequence, legislation by the state granted medicine an exclusive right to professional autonomy, and control of the other health occupations, i.e., 'medical sovereignty', primarily through registration acts which restricted what these occupations could do in providing health care (Starr, 1982: 13-21).10

The professionalisation of medicine in the U.S.A., while different in specifics, can be looked on as the model for the process in other English-speaking countries. For example, in Australia, professional status for medicine did not result directly and inevitably from increased medical knowledge. In reality, the state's recognition and formalisation of the dominant position of medicine in the delivery of health care occurred at a time when there was no clear evidence of the benefits of "scientific medicine" (Willis, 1988: 172). Increasing control of the standards of medical education and medical practice by the formation of medical associations fostered better community attitudes towards doctors (Pensabene, 1980: 99-119; Willis, 1989: 36-60). As the status of doctors improved governments were willing to make alterations to the medical acts granting the medical boards greater self-regulation or autonomy (Pensabene, 1980: 120-132; Willis, 1989: 69-81; Mackay, 1989: 277-301; Daniel, 1990: 92-94). The attainment of cultural (value-laden) authority led to social (legal or regulatory) authority (Lloyd, 1994: 15-

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10 As will be discussed in Chapter 3, A History of Nurse Education in New South Wales, medical control of the Nurses Registration Board gave medicine an effective control over the direction and content of nurse education, limiting the role of the registered nurse to that of doctor's assistant. Medicine has historically "been able to define the conditions under which it will recognise and legitimate other health occupations" (Willis, 1989: 3).
The granting of effectively monopoly powers to medicine enabled doctors to suppress and control the health care opposition (Pensabene, 1980: 133-146; Willis, 1989: 92-124). This legally enforced right for the exclusive provision of medically defined services increased the public's demand for doctors' services and resulted in increased status and remuneration for doctors. Hence, "accounts of the rise of the organised medical profession attribute its strength, [as] 'the most powerful trade union in the British Empire'" to medicine's restrictive and exclusive practices (Gillespie, 1991: x).

A complex pattern of political, cultural (including class and importantly gender), economic, as well as technological factors were involved in the professionalisation of medicine (Ehrenreich and English, 1973: 41-43; Short and Sharman, 1987: 197-200). However, medicine's increased social standing was simplistically attributed to medicine's exclusive association with universities, an increase in the length of training, an overall raising of doctors' abilities and a scientific basis for medical care (McCoppin and Gardner, 1994: 10). This acquisition by doctors of a double bachelor's degree from a university (Bachelor of Medicine and Bachelor of Surgery), was a forerunner of the widespread concern with occupational advancement through credentialism (Freeman, 1976: 197-199; Collins, 1979; Freidson, 1986: 63-91; Freidson, 1994: 113). Taken to its extreme, it has been argued that, this would lead to 'the professionalisation of everyone' as different occupational groups gain more, higher and longer academic credentials reflecting the development of a specialised knowledge base in their area of expertise (Wilensky, 1964).

Medicine, along with law and religion, had become exclusively associated with an elite system of prestigious university learning. Bledstein states that the "seminal institution within the culture of professionalism was the university" (Bledstein, 1976: 121). Each of these professions developed an exclusive body of knowledge complete with its own jargon and highly technical terms which were, and remain, largely unfathomable to the non-initiated. In medicine, as more and more knowledge was acquired about human physiology and illness, an increasingly longer and more specialised period of training was required. The knowledge base of medicine became more isolated from the commonly available knowledge of the lay public.
In 1913, M. M. Randle stated that, "The general esteem in which a vocation is held increases in direct ratio with the educational standards of that vocation" (quoted in Lynaugh, 1980: 266). An occupation which required years of dedicated study in areas of complex knowledge was perceived as deserving special recognition. As one writer put it, "Once the public had come to accept licensing and college training as guarantees of up-to-date practice, the outsider, no matter how well qualified by years of experience, stood no chance in the competition" (quoted in Walsh, 1977: 3). Bledstein states that, "The more elaborate the rituals of a profession, the more esoteric its theoretical knowledge, the more imposing its symbols of authority, the more respectable its demeanour, the more vivid its service to society, the more prestige and status the public is willing to bestow upon its representatives" (Bledstein, 1976: 94).

Medicine was seen to set the pattern for the need for years of study in universities to gain systematically the specialised knowledge base for professional practice (Freidson, 1970b: 288; Collins, 1979: 135-139). At the same time medicine was perceived to be consistently expanding its knowledge about illness through experimentation and research by its own practitioners and it was the university-associated teaching doctors who had the inclination, time and skills to carry out this research (Harvey, 1981: xv-xix). Medicine reinforced the idea that specialised research to expand a profession's knowledge base was associated with universities as centres of learning.

2.4. Other Sociological Perspectives on Professionalism

Because they are more critical of the actual historical development of the professions, alternative sociological perspectives of professionalisation disregard the characteristic or consensus views of professionalism and instead concentrate on the idea of conflict or occupational control as the central concern of professions. The work of Freidson in the early 1970s is significant as he was one of the earliest and most prominent sociologists to challenge the conventional ideology of professionalisation and the emergence of medicine as a profession. This occurred during the same period as the nursing literature in Australia and overseas was increasingly agitating for the professionalisation of nursing. Indeed, Freidson
looked at nursing as a prime example of a paramedical occupation seeking to professionalise and his comments on the strategies employed, difficulties, and inevitable failure of attempting to professionalise American nursing have been shown over time to be largely correct. Nursing has ignored most of his ideas, only, and inappropriately, incorporating his concept of professional autonomy as a professional trait without reference to his analysis of how autonomy emerged and is maintained in the established professions.

Freidson argued that the key distinction, the "irreducible criterion", between professions and non professions is professional autonomy. The professions have been deliberately granted autonomy to control their own activities by the state (Freidson, 1994: 173-175). Legislation has granted exclusive rights to each profession "to determine who can legitimately do its work and how the work should be done" (Freidson, 1970a: 72). The professions possess self-regulation which puts their activities outside the control of others. This autonomy includes technological or scientific autonomy, in that the profession is left to determine what are the 'scientifically acceptable' knowledge and practices required to implement the activities of the profession (Freidson, 1970b: 83; Freidson, 1986: xiii).

This monopoly of practice subordinates other potential contenders for the supply of the professional services (Freidson, 1994: 114-116). Thus, the emergence and continuation of medical autonomy requires the subordination of other health care occupations such as nursing. A major component of medical control over health care delivery is based upon medicine's traditional input into and control over the training of other health care occupations (Freidson, 1970a: 48-49). By controlling access to information, medicine retains control of decision making in health care delivery (Freidson, 1970b: 141, 144). This gives medicine a preeminent and definitive authority over illness and its treatment (Freidson, 1970a: 5). The attempts to remove medical input into nursing education, through the transfer of nurse education from the hospitals and into the tertiary education sector, may be seen as an attempt to challenge medicine's monopoly of health care knowledge.

The granting of professional autonomy is seen as a political process involving the protection and patronage of the state which has been persuaded that there is some special value to the profession's work (Freidson, 1970a: 72). The commonly cited characteristics of a
profession, such as a unique knowledge base, specialised education and ethical behaviour, are arguments useful to negotiate with and to persuade the public and the state to grant autonomy to the profession (Freidson, 1970a: 83; Freidson, 1970b: 135; Freidson, 1986: 3-4; Freidson, 1994: 170). It was argued that only the profession is knowledgable enough to judge the activities of its members and its ethical concern for society ensures that its actions will be in society's best interests. A university based education, a 'scientific' aura and knowledge phrased in abstract terms put the professions, such as medicine, in a stronger political position for persuading the state to give them a superordinate position (Freidson, 1970a: 51; Freidson, 1973: 29-30; Freidson, 1986: 3). The so-called traits of a profession are secondary to the actual political process of professionalisation - this is the critical point that the nursing leadership fails to recognise in its pursuit of professionalism.

In examining the semi professions, Freidson stated that the paramedical ranks are ordered by their length and type of training, with longer and stronger tertiary links correlating with a higher position in the division of labour (Freidson, 1970a: 54-55). The para professions, such as nursing, seek to improve their status and ranking by creating the same institutions as the established professions, including a university based education, the development of abstract theories and the promotion of a code of ethics (Freidson, 1970a: 76). Freidson argued, however, that the enthusiastic adoption of the trappings of a profession will not allow aspiring professions successfully to professionalise because there can be only one dominant profession in any occupational setting (Freidson, 1994: 116). Thus, nursing cannot successfully professionalise because nurses will remain subject to doctors' orders in the hospital setting, with nursing work performed at the request or order of doctors (Freidson, 1970a: 57; Freidson, 1986: 165; Freidson, 1994: 115-117). Much of the change in nurse education seems to be aimed at escaping this medical domination by establishing the professional recognition of nursing in the community setting, with nurses in an independent role removed from medical contact (Freidson, 1970a: 69; Freidson, 1994: 117). However, the seeming autonomy of such new nursing categories as independent nurse practitioners and independent midwives is largely illusory because the scope of their work is carefully limited by legal regulations which, amongst
other functions, help to protect medicine's dominant position (Freidson, 1984: 14; Freidson, 1986: 188).

Freidson argues that the term 'professional' has become so widely used and misused that it reveals 'analytical diffuseness' which relates more to job classifications than to the nature of the occupations themselves (Freidson, 1994: 112-113). As a consequence, the process of "professionalisation may constitute in reality only a flattering symbolic reward by management to conceal career immobility" (Freidson, 1994: 117-118).

Similarly, Johnson's 1972 book pointed out the inadequacies of the trait approach to professionalism, with professional traits representing the 'ideal' in terms of what ought to be, rather than the reality of the established professions (Johnson, 1972: 23-24). The professional rhetoric "clearly functions as a legitimation of professional privilege", so that the established professions' self-generated definitions of their professional services to society have become the state patronised ones (Johnson, 1972: 25). The consequence of the acceptance of this 'unilineal view' was that the professions have been able to implement restrictive practices to their own benefit, while justifying these restrictions on the basis of supposed community welfare (Johnson, 1972: 26-27).

Johnson also discussed the earlier work of Jamous and Peloille on the role of indeterminacy in establishing the role and status of professions in society (Johnson, 1972: 41-47; Jamous and Peloille, 1970: 111-120). Indeterminacy involves the ability to make use of specialised knowledge - to make judgements based upon educational preparation and experience that allow professionals to utilise their esoteric knowledge base. Indeterminacy includes the distinctive mystique, symbols and ideology of an occupation which serve to separate it from outsiders. Opposed to this, technicality refers to the ability to codify, in the form of rules that can be mastered and communicated, what it is that an occupation does; to make it understandable to, and useable by, outsiders. Indeterminacy protects the profession against the routinisation of its scientific base and hence possible fragmentation and external control by bureaucratic means because it involves the application of professional activities which escape rules and which cannot be quantified. Professions have a high indeterminacy/technicality (I/T) ratio since the lay public is excluded from the informed decision making process through lack
of interpretative knowledge and training. The indeterminacy of the professions creates a social distance between the expert professional and the patient/client, and is the basis of professional prestige. Also, because the non-initiated cannot judge the actions of the professions, the consequence is professional autonomy or self-regulation (Wilson, 1983: 51). Indeterminacy reflects the art or mastery of a profession while technicality relates to the science, or scientific justification, of the profession. Professions have to strike a balance between the scientific justification for their actions and the indeterminate 'skills' which serve to separate the professional from the non-professional.

The perceived uniqueness of medical information, and the duration and complexity of educational preparation of doctors required in order to make, literally, life-saving judgements on patient care, served to increase the social status of doctors. This increased social distance between the expert doctor and the patient was based on the emergent high level of indeterminacy in medical care because now only the doctors possessed the specialised knowledge of illness and the learned ability to implement effectively this knowledge (Johnson, 1972: 41-47; Daniel, 1990: 37-38). This expert knowledge possessed only by the doctors serves as the economic base for 'professional' remuneration for the provision of medical services to the patient.

However, it has been argued that the wider availability and dissemination of knowledge to patients about health care through, for example, computerisation, could result in the deprofessionalisation of medicine (Haug, 1975: 197-213; Freidson, 1984: 4-6). Doctors could counter this claim and argue that there are factors relevant to diagnosis and treatment which cannot be programmed into a computer. They might argue that there are medical skills which cannot be taught directly, which develop over time with experience, and through the establishment of the doctor-patient relationship, enable the doctor to recognise and to interpret many "hidden cues" which are essential for comprehensive health care delivery. Though there is a scientific basis - a technicality - to medical care, there is also an essential indeterminacy which cannot be quantified.11 Medicine is seen as both an art (the application of 'clinical

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11 Ann Daniel discusses medical indeterminacy as relating to "personal judgement, treating each case as unique and complex and irreducible to a commensurate bundle of factors" (Daniel, 1990: 37). However, there is an implicit assumption in much of the rhetorical writings in nurse education that medicine does not treat each case
knowledge') and a science ('theoretical knowledge') (Sadler, 1978: 193-204). Freidson's appraisal of the deprofessionalisation thesis argues that, while there has been more public questioning of professional privileges, there has been little actual decline in the status of the established professions (Freidson, 1984: 6-8; Freidson, 1986: 109-133; Freidson, 1994: 128-143). He concludes that a continuing formal knowledge gap and difficulties in the practical application of this knowledge maintains professional monopolies over the exercise of expertise. A similar argument based on the premise of professional monopolies with the concurrent subordination of competing occupational groups counters the opposite contention that increased academic qualifications will lead to 'the professionalisation of everyone' (Freidson, 1994: 116-120).

Medical knowledge and the training required to be able to utilise this knowledge to diagnose and treat illness are seen to be beyond the understanding of non doctors. The mystique of medicine justifies its status and privileges and, above all, its economic base. Exactly the opposite is the case with traditional nursing practice. Nursing is seen as 'inherently feminine', with only a few readily understandable technical rules, and with little specialised knowledge (Baumgart, 1985: 21). The perception is that there is little that nurses do that outsiders cannot. There is little indeterminacy in nursing and, consequently, no real social distance between nurse and patient. In this light, changes to nurse education may be seen as an attempt to increase the I/T ratio and, hence, increase the status and protect and expand the boundaries of nursing, by separating nursing knowledge and technique from both general and medical knowledge and technique through the deliberate creation of a specialised nursing knowledge, language and processes (Richards, 1991: 202).

Collins advances the theory that professional knowledge serves a symbolic purpose as a prestigious ideological basis to give professions high occupational 'status honour' (Collins, 1979). It is not the knowledge per se that is of primary importance, but rather how it is used for its symbolic value. Professions such as medicine surround their work with an as unique, that, for example, medicine treats all fractured femurs the same. Conversely, the 'new nursing', with its holistic emphasis, presents itself as individualising each patient's care. Considerable personal judgement is required by nurses to treat each case as unique. The public sees medical care as indeterminate while nursing depicts it as technical. The public sees nursing care as technical while the nursing literature argues that it is becoming increasingly indeterminate.
ideological covering, rich in ritual, with high uncertainty and “the ceremonial impressiveness of practitioners before the uninitiated” (Collins, 1990b: 36-37).

Academic qualifications have little to do with the actual on-the-job performance of professionals. Rather, useful practical skills, competency and expertise are acquired clinically (Collins, 1979: 146; Collins, 1990a: 19). A profession needs a technical skill which must be taught (technicality) and hence be able to be monopolised by the profession, but, at the same time, there must be mystery, secrecy, ritual, and areas of uncertainty and unpredictability (indeterminacy) to the skill which keeps it opaque to outsiders (Collins, 1979: 132-133). The elaborate educational preparation of a profession has a predominate social rather than a technical function. It serves a screening or gatekeeping purpose to control access to the profession and to keep practitioner numbers small, indocrinates entrants into the profession, presents an idealised facade of the profession to the lay public, and, through the granting of ‘educational credentialling’, helps to confer a monopoly of practice by shaping perceptions about who has important skills (Collins, 1979: 139-146; Derber et al. 1990: 95). A profession’s expertise does not require special brilliance, but rather it is an important form of know-how that happens to be accorded academic credentials (Derber et al. 1990: 219).

It is the abstract or symbolic value of knowledge which is important to professions with credentials serving as part of a monopolisation mechanism. Abbott agrees, stating that “… the knowledge system and its degree of abstraction … are the ultimate currency of competition between professions” (Abbott, 1988: 9). Murphy develops the idea that professions employ educational credentials as state-sanctioned exclusionary barriers for the monopolisation of opportunities, creation of scarcity and subordination of competitors, while also using the state legal system to minimise outside regulation and evaluation of professional practices (Murphy, 1988).

An examination of the work of later sociologists of occupations such as Turner and Willis is useful. Their commentaries on the earlier sociologists such as Freidson and Johnson provide an Australian perspective on professions and professionalisation, and they provide valuable comment on the professionalisation strategies of paramedical groups such as nurses during the 1970s and early 1980s.
Turner perceived that professionalisation was an occupational strategy to maintain certain monopolistic privileges and rewards (Turner, 1987: 154). Turner's application of Foucault's work to the emergence of medical domination of health care emphasised the "relationship between the discourse of scientific knowledge and the exercise of professional power" (Turner, 1987: 10). Foucault perceived power as a 'strategic relationship' in a given society involving a 'hierarchised surveillance' (Armstrong, 1983: 1-6). Doctors have been able to wield 'disciplinary power' over patients and other members of the health care team through their unique possession of a 'dyad of power/knowledge' (Armstrong, 1987: 66-72). The origins of this power began with the linking of physical examination skills and an increasingly 'scientific' understanding of pathological anatomy, which gave doctors a dominant position over patients and other potential health care providers who lacked these essential skills (Brown and Seddon, 1996: 30-31; Turner, 1987: 9-14).

There is a struggle between the language and expertise of the powerful professional elite and everyday speech and knowledge which is linked to the social production and certification of knowledge. It has been argued that "Knowledge that is shared by a large percentage of the population ... cannot confer class power" (Derber et al. 1990: 219). This knowledge needs to be privatised and made into property. While the development of a so-called 'scientific' basis for medical knowledge did not inevitably demonstrate the need for or desirability of medical control of patients and the implementation of medical decisions about health care by other occupational groups, nevertheless, it served as a justification for the establishment and maintenance of a medical monopoly. The professions seek "coercion of a theoretical, unitary, formal and scientific discourse" (Foucault, 1980: 84). The domination of the medical model of illness, the medicalisation of illness, rationalised certain social relationships, with the doctors in a dominant role and others, such as patients and nurses, in a subordinate role (Turner, 1987: 212-226).

Turner also discussed the patriarchal political structure of health care which served to subordinate female nurses (Turner, 1986: 369; Turner, 1987: 146-151). Turner pointed out that nurses are aware of their subordination and limited social status in the hospital setting, and their inability to utilise their skills in professional ways (Turner, 1986: 368-369). In Turner's
'vocabulary of complaint', nurses tend to highlight their independent contribution and importance to the therapeutic process, while devaluing the function and significance of medical input into patient care (Turner, 1987: 157). These 'usurpatory strategies' result from nurses challenging the existing health care system by attempting to assume decision-making roles. The establishment of the "validity of knowledge and a plausible scientific background are important resources in the professionalization strategy" (Turner, 1985: 45). Hence, university based nurse education, with the expansion of nursing research and the promotion of nursing science represent important professionalisation strategies in nursing.

Willis argued that the division of labour in health involved "a continuing political struggle over appropriate 'occupational territories' or 'task domains' for each occupation ... (and) ... the creation of boundaries between these occupational territories cannot be adequately explained by technical factors associated with the development of medical knowledge" (Willis, 1979: 30). Medicine established a hierarchy of health care workers first and then was in a position to exploit developments in medical knowledge (Willis, 1989: 60). The professions originated with the advent of capitalism in the late nineteenth century and professionalism is an occupational ideology which seeks to legitimate autonomy (Daly and Willis, 1988: 114). Professionalism is also an occupational strategy with explicit gender and class dimensions (Daly and Willis, 1988: 115; Willis, 1989: 13-18).

Medical dominance of health care in Australia was established and is maintained by state patronage through legislative backing which defines occupational territories not only for medicine, but, of necessity, for other health occupations as well (Daly and Willis, 1989: 1152). During most of the nineteenth century there was minimal state intervention in, and regulation of, the health sector. From the turn of the century to the Second World War there occurred legal formalisation of medicine's dominance in health care with the state effectively delegating responsibility for health to medicine (Willis, 1989: 36-91). More recently there has been a weakening of the state's wholehearted patronage for medicine's dominant position, and it is possible that the nursing leadership has seen the opportunity in this changed relationship to try to escape from medicine's domination.
Medical dominance is at least partly maintained by medical autonomy; by authority over the work of other health providers through direct supervision and representation on registration boards (e.g., nursing boards), limitation (e.g., of independent nurse midwives) and exclusion; and by medical sovereignty, involving institutionalisation of medical expertise on all matters related to health (Willis, 1988: 171; Willis, 1989: 8-26; Willis, 1994: 12-13). Medicine has argued that the only basis for politico-legal legitimacy and state patronage of health occupations is scientific legitimacy, and that such approval first requires medical acknowledgment of the scientific validity of such claims, for only medicine is in a position to judge the scientific credentials of other health occupations (Willis, 1989: 3 and 25-26; Willis, 1990: 106). Scientific credentials have become a significant justification for professionalism and the privileges that come from being a profession (Willis, 1989: 81).

Implicit in this argument is the concept of a 'technological imperative' which implies that the medical dominance of the health care system is a direct consequence of the development of medical knowledge and medical technology resulting in the existing division of labour and social relationships within health care (Willis, 1989: 4-5; Willis, 1994: 18-24). Changes to the technology of nurse education represent an attempt to challenge this medical dominance of health care.

A Marxist analysis of professions depicts them as “occupations based on systematic or scientific knowledge, occupations with cultural rather than monetary capital” (Murphy, 1990: 71). Professions are occupations which have been successful in their attempts to control market conditions (Collins, 1990a: 24-29). Credentialled professions are seen as a new governing class whose power in a post-industrial society is based on their control of knowledge (Murphy, 1988: 246-247). An inevitable conflict arises between professionals who control and restrict their knowledge and non professionals who do not have access to and the ability to use this knowledge.

The proletarianisation thesis is concerned with economic and organisational factors relating to professional work in large organisations such as occurs with doctors in hospitals. Based upon the class polarisation postulation of Marxist theory it argues that, because these professionals are no longer self-employed and are reduced to wage labour, they have lost
control over the terms of their work (Esland, 1980: 213-250; Murphy, 1990: 71-93). They are reduced to the common proletariat.

Freidson counters this argument by noting that the traditional professions of the military, the clergy and university teaching were never self-employed, while members of the newer professions have also typically been employed (Freidson, 1984: 9). Similarly, while there has been increased bureaucratisation of the professional work environment, control of professional work continues to be maintained by the professions themselves, including members of the professions who have entered the bureaucracy (Freidson, 1984: 10-13; Freidson, 1994: 116-121). Only the professions continue to be deemed to have the expertise to judge and regulate their own work.

Feminist critiques of professions and nursing’s aspirations for professionalism are usually damning with nursing depicted as a “ghettoized profession relegated to the women’s sphere” (Valentine, 1996: 98; Baumgart, 1985: 20-22; Speedy, 1986: 20-21; Sohier, 1992: 62-66; Krieger, 1991: 30). Most feminist writers see the ideology of professions and professionalisation as one of patriarchy (the male domination of females). Historically all professions have been male dominated (Epstein, 1970: 965-982). More specifically they tend to be filled with white, upper middle class males (Ehrenreich and Ehrenreich, 1973: 50).

The concept of professionalism had its origins in Victorian society, which was male dominated, and, as a consequence, professional attributes tend to be male attributes. Sociologists and the general public tend to perceive dominance, autonomy and professionalism as masculine traits, while societal socialisation inhibits female development of these traits (Cohen, 1981: 112; Block, 1980: 321). Viewed in this light, the concept of ‘profession’ is a patriarchal ideology used to dominate women. Barbara Melosh argues that “Because women are the ‘second sex’ ... there can be no women’s profession” (Melosh, 1982: 20). For example, medicine, which has a high professional status in Western countries, has a much lower status, to the extent that it might not even be considered to be a ‘true’ profession, in Russia where it is a largely female occupation (Roberts, 1980: 35).

Nursing is a female dominated occupation with most nurses coming from a working class background (Muff, 1982: 224). It also has the disadvantage of working in
closest proximity to medicine which could be expected to do everything possible to maintain its dominant relationship over nursing. As such, any expectation that nursing can professionalise to any great extent would seem to be totally unrealistic. Despite calls for feminism to be the guiding principle in nursing theory (Speedy, 1987b: 20-27), it has been argued that nursing’s drive towards professionalisation has been drawn to the patriarchal model of professionalism based on the “hegemony of the analytic discourse of the expert” legitimating the power and practice of the professional group (Gray and Pratt, 1995: 323; Wuest, 1994: 357-367). However, “Despite nursing leaders’ continuous attempts to upgrade the profession, the persistent association with aspects of the female world continues to confound their bid for legitimacy and respectability” (Valentine, 1996: 105).

2.5. Conclusion

The sociology of professions and professionalisation has undergone a gradual evolution from a simple trait approach to a far more critical analysis involving complex interactions of politics, economics, gender and class as an explanation for the privileged position of professions in society. Unfortunately, nursing’s drive towards professionalisation remains grounded in an outmoded trait explanation of professions. For example, Patricia Staunton, a former General Secretary of the N.S.W. Nurses’ Association wrote that "the establishment of tertiary educational nursing programs has certainly cast in concrete the general recognition of nursing as a profession" and that "the claim [for higher rates of pay] is made as a consequence of the transfer of nurse education to the tertiary sector" (Staunton, 1989a: 3; Staunton, 1988b: 10). While pay claims for nurses may have been based on the possession of tertiary credentials, it is still doubtful that there is a general perception that nursing is a profession.

The more recent work of sociologists on semi professions offers a more sophisticated means of examining the motivations for, the techniques and difficulties of nursing’s attempts at professional development. Freidson’s work demonstrates that autonomy over crucial areas related to work practice is the hallmark of a ‘true’ profession. Control over entry into training and hence numbers of practitioners, control over both the scope of the area of
work and how that work is done, and control over the evaluation of work practices occurs in a profession such as medicine and does not occur in a semi profession such as nursing. Professional autonomy enables monopolisation of an area of work, leading to subordination and control of related occupations. As a consequence there can only be one dominant profession within an area of work. Collins shows that academic credentials are used as a justification for professional monopolies and contribute towards the indeterminacy of professions, which gives them status honour. Foucault and Turner describe how the control and application of restricted knowledge is used in the exercise of professional power. Feminists perceive ‘profession’ as a patriarchal concept used to dominate females and restrict female occupational development.

Subsequent chapters will examine the particular circumstances which have resulted in the nursing desire to professionalise. The rhetoric of the arguments for nursing professionalisation will be discussed and an analysis performed on the proposed mechanisms and consequences of the professionalisation process, with particular emphasis on its relationship to the transfer of basic nurse education to the tertiary sector in New South Wales.
Chapter 3

A History of Nurse Education in New South Wales

In order to appreciate the events leading up to the transfer of basic nurse education to the tertiary sector in New South Wales in 1985, it is not adequate to confine a history of nurse education just to this state. Not only were educational issues in New South Wales heavily influenced by events in other Australian states, and vice versa, but in many different ways, events have influenced the evolution of nursing over a period of centuries and have involved many different countries. These influences begin as long ago as the emergence of modern civilisation and include the development of Christianity. Prior to the Second World War, Australian nursing was predominantly guided by the British experience. Post 1945 an increasing U.S. influence has emerged, until now developments in nurse education in this state have moved ahead of the American experiences and expectations. Additionally, an understanding of the historical association of nursing with females and the impact of Florence Nightingale on the development of modern nursing education and practice is necessary to understand a number of the aspects of the sociology of nursing which are discussed in the following chapter.

3.1. Early Nursing

While nursing as a respectable paid occupation has existed for little more than a century, the idea of nursing is as old as the human race. Traditionally, the family and tribal division of labour obligated the care of the dependent and sick to the female or, more specifically, the mother (Smoyak, 1977: 51; Reverby, 1987: 6). This sex role delineation of responsibilities continues to this day. In both modern industrialised societies and the few remaining tribal societies, care of minor illnesses not requiring health care intervention, and care of many chronic illnesses, are almost exclusively the domain of female family members. This 'femaleness' of nursing has been a major determinant of the history of nursing outside of the family setting. The word ‘nurse’ is derived from the Middle English word ‘norice’ which is from the Latin word ‘nutrine’ meaning to nourish, or suckle an infant (The Concise Oxford
Thus, the origin of the noun 'nurse' is exclusively female, and this female stereotype has had important implications for nursing as an occupation.

Traditionally, nursing of the seriously ill occurred in the family home. Even if medical intervention, with what would now be considered a very limited knowledge base and capabilities, took place, the nursing of the patient was left to female relatives. In slave owning societies care of sick slaves and the routine care of sick non slaves was often the responsibility of appropriately experienced female slaves (Calder, 1971: 22). One of the earliest examples of nursing, or continuing care of the sick, outside the home environment occurred amongst the early Christian faithful of Greece and Rome (Anderson, 1981: 19). Non family nursing was to become increasingly associated with religious orders including Christian military knights (Grippando and Mitchell, 1989: 4). This association of nursing with religious piety and/or military discipline and obedience, combined with the associated garb, has continued to influence perceptions of nursing till recent times.

During the sixteenth century in Europe with the Reformation and, in particular, the dissolution of the English monasteries by Henry VIII, significant changes occurred in the role of religion in the existing societies (Calder, 1971: 34). In Protestant countries religious nursing virtually disappeared, with England being the extreme case. With respectable women confined to duties in the family home, institutional nursing of the physically ill became the domain of women assigned those duties in lieu of prison sentences (Grippando and Mitchell, 1989: 10). This period of about three hundred years up till the latter half of the nineteenth century is referred to as the "Dark Age of Nursing" (Brille and Kilts, 1986: 18).

It was during this lengthy period of deteriorating nursing care that graphic stories and images of disease and death emerged, as well as the brawling and drunkenness associated with the likes of St. Thomas's Hospital and Bridewell Hospital (Calder, 1971: 38-40). By the beginning of the nineteenth century nursing had reached an all time low. Nursing was depicted as an extremely undesirable kind of domestic service, with poor, illiterate women, incapable of any other kind of occupation, forced by need into the corrupt, drunken and sometimes prostitution-like service of nursing (Oakley, 1984: 24). In describing hospital nursing of this period, Huxley suggests that "sex with nurses on demand was considered to be a surgeon's
perk" (Huxley, 1975: 24). The archetypal nurse of this period is Charles Dickens' 1844 character of the slovenly, venal Sairey Gamp (Dickens, 1953).

3.2. The Nightingale Myth and its Problematics

Such was the lowly status of paid nursing in the mid-nineteenth century, coinciding with medicine's attempts to expand its clientele and promote its scientific credentials. It is at this point, at nursing's figurative nadir, that most histories of nursing devote themselves to the almost mystical appearance upon the scene of Florence Nightingale, 'the Lady of the Lamp'. However, it is historically incorrect to depict Florence Nightingale in splendid isolation, single handedly solving all of nursing's problems. There were a number of nursing reformers who preceded her and who influenced her ideas and ideals (Calder, 1971: 48). And for all the good that Florence Nightingale's actions had in elevating nursing to a respectable occupation for women, she also left nursing with a number of problems which persist to this day. It is also important to examine the influence of Nightingale's cultural setting upon her actions, to expose the myths about her life and achievements and to describe some of the unintended consequences of her actions.

Florence Nightingale was born into a wealthy and widely travelled family. She received a much broader education than was usually given to girls at this time and, through her family, became associated with many prominent and influential people, especially a number of politicians (Calder, 1971: 51). From an early age she was deeply religious and she and her mother engaged in many charitable acts, such as visiting the sick. Remaining single, Florence Nightingale became deeply involved in agitation for reform of a number of injustices in Victorian society, especially in the area of public health. Against the strong objections of her family she underwent a limited nurse training in 1850 (three months at Kaiserwerth) and subsequently became superintendent of an "Establishment for Gentlewomen during Illness" in Harley Street (Boyd, 1982: 179-181). However, this position was more administrative and supervisory and her hands-on nursing experience was minimal (Fitzpatrick, 1978: 31).

With the outbreak of the Crimean War in 1853, newspaper accounts of the appalling hospital conditions and loss of life amongst wounded British soldiers prompted
public outrage. There were at least two offers by experienced administrators to lead parties of nurses to the Crimea. Nightingale seems to have used her old acquaintance with the wife of the Secretary of War to establish her single authority over the 38 nurses who were dispatched (Dingwall et al. 1988: 42). Nightingale, along with most other people, seemed to have considered the nurses of this time as "women of low moral character with no academic background" (Fitzpatrick, 1978: 38). Nightingale's actions in the Crimea in 1854-5 and later in establishing nurse training schools reflect a middle to upper class approach to overcoming these problems. She demanded and was given absolute and sole authority over her nurses (Palmer, 1983: 4). She insisted that her nurses be of absolutely impeccable moral character and that they display the ideals of Victorian womanhood. Those who did not conform to this stereotype were dismissed on the flimsiest of excuses. Within a short period of time Nightingale had sent back from the Crimea 13 of the 38 nurses in her original party (Dingwall et al. 1988: 44).

Nightingale's beliefs and actions reflect both her class and religious beliefs, but also demonstrate an astute understanding of the male medical reaction to her arrival at Scutari. The initial response by the military to her and her nurses was vilification, but her strict adherence to a policy of only allowing her nurses to perform any activities at the behest of the attending doctors, together with a measurable improvement in hospital care and survival rates, won her grudging approval from the military doctors and public acclaim at home through highly complimentary newspaper reports (Palmer, 1983: 6). This subordination of her nurses to the authority of the doctors brought eventual acceptance of the nursing role by the medical profession, but also set a lasting precedent that has dogged nursing ever since. This tradition of obedience has been dubbed "the ghost of the Crimea" (Cohen, 1981: 54).

This subservient role for nurses also reflects Nightingale's cultural stereotypes. She saw nurses as embodying the role of the Victorian mother - virtuous and chaste, altruistic and caring, yet bowing to the superior power and knowledge of the male. She did not wish to compete with the male doctors, seeing instead a purely female occupation of nursing to assist the male occupation of medicine (Reverby, 1987: 7). This gender distinction by occupation is demonstrated by Nightingale's perception of female doctors as third rate men, and by the
subsequent resistance over decades by female nurses to the admission of males into (mainstream) nursing (Ehrenreich and English, 1973: 56; Palmer, 1983: 7).

The popularity that she gained from her actions in the Crimea enabled Nightingale to initiate a number of proposals designed to improve nursing and nurse training. Unfortunately, Nightingale contracted Crimean fever while there and she suffered from ill-health for the remainder of her life (Prince, 1984: 153). This partly explains why there is such a dichotomy between her recorded ideas and the associated myths that surround her, and the reality of events. While adept at putting forward new ideas (she was to write a total of 147 articles, pamphlets and statistics) and astute in gaining political and popular support for her schemes, she was never subsequently involved in the close supervision of the development and implementation of her reforms in nursing (Fitzpatrick, 1978: 34).

In response to public acclaim over her role in the Crimea, the Nightingale Fund was established for the training of nurses (Woodham-Smith, 1950: 236). The first training school for nurses was established at St. Thomas's Hospital in 1860 and eventually there would be a total of four Nightingale training schools (Davies, 1980: 103; Prince, 1984: 154). Nightingale proposed certain rigid criteria for her training schools. There were strict entry requirements for probationary applicants based on considerations of morality and character. Nurse training was to occur in hospitals in a manner similar to that by which doctors were taught. If hospital training was appropriate for English doctors, than so it should be for English nurses (Bullough and Bullough, 1983: 181). Authority and discipline over the nurses was to be the responsibility of the female matron of nurses with a strict hierarchy of order passing down from the matron to the newest probationer (Reverby, 1987: 7). Probationer nurses were to be "trained to train", that is, student nurses were to be taught by more experienced student and trained nurses (Chaska, 1983: 17). Nurse training in the Nightingale schools was essentially practical and iron discipline was the rule (Davies, 1982: 125).

For years nurse historians have accepted these criteria at face value. Only recently have some authors begun to challenge their reality. Baly states that after ten years the Nightingale schools had achieved little, and that even forty years later there were in fact very few Nightingale nurses (Baly, 1986: 3-4). The reasons for this failure are complex and include
a lack of supervision of these schemes by Nightingale (from 1859 control of the Nightingale Fund was effectively relinquished by Nightingale to the exclusively male board), often poor choices of matrons to implement these schemes and the male domination of various committees and authorities (Prince, 1984: 153-154). The Nightingale training schools had a high wastage rate, misused funds and often produced poorly trained graduates (Baly, 1986: 3).

The appointed female matrons such as Mrs. Wardroper, first matron of St. Thomas's Hospital, were incompetent and easily swayed by the demands of the male hospital boards and male doctors, so that the service needs of the hospitals quickly overcame the training needs of the probationers (Baly, 1986: 2). The theoretical content of the training courses was minimal, initially consisting of only 36 hours of lectures, mostly given by doctors (Grippando and Mitchell, 1989: 24). Opposed to this, some earlier European nurse training schools had about 120 hours of lectures (Grippando and Mitchell, 1989: 18). Student nurse probationers were a source of cheap labour for hospitals, with many entrants paying for their training in the early years, and subsequently student nurses being paid extremely low wages for a considerable workload.

This agitation for hospital based nurse training occurred at an opportunistic time for the medical profession (Starr, 1982: 146; O'Brien, 1987: 16; Lloyd, 1994: 23). In the first half of the nineteenth century medical knowledge had been scant and hospitals decidedly unhealthy places for the poor. A Foucauldian analysis of doctors within hospitals of this period depicts the doctors as utilising their professional and institutional power, derived from their control of a supposed 'scientific' body of knowledge, to coerce and maximise control of the poor patients and untrained staff (Foucault, 1973: 54-87; Sadler, 1978: 185; Turner, 1987: 9-17). Having established a dominant position within the hospital setting, the doctors' expectations of the new trained nurses would be that they would continue to assume a subordinate role to the medical profession (Sadler, 1978: 188). Medical professionalisation created a need for cooperative assistants for doctors, who could not compete with doctors, but who could and would

12 As long as middle class patients continued to be cared for in the home, the doctors had a much less dominant relationship with their patients (Waddington, 1973: 213; Davis and George, 1993: 139). This lack of entrenched medical domination outside the hospital setting is illustrated by the lack of general practitioner concern in the late nineteenth century over independent nursing practice, as it was mainly the hospital doctors who were determined to suppress and control the new trained nurses (Johnstone, 1994: 17).
implement care regimes dictated by doctors, and who would create a much more socially acceptable hospital environment where the middle class would be willing to come and pay for medical care (Johnstone, 1994: 12-13; Lloyd, 1994: 23). The theoretical training of nurses would become increasingly medically orientated so that nurses could confidently be left to carry out the doctors' orders.

Initially there was considerable resistance by doctors to the hospital training of nurses. Mr. South, the senior consultant surgeon at St. Thomas's Hospital, was extremely critical of the new Nightingale nurses, arguing that they were subordinates "in the position of housemaids" (Herbert, 1981: 212). Contemporary reports speak of hospitals as being battlegrounds among nurses, doctors and administrators (Reverby, 1987: 6). However, the attitudes of doctors changed as they came to appreciate the desirability of having in hospitals large numbers of biddable, skilled auxiliaries who could relieve doctors of many of the tedious details of bedside care and who would not question the doctors' authority. Initially the tasks allocated to nurses by the doctors varied with the physician, but as doctors gained increasing control over nurses the worthiness and value of nurses came to be equated with their usefulness to doctors (Keddy et al. 1986: 746). The criterion for nurse education changed from training to train others, to that of submissive practitioners. A later observer was to write that the nurse training school "was a place where ... women learned to be girls" (Sheahan, 1987: 8).

For many years calls to increase the length and content of nurse training were often led by interested doctors because they perceived a need to improve the knowledge base of nursing in response to an increased medical knowledge base. Nurses were to become the "handmaidens of the doctor", taking over increasingly complex but routine ward procedures as doctors discarded them in favour of spending their time on new and yet more complex patient interventions (Bullough and Bullough, 1983: 181). Thus, taking the patient's temperature and pulse was initially the sole preserve of medical students and doctors, but when these procedures became less technologically attractive to doctors, then the doctors were willing to accept that nurses were capable of performing these activities, and relegated them to nursing observations (Dingwall et al. 1988: 55). 13 Similarly, the measuring of blood pressure was not a nursing

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13 Medical dominance over nurses is said to have been aided by this 'silent support' of nurses who willingly
procedure till after the First World War, while doctors permitted nurses to take over recording of electrocardiographs (E.C.G.s) in the years after the Second World War (Rye, 1983: 65). More recently a shortage of Resident Medical Officers (R.M.O.s) in New South Wales public hospitals has led to registered nurses (R.N.s) being at last legally permitted to carry out routine cannulation, venipuncture and loading of intravenous flasks (N.S.W. Nurses' Association Response, 1989). Thus, there has been a continual delegation of what were once exclusively medical tasks to nurses as the doctors lost interest in the procedures and/or have had too many other conflicting demands placed on their time. Salvage comments that "nursing is increasingly becoming an extension of the doctor's diagnostic and curative role ... the tasks undertaken by nurses ... used to be regarded as medical tasks" (Salvage, 1985: 15).

The popular mythology of Florence Nightingale has it that the slow but progressive adoption of her ideas on nurse training by various interested groups, hospitals and countries changed the status of nursing as a paid occupation. From a completely undesirable, low status, working class job, nursing emerged as an acceptable female, middle class occupation. By the late nineteenth century the two main socially acceptable positions for unmarried females were nursing and teaching (Mauksch, 1984: 56). Hospital based training required that nurses have an increasingly wider knowledge base gained during their training, so that nursing slowly changed from an unskilled to a skilled occupation. It is assumed that Nightingale popularised the idea of systematic lectures and training for nurses (Prince, 1984: 161).

Today we see a number of unfortunate consequences of actions that are conventionally associated with Nightingale.14 These consequences were not necessarily unrecognised by Florence Nightingale, and within her own culture may have been acceptable to her and others, but the changing status of women in this century has highlighted some of the long term drawbacks of her initiatives. Nurses were locked into an apprenticeship style of hospital training 15 so that while Nightingale's subsequent philosophy of nurse education

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14 This reversal in attitude towards Florence Nightingale is seen in the fact that some modern nursing historians have argued the position that "... Miss Nightingale served the cause of nursing less than it served her " (Smith, 1982: 178).

15 Previously, most nurses had no formal training. The gradual adoption of the Nightingale method of nurse preparation meant that nurses were entering a hospital based apprenticeship training during the same time span that doctors were abandoning such a system of training for a university based preparation.
strongly supported university education for nurses, this was not widely achieved until just recently (Mauksch, 1984: 56). As well, her concepts of the 'feminine' virtues of 'good' nurses, and the subservience of nursing to medicine, established a complex stereotyping of nurses and perpetuated the inferior relationship of nurses to both doctors and the health care bureaucracy.

The Nightingale development of such new concepts as the nurses' home, used to regulate the behaviour of nurses and to ensure a ready availability of nurses, helped to achieve both general and medical acceptance of the role of the nurse (Abel-Smith, 1960: 21). Nurses' homes kept nurses safe and chaste, but also well monitored, especially when off duty. These functions of the Nightingale nurses' home are consistent with the Foucauldian concept of power (over nurses) through surveillance and discipline (Armstrong, 1983: 3-4; Armstrong, 1987: 67). In many ways this new nursing did not represent much of a change from the existing subservient position and duties of females in the home environment and as such was a suitable outlet for the moral enthusiasms of Victorian middle class women and served as a suitably elevated goal for working class women. Unfortunately, this antiquated characterisation of nurses was to perpetuate gender stereotypes and impede the professional organisation and social development of nursing.

The image of Nightingale nursing spread worldwide and had a crucial impact on the development of nurse education in many countries, most notably amongst the British Commonwealth nations. America was an important exception to this general trend, with certain aspects of Nightingale's philosophy adopted more selectively. In Australia, with its British origins, nurse education was predominantly influenced by the Nightingale ideals and the subsequent changes in nurse education in Great Britain. Only recently, perhaps as part of the general trend of world domination by American culture, has Australian nurse education looked more to the American example and paid less heed to events in Britain.

3.3. Nursing in New South Wales

Upon the arrival of the First Fleet in Sydney Cove in 1788 several hundred sick convicts were housed in a temporary wooden hospital in 'The Rocks'. The nurses were convicts (Martin, 1981: 64). This set the precedent for hospital care in the new colony. The
poor and convicts were nursed in unhygienic hospitals by untrained, uncaring staff, while the better off were looked after in the family home by relatives. In 1816 Governor Macquarie established the 'Rum Hospital' on the site of what was to become Sydney Hospital (Elder, 1988: 70-71). It was not until 1838 that the first religious sisters, with limited nurse training and experience, arrived in Australia and set up domiciliary nursing (Martin, 1981: 64-65).

By the 1860's hospital conditions in New South Wales were as bad, or even worse, than anywhere else in the world. Nursing vacancies were often filled by illiterate female domestic staff (Russell, 1990: 7). Conditions were so bad at Sydney Infirmary that it was known as the "Slaughter House", and eventually the Colonial Secretary, Sir Henry Parkes, felt compelled to write to Florence Nightingale in 1866 to request that some Nightingale trained nurses be sent out to Sydney to establish a proper nursing service in the colony (Armstrong, 1969: i). Nightingale felt obligated to respond positively to this request because of previous contributions from the New South Wales military to the Nightingale Fund and because of the favourable publicity such a move would generate (Baly, 1986: 138). This importation into New South Wales of Nightingale trained nurses was amongst the earliest of a significant spread of her disciples throughout the Empire due, at least in part, to increased job opportunities and the social elevation of these 'Lady Nurses' within the Empire.

In 1868 Miss Lucy Osburn arrived with four other nurses at the Sydney Infirmary. She was to take responsibility for all female staff and to establish a nurse training school. The four other Nightingale trained nurses were to be in charge of the nursing care and be responsible for nurse training on the wards (Russell, 1979b: 22). Subsequently, other Nightingale nurses were sent to Australia to set up training schools in other state capitals, including Adelaide (1886), Brisbane (1888) and Melbourne (1890) (Dragsvold, 1979: 46).

Lucy Osburn was a distant relation of Florence Nightingale, and had taken a shortened training at St. Thomas's Hospital (McCoppin and Gardner, 1994: 3). At this point most histories of nurse education in Australia speak in glowing terms of the wonderful success of Lucy Osburn in establishing Nightingale style nurse education in Australia. While ultimately her impact was significant and many graduates of the school of nursing at Sydney Infirmary went on to have important roles as matrons of other Australian hospitals, the early years were
anything but easy or successful (Russell, 1990: 10-11). There was considerable medical
distrust of the new nursing order with conflict arising over such issues as the control of female
domestics, the female nurses caring for both male and female patients, and the trainee nurses
having scheduled lectures (Armstrong, 1969: i). In 1873 a Commission of Enquiry was held
into concerns over nursing at Sydney Infirmary, but ultimately Osburn was exonerated, gained
full authority over her nurses and was to continue to supervise for twenty-five years (Russell,
1979b: 28). However, for other reasons, Osburn had a falling out with Florence Nightingale
who subsequently condemned Osburn as "an utter failure" (Baly, 1986: 142).

Applicants for nurse training at Sydney Infirmary were to be of "good moral
classification" and throughout their training lived in the nurses' home (Russell, 1979a: 38-39).
Initially probationers were given two hours of nursing lectures per week, with Osburn giving
lectures on anatomy and physiology and doctors giving the other lectures (Creighton and
Lopez, 1982: 9; Dean, 1983: 8). This formal lecture content lapsed with the heavy workload of
the nurses. This was typical of the Australian adoption of the British orientation towards
practical rather than theoretical learning for nurses. As nurses gained acceptance from the
doctors, who perceived the benefits to be gained by their assistance, a formal program of
lectures was revived at the insistence of the Honorary Medical Officers (HMOs) (Creighton and
Lopez, 1982: 9). By 1894 lectures were being given by doctors on anatomy and physiology,
medical-surgical nursing and invalid cookery. In order to meet the increasing demands placed
on the nurses by the doctors the theory content slowly grew with the addition of lectures on
bacteriology, medications, hygiene, ophthalmic nursing and the nursing of children - to a total
of 117 hours (Russell, 1979a: 39). A description of nursing care in the 1880s states that "much
of the nursing consisted of baths and spongings, foment and poultices, hot packs, cold packs,
ice-cradling, irritants and counter-irritants" (Armstrong, 1969: 37). Other training schools were
set up in New South Wales, most notably at Royal Prince Alfred Hospital. In 1888 the period
of training was increased from two to three years and in 1899 the duration was increased to
four years (Armstrong, 1969: 78-79).16

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16 Not for any educational reason, but rather for an extra year of cheap labour on the hospital wards. Qualified
nurses, who were more expensive, found it difficult to continue hospital employment.
The Australasian Trained Nurses Association (A.T.N.A.) was formed in 1899 to organise the control of nursing and nurse education. It established itself as the governing body for all trained nurses, and from 1906 till the formation of the New South Wales Nurses Registration Board in 1924, it recognised certain hospitals as training schools and conducted final examinations (Armstrong, 1969: 81-82). The President, Vice-President, Honorary Secretary and the majority of members of the committee were medical doctors, while its early membership consisted of 174 trained nurses and 50 doctors (Russell, 1990: 18-20). So, from its very beginning, one of the major institutions helping to shape Australian nursing was medically dominated. In 1903 the A.T.N.A. published the first nursing journal in Australia, which was subsequently to become the Australian Nurses' Journal. Amongst its stated aims were the recognition of training hospitals, minimal standards of nurse education and requirements for registration of trained nurses (Russell, 1979a: 39).

During the first half of the twentieth century very little change in nurse education occurred in New South Wales. With its overwhelming female membership and stereotyped characteristics, nursing maintained its traditional subservient role in the entrenched patriarchal health care system. The medical profession had a strong interest in maintaining this situation and there was little incentive for changes in nursing practice and nurse education. Hand in hand with this went the traditional conservatism of nurses who had little opportunity or incentive to change. The majority of nurses were content with the status quo and were resistant to changes to the way in which they had trained and in their ward practice. This conservatism, similar to that found in the military and religious orders, was a major factor which prevented change. Perhaps equally important was the general prevailing poor quality of education and opportunities for females of all ages and occupations during this period in Australia. Lacking any alternative role models, conservative nurses were unlikely to be the trendsetters for improved education.

Nursing in New South Wales saw two significant events before the Second World War - the state registration of nurses and the unionisation of state nursing. A Midwifery Nurses Bill, to cover the registration and practice of appropriately qualified nurses, was discussed by the New South Wales Legislative Assembly as early as 1895 (History of the N.S.W. N.R.B.,
But despite the Bill having general support, and in sharp contrast to the early adoption of various Medical Acts, the final draft of the bill was not passed by the state parliament until 1924 (History of the N.S.W. N.R.B., 1990: Ch I, 23). At the same time a (general) Nurses Registration Act was enacted and the Nurses Registration Board of New South Wales (N.R.B.N.S.W.) was established by parliament to oversee all aspects relevant to the keeping of a register of practising nurses. Johnstone speaks of "the pyrrhic victory of state registration", as she claims that state registration, in Australia and overseas, did not improve the status, quality or professionalism of nursing, but rather reinforced and legitimated the cultural hegemony of medical men over female nurses (Johnstone, 1994: 83-124).

The initial Board of the N.R.B. consisted of seven members; three nurses and four doctors with the chair always held by a male doctor. For most of the next 50 years nurses were a minority on the N.R.B. (History of the N.S.W. N.R.B., Chs VII-VIII). It was not until 1978 that a nurse was appointed the first chairwoman of the N.R.B. (History of the N.S.W. N.R.B., 1990: Ch VIII, 13). So, throughout most of its history the N.R.B. was controlled by a non nursing, male majority and chairman, while all other New South Wales state registration boards have had a majority membership drawn from the people that were being registered (Henlen, 1969: 3). Also important was the fact that most of the nurses on the Board were nurse administrators who had a vested interest in maintaining the status quo by supporting the doctors and health bureaucracy, and there was little representation from nurse education and the vast majority of bedside nurses. As such, the Board was strongly resistant to change, especially in nurse education, being slow and unenthusiastic in its support of recommendations from various post World War Two committees for the upgrading of nurse education.

The other major event during the early part of this century was the unionisation of nursing in New South Wales through the formation of the New South Wales Nurses' Association (N.S.W.N.A.). During the 1920s there was strong pressure from the state Labor government for unionisation of all workers and in 1931 a Bill (which subsequently lapsed) was placed before parliament to effect compulsory unionism ("Origin of the N.S.W.N.A.", 1981: 9). The A.T.N.A. was approached but argued that, because of its constitution, it could not
easily register industrially (Godden, 1989a: 14). The A.T.N.A. was dominated by doctors who presumably would have been unhappy to see nurses adopt trade unionism.

Instead a number of leading nurses called upon a prominent feminist of that period, Jessie Street. Although a non nurse, Jessie Street was invaluable in the formation of the N.S.W.N.A. in 1931 as a union representing most trained nurses in this state. Subsequently, the union merged with the male dominated psychiatric nurses in 1945 and for a long period in the late 1950s and 1960s played a generally conservative role (Godden, 1989b: 26). This perhaps reflects the fact that, "Now in 1966 the Nurses' Association is run by a male secretary [Mr. Hart] (a psychiatric nurse) and mostly male committee" (Street, 1966: 91). So, even though nursing was a predominantly female occupation it was willing to hand over its union control to a small minority of male nurses. Despite long periods of conservatism, the N.S.W.N.A. came to take a leading role in the movement for changes to nurse education, especially by acting as a forum for views and discussion through its journal The Lamp (which first appeared in 1944 as Nurses Magazine). Meanwhile the A.T.N.A. merged with the Royal Victorian Trained Nurses' Association in 1924 to become the Australian Nurses Federation, which represents nurses in other Australian states and nurses working in Commonwealth hospitals in New South Wales (Beaumont, 1989: 7).

In the period up to the Second World War nursing can be characterised as conservative and medically dominated, with little change to both nursing practice and nurse education. However, as shall be seen, while there was an initial period of minimal challenge to existing circumstances after the Second World War, this was followed by an almost exponential growth in dissatisfaction with medical influence over nursing, culminating in radical changes in nurse education and the rhetoric of nursing practice.

A number of factors have influenced these changes. The increasingly technological orientation of medical practice necessitated a technologically competent nursing workforce, which needed to be better educated in order to perform, understand and recognise the significance of results of technical procedures. Hence, the Medical Journal of Australia was strongly supportive of the upgrading and increase in theory hours in nurse education so long as this extra knowledge complemented the medical model ("The education of nurses in N.S.W."),
1969: 525-527). More generally, the growth of the feminist movement challenged the subservience of female workers and their substandard education. While feminism did not, and probably still does not, sit easily with the traditional conservatism of many nurses, they, and especially many nurse academics, were influenced by this movement (Speedy, 1987b: 20-27; Chinn, 1985: 74-77; Heinrich and Witts, 1993: 117-124: ). Most importantly, change in nurse education in New South Wales was also strongly influenced by changes in nurse education in other Australian states and overseas, especially the U.S.A. and to a lesser extent Canada (Goals in Nurse Education, 1976; A Crisis in Nursing Education, 1976). Changes in this state were often in response to these outside influences and examples, with New South Wales belatedly catching-up to upgradings in nurse education in the other Australian states, notably Victoria. Surprisingly, events in this state from 1985 onwards have reversed this trend, with New South Wales setting the example for radical changes in nurse education, forcing other Australian states to follow suit and outstripping developments overseas.

When the N.R.B.N.S.W. was set up in 1925 it prescribed 78 hours of lectures during the 4 years of general nurse training (including 12 hours of anatomy and physiology, 12 hours of general nursing, 12 hours of both medical and surgical nursing, 12 hours of invalid cooking and 6 hours of hygiene). This was based on the A.T.N.A.'s minimum standard syllabus of 1905 and it compares poorly against the 117 hours of lectures required at Sydney Hospital at the turn of the century (Russell, 1990: 30-37). It was not until 1953 that the N.R.B. increased the minimum standard syllabus to 242 hours during the four years of training with an increase in subjects from six to sixteen, including classes on operating theatre, community health and other specialist nursing areas such as gynaecology (Nurses' Registration Act, 1953 (NSW), Regulations, 1967: 10-54). The syllabus was based on one that had been operating in Britain for a number of years. Classes were taught by sister-tutors (a nursing classification introduced in the late 1940s) who did not need formal tutor (teaching) qualifications. Many specialist lectures were given by doctors and were suitably reduced in complexity to a level deemed appropriate to nurses. Lectures were often given intermittently and were mainly arranged during non-working hours. Lectures remained medically orientated with the content
consisting of information and procedures needed to support the medical staff (Russell, 1990: 68-71).

By 1968, in response to various reports and committees, an Interim Syllabus was introduced with 720 hours of theory over 90 days in a three year period of training. For the first time lectures would be given in blocks of release from service duties on the wards (N.S.W.N.R.B. Syllabus, 1968: 1-7). Yet, for a number of years the N.R.B. state registration examination continued to be set on the 1953 syllabus. A 1978 report showed that less than half of all nurse teachers had any formal education beyond their basic nurse training (Report of the Committee Established by the Nurses Education Board, 1978: 22). Provision was made to enable nurse teachers to acquire at least an Associate Diploma of Nurse Teaching through such institutions as the N.S.W. College of Nursing, Glebe, and the Armidale College of Advanced Education (Report of Committee, 1970: 12).

Similarly, in response to continued criticism of nurse education in this state, the basic training syllabus was upgraded to a General Nursing Syllabus of 1,000 hours of theory in 1978 (N.S.W. Government Gazette, 1978). This meant that student nurses would be off the wards for 25 weeks during their three year training. Still, with 1,000 hours of education and 4,250 hours of hospital service, only about 20% of their training was directed to classroom education (Dean, 1983: 9). In 1970 it had been suggested that the poor quality of N.S.W. nurse education, as reflected in the paucity of theory hours, could lead to a lack of automatic registration reciprocity with Victoria, the then leading state in improvements in nurse education (N.R.B. Minutes, 1972: 274). During the 1960s and 1970s there existed considerable disparity in theory hours amongst nurse training syllabi in different Australian states. In 1968 theory hours varied from a low of 67 in Queensland, to 242 in New South Wales, to a high of 370 in South Australia. By 1978 there had been a marked improvement but there was still an almost twofold variation in hours from a low of 840 in Queensland, to 1,000 hours in New South Wales, to a high of 1,600 hours in Victoria (Report of the Committee, 1980a: 125).

In 1944/45 the Institute of Hospital Matrons of New South Wales and the A.C.T. was formed. It was an influential body with representatives on many bodies reporting on and controlling nursing and nurse education in this state. It was also conservative, with medical
domination and a preoccupation with the service needs of the hospitals represented by the
matrons (Russell, 1990: 78). In 1949 the New South Wales College of Nursing, Sydney, and
the College of Nursing, Australia, in Melbourne were established (Graham, 1977: 38-40;
Schultz, 1974: 14). They offered a number of post-registration courses in administration and
education. Over the years they developed an influential voice and were to become, and continue
to be, strong advocates for the upgrading of nurse education.

Calls for the advancement of nurse education are not new, but were rare and
lacking in support prior to the 1950s. For example, in May 1912 the Editorial of the
Australasian Nurses Journal called for a Faculty of Nursing at Sydney University saying that,
"In this age of progressive higher education when universities all over the world are opening
their doors to the students of many commercial and utilitarian services and arts of today, should
not the profession of nursing be considered worthy of recognition by the universities of the
states?" (quoted in Hosplan Seminar Report 53, 1985: 5).

It was not until after the Second World War, with increasing interest from some of
the nurse leadership in this country, that a push emerged for the need for change in nurse
education. As early as 1948 nurse education in Australia began to be seriously examined, but it
was not until the 1960s and 1970s that a comprehensive examination occurred (Patten, 1979:
36). Between 1967 and 1978 no fewer than fifteen expert committees of investigation were
formed to examine the question of nurse education - within New South Wales there were a total
of nine reports (five government and four non-government), plus five reports from other states
and one federal report (Russell, 1990: 117). Highly influential upon the establishment of these
committees was the 1966 World Health Organisation (W.H.O.) Nursing Report which called
vigorously for a rethinking of nurse training, for the "complexity of nursing required an urgent
upgrading of nurse education to a level comparable to other 'professions', preferably in the
tertiary education sector" (W.H.O. Expert Committee on Nursing, 1966: 17). This report
strongly influenced many N.S.W. nursing leaders, and many of its recommendations appeared
in subsequent Australian reports. In 1962, prior to the W.H.O. report, the Royal Australian
Nurses' Federation and the College of Nursing, Australia, had made a submission to the
Australian Universities Commission that contained a proposal for "the location of basic nursing
education in universities to raise standards and status and to prepare effective nursing leaders" (Submission on Nurse Education to the Australian Universities Commission, 1962: 3-4). This submission met with little support.

In 1967 the Matrons’ Report from the Hospital Matrons of New South Wales and the A.C.T. argued strongly that nurse education in this state had not kept pace with the scientific and technological advances in medicine and other health fields and called for a significant increase in theory content (Report of the Committee, 1967: 12-13). They were in favour of increasing theory hours in order to make nurses better able to implement the medical model of health care. The report’s recommendations added impetus to the N.R.B.’s concern about the existing syllabus and greatly influenced the introduction of the 1968 Interim Syllabus of 720 hours of theory in study blocks, and the concurrent reduction in the length of nurse training to three years to bring N.S.W. into line with all the other states. The conservative nature of the report (not surprising with the medical domination of the Institute of Hospital Matrons and with a medical chairman), with its recommendation to retain nurse education under the control of the Minister for Health, was widely supported by the medical profession as it was perceived to be beneficial to better educate nurses to be better assistants to doctors.

In 1969 two reports, the Truskett Interim Report and the 1969 Matrons’ Report, were released simultaneously. The Truskett Interim Report was the more controversial with four major recommendations that:

1. Control of nurse education be transferred to the Minister for Education;
2. The N.R.B. be split into separate bodies controlling education and registration;
3. Nurse education should be slowly moved from the hospitals to the tertiary education sector;
4. The Higher School Certificate (H.S.C.) become the entry standard to nursing.

(Committee of Inquiry (Truskett), 1969).

Both reports were strongly criticised by the Australian medical profession with the Medical Journal of Australia claiming that, “The most important of the recommendations
accepted - and the most undesirable as we see it - was that nurse education should pass out of
the control of the Minister for Health into that of the Minister for Education" (Editorial, 1972:
education given at universities and Junior Colleges is not favoured" was deemed by the medical
profession as being much more realistic in meeting the needs of medicine and hospital patient
care (The Education of the General Nurse, 1969: 8). Interestingly, within ten years, many of
the members of the Matrons' Committee had changed their position, accepting the advantages to
nursing of the Truskett idea of college based learning (Report of the N.E.B. of N.S.W., 1975:
5).

During this period there was much confusion and concern about what nurses
wanted in their nurse training. An N.R.B. workshop in 1970 clearly showed dissension about
where nurse education should go, especially regarding the notion that nursing would be
improved by having full-time tertiary students in nursing (Report of Proceedings, 1970). The
1973 Briggs Report of the Committee on Nursing in Britain clearly shows this disunity
amongst nurses with findings that "the overwhelming majority (over 75%) of recently trained
and trainee nurses were against it [tertiary education] believing that the only place to learn about
nursing is in hospital" and that they would "prefer to learn only with other nurses" (Briggs
Report, 1973: 224-225). Similarly, it was found that "65% of midwifery students found that
the present lecture program adequate or more than adequate despite almost universal discontent
expressed by nurse educators at conferences" (Bennett and Steele, 1974: 58). It seems likely
that these British nurses' concerns would have been equally applicable to the N.S.W. situation
because of their common cultural heritage and the similarities between the two nursing systems.
The Australian nurse educator M. Dunlop in 1974 lends support to this notion of disunity by
suggesting that, "The Truskett Report followed an elitist philosophy - those consulted were the
professional elite, on the assumption that they, as the better educated members of the
profession, would be more capable of planning the future of nurse education. No attempt was
made to consult the rank-and-file" (Dunlop, 1974: 59). Hence, it is difficult to determine just
how much dissatisfaction there was with the existing training system and how much general
support for wide ranging change.
The New South Wales government was slow to adopt the major recommendations of the Truskett Report. The Nurses' Education Board (N.E.B.) was established in 1973 under the Minister for Education and was responsible for the planning, development and coordination of nurse education in this state (*Report of the N.E.B. of N.S.W.,* 1974: 3). Six of the twelve appointed members were nurses, with experience and qualifications in nurse education. However, the chairman, who had a casting vote, was a non nurse (*History of the N.S.W. N.R.B.,* 1990: Ch VIII, 3-4). It was the N.E.B.'s recommendation that the general nurse training syllabus be upgraded to the 1,000 hour curriculum from 1978.

In 1975 and 1976 small pilot tertiary based courses in basic nurse education were established at Cumberland College of Health Sciences, Sydney and at Riverina College of Advanced Education. These three year Diploma of Applied Science (Nursing) courses were among the first in Australia. They and other interstate pilot courses suffered from several drawbacks making it difficult to extrapolate studies of these students to the general student nurse population. Firstly, their student intakes were quite small and possibly atypical of general nursing intakes, and, secondly, they were not true tertiary courses in that their course content was constrained by the fact that their graduates still had to pass the N.R.B. state registration examination. Because the N.E.B. syllabus was highly specified, this put major restrictions on possible teaching innovations. A number of longitudinal studies of the small numbers of graduates from these various pilot courses in Australia, and also in New Zealand, concluded that these graduates were 'superior' (as measured by a number of varying criteria) to hospital trained nurses in some areas such as interpersonal skills and 'inferior' in some other areas such as technical nursing skills, but that any perceived differences quickly disappeared (Parkes, 1984b: 177-182; Mackay *et al.* 1981; McArthur *et al.* 1981).

This could be seen as both good and bad news. Good, in that tertiary education did not disadvantage nursing students, and possibly bad, in that it did not significantly alter nursing students for the 'better'. If it could not be clearly demonstrated that tertiary educated nurses were in fact 'better' educated nurses, much of the stated argument for a large scale transfer of nurse education to the tertiary sector is undermined. The last of the major Truskett Report
recommendations, that of the H.S.C. as the entry requirement to training, was accepted from January 1980 after a delay of almost ten years (Educational Standard of Entry, 1978).

The Matrons' Reports, the Truskett Report and the subsequent 1974 Noble Report and West Report, all recommended the establishment of group or regional schools of nursing, each associated with a number of hospitals and under the control of the Minister for Education (Report of the Committee to Consider all Aspects of Nursing, 1969: 40; The Education of the General Nurse, 1969: 10; Committee of Inquiry, 1969: 6-7; Report of the NEB, 1974: 9-10; The Establishment of Regional Schools, 1974: 4). From 1977 a number of regional schools were established, often with arrangements between the schools of nursing and tertiary education institutions, as, for example, between Newcastle Regional School and Newcastle Technical College, and between the Illawarra School of Nursing and the Wollongong Institute of Education (Lyons, 1978: 14-21; Bell, 1982). The advantage of this arrangement was claimed to be a better utilisation of staff and resources, with student nurses removed from the hospitals to a central campus in the grounds of a tertiary institution for study blocks and then rotated through a number of hospitals during their practical training.

Nursing opposition grew to the perceived slow implementation of the earlier reports' recommendations, with each report spurring the formation of a new committee to further examine the preceding recommendations. This continuing review has been likened to "delay by committee" (Russell, 1990: 125). The important Australian nursing bodies and journals during the 1970s issued various policy statements which proposed that basic nurse education be conducted in multi-disciplinary settings at not less than a tertiary diploma (UG2) level and as such should not be conducted in 'sub tertiary' and 'sub professional' Tertiary and Further Education (T.A.F.E.) institutions but, rather, in Colleges of Advanced Education (C.A.E.s) (Goals in Nursing Education, 1976; A Crisis in Nursing Education, 1976: 8).

The final influential report was the federal Tertiary Education Commission report known as the Sax Report which was presented in 1978. The inquiry was commissioned in response to growing pressure from nurses and the C.A.E.s for the movement of basic nurse education into the tertiary sector (Committee of Enquiry into Nurse Education and Training, 1978: 1-2). A major recommendation of the report was that, "There is no reason in principle
why the preparation of nurses should be carried out in a different setting from that of other
health personnel. However the logistic, educational and financial problems which would
accompany a departure from present arrangements suggest that change should be cautious,
evaluated step by step, and taken forward only after validation justifies each change" (The
Report of the Committee, 1978: 15.8). The federal government did not respond to the Sax
Report recommendations till 1980, settling for a continuing evaluation of pilot tertiary nurse
education programmes - in effect maintaining the status quo (Wood, 1990: 166).

The multitude of reports during the 1960s and 1970s had done much to stimulate
discussion amongst nurses about where nurse education should be going. The major nursing
groups and their journals had reached agreement about the desire for nurse education to move
into the tertiary level at, at least, a UG2 diploma level. In the late 1970s and early 1980s
increasing militancy of nurses in New South Wales over issues of wages and work conditions
drew considerable media attention of high profile meetings and rallies, a most unusual action by
nurses up to this time (Russell, 1990: 137-140). The relatively new state Labor government
took a number of actions to meet the nurses’ demands. Then in what came as a major surprise
to most nurses on January 7th, 1983, the state Minister for Health, Laurie Brereton, announced
"the transfer of basic nurse education from hospitals to Colleges of Advanced Education from
January 1, 1985 ... (and that) ... the N.S.W. government would pay the full cost of the
transfer" (Media release, 1983).

In one step, the N.S.W. government had surpassed the recommendations of the
various reports, opting for a three year Diploma of Applied Science (Nursing) in C.A.E.s. By
1988 the last of the hospital trainees would have completed their training and only non-salaried
students of nursing would be found in New South Wales. The N.R.B. was to supervise and
advise on the transfer of nurse education over to the colleges. The N.R.B. agreed to accept the
entry standards set by different colleges (History of the N.S.W. N.R.B., 1990: Ch IX, 4-5).
Tertiary graduates, having satisfied the graduation requirements of their own institution, were
still required to be placed on the state comprehensive nursing register. While they no longer had
to sit a state registration examination, the N.R.B. continued to have a strong say in accrediting
the structure of various curricula.
Finally, in 1987 the N.S.W. parliament passed the Nurses Registration (Amendment) Bill which set membership of the Board at eighteen, of whom thirteen would be nurses and a president who must be a registered nurse. At last nurses had gained control of their own registering body (History of the N.S.W. N.R.B., 1990: Ch X, 1-4). Superficially, nursing gaining control of its own registering body might seem like the attainment of a major attribute of professionalisation - self regulation over its work. However, the scope of nursing practice remains circumscribed by the various Medical Acts, which limit many of the independent or autonomous behaviours which nursing desires. Nursing self regulation has only been obtained within very narrow parameters.

At the federal level in 1984, in response to the N.S.W. initiative of 1983, an Interdepartmental Committee was formed to again examine the question of nurse education. The committee "acknowledged that over many decades the nursing profession had been a classic example of a female dominated occupation which has lower status, lower training requirements, lower pay and poorer conditions of work than comparable male dominated occupations. Nurses were the only health professionals required to combine study with work in an environment where both employment and educational demands were changing rapidly and becoming increasingly complex" (Wood, 1990: 210). The result in 1984 was Federal government in-principle support for the total transfer of nurse education to tertiary institutions by 1993, which it was felt would bring an "enhanced status for nurses to bring them into line with other health professions" (Media release, 1984). The Federal government agreed to take over funding of tertiary nursing courses in N.S.W. from 1993 in line with the other states. The only disagreement amongst the committee was that the nurse representatives felt that the basic qualification should be a Bachelor of Nursing while the government opted for a Diploma of Nursing.17

Having suddenly achieved the transfer of basic nurse education to the tertiary sector, nursing groups then turned their attention to further advances in nurse education. Examining the needs of nurse education for the turn of the century, all Australian nursing

17 Note the name change from Diploma of Applied Science (Nursing) which was seen as implying that nursing was secondary to the science. The title of Diploma of Nursing was thought to emphasise more strongly the nursing nature of the course.
unions, colleges and academic groups called for a bachelor degree as a first qualification with provision of extra places for nurses to undertake post-graduate study at honours\(^\text{18}\), masters and doctorate levels in their discipline (*Nursing Education Targets*, 1989). The only area of debate was over the duration of the Bachelor of Nursing course with many nursing groups favouring a three and a half or four year degree ("N.S.W. branch response to D.E.E.T.", 1990: 13; *Submission from the Australian Council of Deans of Nursing*, 1993: i). Professionalising occupations tend to want to increase the duration of their basic tertiary courses into line with the length of the profession towards which they aspire - a process of credentialling (Freidson, 1970a: 54-55; Riffle, 1985: 210; Freidson, 1986: 63-91). In this instance, nursing could be seen as seeking a similar period of study at university to that of medicine.

The Federal government agreed to the upgrading of the basic nurse education course to a bachelor degree as from 1992 but with only three years of funding. So, while individual institutions may run longer course, they are limited by funding to a three year degree (Reid, 1994: 9). Professor J. Lawler of the Department of Nursing, University of New England said that with "a three-year degree, we would be the only country in the world offering a degree in nursing that was of three years duration" (Morris, 1990: 14). Recently, as a way around this restriction, there have been suggestions by nursing departments to offer four year double major degrees, with such combinations as nursing and bioscience, or nursing and psychology (McDonald, 1992: 4).

### 3.4. The Influence of Overseas Changes to Nurse Education

All these changes in nurse education in New South Wales and Australia did not occur in isolation. Their state and national political context apart, they were strongly influenced by, and eventually overtook, events overseas. As has been previously discussed, prior to the Second World War, Australian nursing was primarily influenced by British nursing and nurse training, which was more practical than theoretical, highly stratified, and with a hospital

\(^{18}\) Since then a shift in university policy towards commercialism and paying students has meant the emergence of increasing numbers of Postgraduate Diplomas in very specific and work orientated nursing categories such as Critical Care and Paediatrics. In nursing, non fee paying postgraduate student numbers remain low because of lack of government funded positions, despite what is claimed by the National Tertiary Education Union to be the crucial role of postgraduate studies in establishing the status and significance of nurse education in academe (Ilting, 1994a: 6).
emphasis. After the Second World War Australian nurses began increasingly to look at events occurring in North America.

From its earliest days American nursing departed from the British model. There was always a much greater emphasis on public health nursing, with its separation from the hospital sector. The Nightingale model was imported into the U.S.A. in the early 1870s and the first three hospital schools of nursing were established in 1873 (Abdellah, 1972: 224). Subsequently, the American version of nurse education progressed much closer to the Nightingale ideal of tertiary based training. In 1910 the University of Minnesota established a School of Nursing with a three year diploma course (Abdellah, 1972: 225). This decision is seen as the beginning of professional nursing in the U.S.A. In 1923 Yale University appointed a Dean of Nursing and established a School of Nursing offering a bachelor degree (Krampitz, 1987: 67). Over the years a number of studies were conducted into nurse education including the 1912 Nutting Report, the 1923 Goldman Report and the 1948 Brown Report (Bullough and Bullough, 1984: 53-56). These reports were all critical of hospital based, service orientated nurse training and, for example, the Goldman committee "consisted of leaders in nursing and medicine who strongly supported the university preparation of nurses" (Kramitz, 1987: 62). The post Second World War Brown Report was the most influential, leading the way for the transfer in the 1950s away from hospital training to various types of tertiary affiliation. After the war America suffered from a severe nursing shortage. Various types of tertiary education for nurses were deemed one way to attract applicants into nursing (Croft, 1979: 62).

A triple system of nurse education arose for registered nurses. There was the three year hospital based diploma program with varying degrees of association with tertiary education institutions. A two year associate degree program based in community colleges (unique to the U.S.A.) grew in popularity, and a four year college or university Bachelor of Science in Nursing (B.S.N.) course developed, often with the first two years of study of purely support strands and the last two years of purely nursing subjects (Bruker, 1985: 36-37). Thus, there was a wide range of courses leading to registration as a nurse. In recent years the hospital based diploma has virtually disappeared so that a chasm has developed between the four year bachelor degree and the two year associate degree (Leddy and Pepper, 1985: 7).
There was considerable concern among many nursing groups about this wide variation in training (although all graduates had to pass the same state registration examinations). From 1965, the American Nurses Association (A.N.A.) called for a baccalaureate degree as the minimum preparation for beginning professional nursing practice, and during the 1970s set the year 1985 as its target date to achieve this (Primm, 1986: 135). This requirement has still not been achieved, though some individual states are beginning to implement it. Further proposals have called for the phasing out of the diploma program and the conversion of the associate degree to one leading to a technical degree (Chapman, 1988: 32-33). Hence, the American professional degree would be held by the equivalent of our registered nurses, and the technical degree would be held by the equivalent of an upgraded version of our enrolled nurses. It is worth noting that a number of American studies have rated diploma graduates (from a modified hospital based training system) as 'better' than other types of graduates on state registration examination results and initial ward competency (Riffle, 1985: 203-204).

For much of the 1960s and 1970s the leaders of Australian nursing took their cue from events in the U.S.A., and this strengthened their linkage of improvements to nurse education with its placement in tertiary education institutions. Events in Australia in the 1980s and early 1990s have overtaken the situation in the U.S.A. with the achievement of a single entry to practice pathway, firstly at a diploma level and then at a bachelor level (though of three and not four year duration). The reason that a four year degree was not instituted probably has more to do with the Australian government being more closely involved with tertiary student funding than is the case in the U.S.A. Now, Australian nurse academics are looking to the American example regarding post-graduate upgrading to masters and doctorates as their next objective, for increasing student numbers at the post-graduate level would be in line with official Australian government and university policy (Bennett and Parker, 1987: 7; Downs, 1988: 18-20). Yet again, the American example has acted as a model for Australian nursing objectives.

19 Recent nursing authors in examining the history behind this historic pronouncement now suggest that "... the need to make nursing more professional was the impetus behind the Position Paper" (Lawler and Rose, 1987: 19).
Another external stimulus came from the Canadian experience where, for example, in Ontario all nurse education moved into post-secondary colleges in the 1970s (Wood, 1984: 183-192). New Zealand piloted nurse education in technical institutions from the early 1970s, and, in the early 1980s, phased out hospital training, moving it into technical institutions (equivalent to our T.A.F.E. colleges) (Cherrington, 1984: 10-11; Kinross, 1984: 193-199). While Australia preferred to move into C.A.E.s (which subsequently became universities) rather than into T.A.F.E. colleges, the example of these Commonwealth countries undoubtedly reinforced existing ideas amongst Australian nurses. Meanwhile, Britain has been left behind with the retention of hospital based nurse training, and with their Project 2000 giving government support only for 'links' and pilot courses for nurses within higher education institutions (Salvage, 1988: 1553).

3.5. Conclusion

Nursing has historically been linked with femininity. The influence of religious nursing and Florence Nightingale resulted in a subordinate, handmaiden role for female nurses. The new Nightingale model of nursing was readily adopted in New South Wales. The history of nurse education in New South Wales has traditionally been one of very slow change based on a hospital apprenticeship training. Then there was a sudden transfer to the tertiary education sector with the basic entry to practice requirement now a three year Bachelor of Nursing degree and an increasing emphasis on post-graduate studies in nursing. These radical changes are consistent with Australian nursing's uncritical support for American nursing's ideas about nurse education. What needs to be more closely examined are the stated and unstated reasons for these changes to nurse education. In order to do this, it is first necessary to examine some of the social impetuses for changes in nursing and nurse education, and changes in the technology of tertiary based nurse education.

20 Again, some more recent nursing authors are beginning to challenge the purpose of proposed radical changes to nurse education. Holloway and Penson argue that: "Project 2000 suggests that professionalization of nursing is in the interest of patients. This may be so. It certainly is in the interest of the nursing profession as it - like other professions - becomes more protective of its own interest" (Holloway and Penson, 1987: 240).
Chapter 4

Professionalisation and the Sociology of Nursing

Several years ago the British sociologist Ann Oakley confessed that, in all her years of studying the sociology of medicine and health, she had ignored the contribution nurses make to health care because she had taken their presence for granted (Oakley, 1987: 13-16). It was only when she was hospitalised with cancer that she discovered the importance of nurses and began to study the sociology of nursing. With the exception of nurse academics, other researchers into the sociology of health care have also paid only minor attention to nursing, preferring to concentrate on the dominant role of doctors.

This chapter uses a number of sociological issues in nursing as a way of understanding how the transfer of basic nurse education to the tertiary sector is seen as a professionalisation strategy. To begin with, it is claimed that there are "two normative worlds" for student nurses - that of hospitals and that of academic institutions, with differing cultures and ideologies (Batey, 1969: 4). Hospital based education is perceived as retarding the professionalisation of nursing because a negative form of socialisation occurs in this setting which instils behaviours contrary to that claimed to be displayed by professionals. In the hospital setting the nurse-doctor game, patriarchy, nurse uniforms as a tool for conformity, low numbers of male nurses and reinforcement of the public images of nurses as handmaidens and non professionals help to maintain nurses in a subordinate position to doctors. On the other hand, it is claimed by many nurse writers that tertiary based nurse education will lead to a different type of socialisation of nurses and will help to foster, among large numbers of both graduate nurses and reeducated hospital trained nurses, behaviours more appropriate to professionals.

4.1. The Nurse-Doctor Game

The term 'the doctor-nurse game' was first coined by the medical psychiatrist Dr. Leonard Stein in 1967 to explain a unique form of communication between nurses and doctors (Stein, 1967: 699-703). Although little additional research has been done on the topic, it has
received considerable uncritical mention in the nursing literature, where the words have been reversed to 'the nurse-doctor game' presumably in order to emphasise the importance of nursing ("The nurse-doctor game", 1991: 60). Nurses use 'the nurse-doctor game' as an example of medical subordination of nurses.

Stein's theory of 'the nurse-doctor game' has the following components. In the late 1960's the health care system was a rigid hierarchy with the dominant position held by male doctors and with female nurses in an inferior position. 21 The doctors had been socialised during their training to an assumption of omniscience, in the sense that they were all knowledgeable, or at least, had to be seen to be all knowing about what was correct for their patients. The education of medical students emphasises a reliance on individual resourcefulness and knowledge, discouraging the admission of doubt or the seeking of help from other health care providers when unsure how to proceed (Murphy, 1983: 23; Heenan, 1991: 26). While it was permissible for doctors to seek professional advice from their colleagues (other doctors), it undermined their authority and would "lead to a loss of professional control over their patients" if they were to be seen to accept advice on patient care, as opposed to information about patients, from non professional nurses (Rizzo, 1993: 1452). Meanwhile, the nurses had been socialised during their training in hospitals to be subservient, to be passive and totally supportive of doctors, to avoid 'embarrassing' the doctors by not deviating from the accepted role and to believe that doctors know far more about all aspects of patient care at all times than nurses (Mackay, 1989: 16; Bradby, 1990: 1222; Bottorff and D'Cruz, 1985: 10).

Unfortunately, there are problems with this hierarchical system. Nurses spend much more time with patients than do their doctors in the hospital setting and often have more individual knowledge about particular patients which could be useful in decision making. In particular, the experienced registered nurse often has more practical knowledge about patient care, including medical care, than has the new junior hospital doctor (Resident Medical Officers in Australian hospitals) (Lublin and Gething, 1993: 5; Heenan, 1991: 26). Doctors often need

21 Feminist theory would see this as a classic example of males dominating females, and so it is often depicted in the nursing literature (Smoyak, 1987: 35-37; Dimond, 1987: 28-31; Sohier, 1992: 62-66; Krieger, 1991: 30-31).
nursing advice to optimise patient care and it is suggested that there is often considerable (hidden) nursing input into decision making (Porter, 1991: 734).

However, according to Stein's theory the nurse cannot be seen to give advice to the doctor and open disagreement about patient care must be avoided at all costs. The participants must play a carefully orchestrated game. If the nurse plays the game right she (I have deliberately used the female pronoun here) can lead the doctor to the correct decision on diagnosis or treatment by supplying non requested, but important information and by giving her opinion in the form of a question. Instead of saying 'I think that Mrs Smith has ...' she rephrases this statement as a question, 'Do you think that Mrs Smith has ...?', or gives the doctor information which she already knows will inevitably lead the doctor to the correct and desired conclusion. The greater the significance of the recommendation the more subtly it must be conveyed. Both participants in the game must be aware of both the verbal and nonverbal communications involved. The nurse must exert great care when making recommendations to the doctor so that it appears such input was actually the doctor's idea. In this way the doctor can accept the advice without losing his authority in front of the patient or other health care workers.

There are both rewards and penalties in this game. If the 'game' is played correctly, nurses get a say in medical decisions without upsetting the system, gain self-esteem and occupational satisfaction, possibly gain increased prestige because they are deemed useful to the doctors and because they have not been seen to interfere with medical practice, then presumably the doctors will not interfere with accepted nursing practice (Vaughan, 1985: 72-75). If the relationship is challenged, then nurses are labelled aggressive (i.e., non-feminine) and trouble-makers (Heenan, 1990: 47).

If the doctor accepts the hidden advice then he (I have deliberately used the male pronoun here) is helped towards what is best for the patient, maintains his authority and has a good working relationship with the nurses. If the doctor, especially a junior doctor, is 'too arrogant' to accept the nurses' advice then the nurses can make life difficult for the doctor with trivial and annoying problems such as seeking constant clarification over every little point of treatment, even if this means contacting the doctor in the middle of the night, and by displaying
little if any initiative over patient care, or perhaps, most effectively, by withholding information from the new RMOs about the likes and dislikes of the Honorary Medical Officers under whom they are working on the hospital wards (Lublin and Gething, 1993: 5). Not surprisingly, most doctors quickly learn to play the game, as they have everything to gain and nothing to lose. The new RMOs are seen as being socialised into their (dominant) role in the nurse-doctor game by the ward nurses themselves, who effectively are perpetuating their own subordinate position in the relationship (Heenan, 1990: 48).

The summary is how Stein's rules of 'the nurse-doctor game' are presented in the nursing literature, which then goes on to analyse the game (Keddy, et al. 1986: 745-753). Nurse writers usually challenge this relationship as one of dishonesty and as a clear example of the way in which the medical patriarchy suppresses the female nurses (Beaumont, 1987: 48). Doctors retain control over diagnosis and treatment, and diagnostic autonomy is important in exercising power over other health care workers (Kenny and Adamson, 1992: 319). Meanwhile, doctors continue to doubt that registered nurses possess the diagnostic skills to initiate many independent nursing interventions in patient care (Johnston, 1983: 19). The game has been described as possibly "the last vestigial remains of the nineteenth century relationship between the sexes." (Cockerham, 1986: 193). This interaction has been displayed in the nursing literature as typical of professional to non professional communication between two groups of health care workers; as a consequence of nurse socialisation during hospital training; as a reflection of differences in educational preparation, with doctors' higher paper qualifications dominating over less academically qualified, but often more practically experienced nurses; and as a manifestation of the socio-economic gap between nurses and doctors, with doctors traditionally coming from a higher social background than nurses and receiving higher status and deference from nurses (Aaronson, 1989: 274-279).

This analysis and explanation of the elaborate ritual of inter-occupational communication between nurses and doctors has long been accepted as a typical version of events in the period around 1967. With few exceptions, such as Hughes and Porter, it has remained unchallenged (Hughes, 1988: 1-22; Porter, 1991: 728-735). However, the theory is based on little empirical research, and has attracted virtually no further research during the
intervening years. It is difficult to ascertain how accurately this assessment describes the nurse-
doctor relationship. For example, one supporting study in 1977 involved a number of nurses being given a phone order to give a patient an unusually large dose of a drug by a supposed doctor (Rank and Jacobson, 1977:193). While none of the nurses challenged the doctor's orders at the time, most subsequently refused to administer the drug and sought clarification of the order. This could be seen as an example of nurse-doctor communication in which the nurses avoided open conflict with the doctor, used their own knowledge and judgement in not giving the drug and then tried to influence the doctor's decision by seeking 'clarification' at an appropriate time. Undoubtedly most nurses can relate their personal experience to this scenario. However, it also seems likely that other more direct forms of communication also occur between nurses and doctors.

In the last few years researchers have begun to look at the contemporary nurse-doctor game. In 1990 Leonard Stein re-examined the doctor-nurse game, and concluded that "one of the players (the nurse) has unilaterally decided to stop playing the game and instead is consciously and actively attempting to change both nursing and how nurses relate to other health professionals." (Stein et al. 1990: 24). In the same year, a survey of over 1,000 American nurses found that only 29% of nurses characterise their relationship with doctors as collegial, but the survey also found that the nurses in the study were more critical of doctors and more willing to be more direct in communications with doctors than previous studies indicated ("The nurse-doctor game", 1991: 60-64). Similarly, only 30% of British nurses perceived that doctors see nurses as partners in delivering patient care, although 90% of nurses thought it was a realistic expectation (Heenan, 1991: 26). Verbal abuse of nurses by doctors is still reported as prevalent (Cox, 1987: 47; Cox, 1991: 66). A major factor in this manifestation of the unequal relationship between nurses and doctors is explained by the passivity of nurses (Cox, 1991: 66-68; Johnston, 1983: 19). Nurses have claimed that this abuse results in low morale and job satisfaction among nurses and contributes towards a high turnover in hospitals, and national nursing shortages in the U.S.A. and Britain (Carroll and Dwyer, 1987: 17-18; Pilliteri and Ackerman, 1993: 113; Staunton, 1994a: 3).
Nurses would suggest that they are now more open in their communication with doctors, that this is an example of nurses' growing professionalism and is a consequence of their altered education. With an increasing percentage of nurses undergoing tertiary education, nurses have an improved knowledge base and a different socialisation which challenges the mystique of medicine and conveys the idea that nurses have an important and independent input to make into patient care (Vaughan, 1985: 72-75). Hospital based training had resulted in "Nursing (having) a history of consent and humility which is perpetuated by training methods." (Canham, 1982: 50-51). Nurse authors tend to suggest that more and better tertiary nurse education could only go on to improve nurse-doctor communication to a more equal professional to professional dialogue, i.e., that tertiary education of itself would improve professional relationships and communications.

While Stein's theory could be defined as an over simplistic explanation of nurse-doctor communications, and particularly of nursing input into medical decision making, its real importance lies in the emphasis given to it in the nursing literature. Nurses were and are ready to use this theory as an obvious example of medical arrogance and dominance. The vehicle suggested by nurse academics to overcome this unequal relationship and achieve a collegial goal is increased tertiary education (Cohen, 1981). It is deemed unsuitable and unrealistic for the hospital nurse to be more direct in her communication with doctors. Rather, nurses must be resocialised in a different educational setting and their status must be increased, through education, to a level closer to that of the doctors.

4.2. Gender and Subservience

Gender differences between health care occupations are an important component of the unequal relationships between these occupations. Nursing is a predominantly female occupation while the medical leadership, Visiting Medical Officers (V.M.O.s), medical professors and hospital administrators, especially Chief Executive Officers (C.E.O.s), are almost exclusively male. Hospitals are conventionally characterised by medical and

22 I have used the term 'subservience' here rather than the traditional term 'subordination' because I feel that the word subordination conveys an implication of passivity on the part of those being subordinated. I have used the word subservience instead because, I feel that in the particular case of nursing, female nurses have actively participated in their own domination by male doctors.
administrative dominance and nursing subservience. Female gender equates with subservience, while male gender represents dominance. While the C.E.O. may control the hospital budget, senior doctors maintain other forms of control because the delivery of health care to their patients in hospitals is still largely determined by the doctors themselves (Davis and George, 1993: 168; Daniel, 1990; Bates and Lapsley, 1985: 201-209). They have successfully negotiated with the government and manipulated public expectations to maintain their autonomy and excellent remuneration. Doctors can generally use existing hospital facilities fairly freely. Their main concern in times of budgetary constraint is in obtaining access to new, i.e., complex and expensive, equipment and procedures. On the other hand, nurses continue to have little power or control over the medical, budgetary and administrative decisions of hospitals.

There are many ways to explain these interrelationships among the various groups of health care workers. Social exchange theory suggests that society has granted extensive power, status and remuneration to doctors because they are perceived to provide a valuable commodity - curing the ill - and their numbers are relatively small, and thus they are an important resource (Aaronson, 1989: 274-279; Cockersham, 1986: 149). Doctors have sought to strengthen this relationship by controlling the number of practitioners, especially in specialist areas, and over time the ratio of doctors to the general population has actually fallen (Aaronson, 1989: 275). They have also maintained a relatively homogenous group with similar attitudes to health care and until recently, have been predominantly white males from a middle-class background.

Hospitals accord nurses a different, and in many ways, a lesser role because the commodity they provide - caring for the ill - is perceived by most people as not as valuable, not as skilled and as almost inherent in feminine nature. Nursing is regarded as quintessentially "women's work", and the caring role of female nurses is regarded as a corollary of their reproductive role - a socio-biological construct which devalues nursing work (Hartnett et al. 1979: 57-67; Turner, 1986: 369; Johnstone, 1994: xi, 1). Nurse numbers are much larger.

23 In the late nineteenth century nursing numbers were much smaller than medical numbers. There was a rapid growth in nursing numbers as the result of a shift from private duty to wage based hospital work, until there are now many more nurses than doctors (Coburn, 1988: 439-440; Willis, 1994: 13). The enormous turnover of nurses creates a 'reserve army of labour' which has made it impossible for nurses, unlike doctors, to negotiate their pay and conditions from a position of scarcity.
than medical numbers as they have little control over and probably not much interest in regulating their number of practitioners, and they are a much more heterogeneous group than doctors with little mutual support (Freidson, 1994: 122-123; *Separation from Skilled Occupations*, 1989: 68, 75). The medical profession, which is predominantly male in membership and social dynamics, has utilised its valued position to maintain its dominance, while nursing, which is predominantly female in membership and social dynamics, has been largely ineffectual in elevating its subservient position. It has been suggested that, "Women [i.e., female health care providers such as nurses] were the casualties of medical professionalization" (quoted in Walsh, 1977: 3).

This health care male dominance and female subservience has been referred to as a patriarchy; the health care service as a structured misogyny; and the health care system as androcentric (Bond and Bond, 1986: 301; Vidovich, 1990: 12-15; Carter, 1994: 367-372). These hospital based relationships can best be visualised by the concept of the hospital family with male doctors symbolising the father, female nurses analogous to the mother and the patients as children (Beaumont, 1987: 48). The doctor is head of the family and oversees the actions of others. The nurse fulfils a maternal role, accepting and implementing paternalistic orders in caring for the sick children - the patients. Junior doctors or R.M.O.s are analogous to teenage sons. While they are 'teenage' novices they gladly accept the guidance of the more experienced registered nurses, but once they gain confidence and skills they reach maturity, become like their 'fathers', and role reverse and begin to dictate to the nurses (Game and Pringle, 1983: 109). This visualisation is even more appropriate to late nineteenth century hospitals, which almost did act as 'households', with the nurses not only being responsible for caring for the ill patient but also involved in provision of meals, ward hygiene, and control of domestic assistants (Spicker and Gadow, 1980: 25).

Gender relationships in hospitals reflect gender relationships in Western society. This was most obvious in Victorian society when nursing was newly emerging. The time and place, and the way in which nursing developed as a new occupation, were important in shaping the relationship between nurses and doctors. In a sense, nursing emerged when it did to service an existing profession - medicine, and, in particular, medicine in hospitals. Nursing started
with this distinct disadvantage in its relationship with medicine. It started in a subservient position because it was created to assist doctors. These new respectable, trained hospital nurses had no sense of belonging with other female health care providers and, for example, saw themselves as different to, and better than, midwives, who at that time were being suppressed by the medical profession (Willis, 1989: 104-117).

This new nursing appeared in England during the Victorian era when females were just beginning to move out of the home and domestic work, and into the job market. In particular, circumstances created a surplus of middle and upper class spinsters for whom it would be desirable to find respectable, self-supporting occupations (O'Brien, 1987: 16; Stacey, 1988: 93). Females seeking to broaden their job opportunities needed to avoid alienating male workers. One way of doing this was to create new occupations, especially purely female occupations such as nursing. Nurses could not afford to antagonise doctors because the role created for them was to care for hospital patients and doctors had the ultimate control of these patients. Doctors quickly came to see the advantages of these new, reliable, trained nurses and soon became amongst their most ardent supporters; not just their supporters, but also their controllers.

There were three powerful influences on the development of nursing: the church and the military with their hierarchical structures and unquestioning obedience to superiors; stereotyped gender relations; and the concept of 'science'. Medicine was promoted as scientific while nursing was labelled non-scientific because it relied on a natural female instinct. Because nursing was depicted as non-scientific it was argued that it required little formal education, and raw skills could be refined by hands-on experience (Hartnett et al. 1979: 57-67). Medicine retained and expanded its knowledge base while nursing did not.

Nightingale and other nursing leaders recognised the importance of altering the popular image of nursing to one of respectability and in so doing making it a desirable occupation for Victorian females. This required strict control over probationers and trained nurses in order to weed out undesirables and instil notions of feminine obedience. This strict regimentation of nurses by nurses reinforced respect for medical control. Importantly, strict regimentation of nurses was very necessary to minimise the opportunities for sexual harassment
which was a real risk from doctors, porters and male patients (Bullough, 1990: 5). Minimising the risks of sexual impropriety helped to establish a positive public image.

In order to fit the Victorian ideology of what befitted a female, it was desirable to present females as eminently suitable to nursing due to their very nature. Because it was natural, female nurses had the stamina and sensibilities for difficult and disgusting tasks which otherwise might have excluded them from nursing in the Crimean War and the American Civil War (Muff, 1982: 104). Victorian society believed in divided spheres of activity for males and females. Doctors were strongly opposed to females entering medicine but rapidly came to support female entry into nursing, albeit in a subservient role (Ehrenreich and English, 1973: 38-40; Walsh, 1977). The Lancet has noted that, "Woman as a nurse is the natural help of man as doctor. Woman as a doctor is a conceit contradictory to nature" (quoted in Wright, 1985: 34). Similarly, "right up to the 1900s, voluntary hospitals would not admit men for nurse training because it was thought they might 'usurp the function of the doctor'" (Chua and Clegg, 1990: 143).

In the early days of the new nursing there were two types of nurses. First, there were matrons and the Lady Nurses from the upper class, who were often socially equal to the hospital Governors and who normally came from a higher social class than the (middle class) doctors (Davies, 1982: 126; Bond and Bond, 1986: 302). They needed to act subserviently to the doctors in order to gain their support. Then there were other nurses who came from the lower classes and who were using nursing to elevate their status (Game and Pringle, 1983: 100-101). They were socially subservient to doctors and matrons and would not seek to jeopardise their occupational and social advancement through disobedience. The early matrons personified a reinforcement of patriarchal authority. Those aspects of nursing not controlled by doctors were controlled by the matrons in the name of, and for the benefit of, the doctors. This is a typical "divide and rule" strategy which kept nursing disunited by pitting the somewhat prestigious nursing administration against the bulk of lower status, bedside nurses (Willis, 1994: 49). In many ways the role of the matron was analogous to that of an upper class woman in a Victorian household with authority over her own sphere but subordinate to the male
authority (Game and Pringle, 1983: 100). This model of hospital relationships was exported throughout the British Empire and to the U.S.A.

The perpetuation of female nursing subservience within the health care system begs the question of why nurses have remained largely passive over time despite significant changes in gender relationships in general Western society. Until comparatively recently, nursing has been equated with conservatism and support for the status quo (Chinn, 1985: 76).

A critical factor was the early professional control of nursing by doctors. Early in the twentieth century doctors acted to regulate their own profession. They were also prompt to enact legislation to protect their own interests (Beaumont, 1987: 49). Such legislation greatly restricted the boundaries of nursing and left nurses with the only viable option of acting as assistants to doctors. The medical profession was also quick to establish control of nurse education. Schooling of nurses had to be sufficient to make them useful assistants to doctors, but not great enough for them to be able to challenge doctors. In 1906 the Journal of the American Medical Association wrote that, "Every attempt at initiative on the part of nurses ... should be reproved by the physician and the hospital administration"; and in 1909 a Board of Medical Examiners stated that, "The instruction commonly prevalent in hospital training schools is not only too comprehensive, but dangerous. It is sufficient to almost entirely result in nurses assuming the right to usurp the functions of physicians" (quoted in Aaronson, 1989: 275-276).

Some authors suggest that in the late nineteenth and early twentieth centuries neither medicine nor nursing had a strong scientific base, and that nursing, with its emphasis on hygiene, did more to reduce hospital mortality than did medicine with its crude attempts at curing (Aaronson, 1989: 275). Subsequently, when medicine developed a scientific base for its actions, nursing was denied a reciprocal response because of medical control over nurse education which prevented development and testing of nursing theories.

The popular image that had been created of the nurse as a passive, poorly educated female served to reinforce this subservience by influencing those wishing to enter nursing.

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24 It should be acknowledged that these relationships were not always so clearcut. There is evidence that in the early days there were examples of conflict between matrons, doctors and the hospital administrators contesting realms of authority, but this settled down to amicability once jurisdiction was established (Reverby, 1987: 6). The main health care workers not involved in these power struggles were the bedside nurses.
Nursing was presented to the public as, "Prepare for marriage and motherhood: become a nurse" (Muff, 1982: 160). If females were only going to practice nursing for a short time and then leave, it was hardly worthwhile to give them an extensive education. As attitudes changed to female entry into medicine, it was considered more appropriate for "smart girls (to) become doctors" as opposed to entering nursing where they would be wasted (Muff, 1982: 178). So, the more dynamic and academically successful females who might have become nursing's leaders were actively discouraged from entering nursing. The women's movement saw nursing as a lost cause, the classic example of female suppression with nurses not recognising, nor wishing to change their inferior role (Muff, 1982: 178). It is only in recent years, when the nursing leadership embraced aspects of feminist ideology, that the desire for change has been expressed by nurses themselves.

For many years organised medicine opposed the raising of nurse entry standards as unnecessary, while still encouraging the maintenance of an apprenticeship training system for nurses (Campbell-Heider and Pollock, 1987: 424). Lack of education and the medical control of nurse education helped to maintain nursing as a dependent occupation. Nursing schools as late as the 1960's and early 1970's have been described as authoritarian, influencing the socialisation of student nurses into the existing hospital system (Spicker and Gadow, 1980: 27). Non-conformity would usually lead to leaving nursing early in training. Up to this period nursing philosophy was based on altruism with the nurse being educated to value others (patients and doctors) higher than herself (Muff, 1982: 234). Nurse education thus inculcated subservience in nurses.

There is evidence that even today the practical and theoretical education of medical students (both male and females) acts to socialise these emerging doctors to assume the inferiority of nurses (Webster, 1988: 130-135). Thus, while nurse education over the last two decades has developed the idea of the team approach to patient care, with collegiality between nurses and doctors, doctors have learnt to adopt the ideology of team care but with the difference that they maintain leadership and control, even over nursing matters (Campbell-Heider and Pollock, 1987: 421). Even more evident than in the late nineteenth century, nursing students tend to come from a lower socio-economic class (working class parents) than do
doctors (who are middle class and tend to come from a middle class background) (Muff, 1982: 224; Willis, 1994: 20-22). This difference in socio-economic class means that nurses, and especially nursing students, tend to defer to doctors.

It is against this long history of nurse subservience to doctors that the nursing leadership currently seeks to change the attitudes of nurses and, particularly, nursing students (McCarthy, 1994: 51). A different type of socialisation is a significant factor in the desire to transfer basic nurse education from hospitals to the tertiary sector.

4.3. Men in Nursing

Nursing is stereotyped as a female occupation. With the exceptions of Christian monks in their monasteries and military knights, such as the Order of St. John of Jerusalem, the popular image of nurses has been that of females. The Nightingale movement reinforced this image by linking the occupation of nursing with ladylike qualities. Men in nursing were originally almost solely confined to psychiatric nursing where, presumably, it was thought that their superior strength and assertiveness would be useful in subduing violent patients (Chua and Clegg, 1990: 148).

Though the New South Wales Nurses' Association merged with the male dominated psychiatric nurses in 1945, the numbers of males in general nursing in the state remained low. Only in recent decades have males begun to enter general nursing in greater (though still small) numbers. In 1990 only 6% of nurses in Australia were males (Southward, 1990: 45).

There are two major issues regarding males in nursing. First, there is the observation that males have tended to advance through the ranks to senior nursing positions in disproportionate numbers. While some (female) nurses view this with concern, others seem to imply that this is beneficial to nursing. Second, there is a general concurrence in the nursing literature that it is needful to attract more males into nursing. The reasons for this and the ways proposed to achieve it are very interesting.

There is a paucity of information about the rapid advancement of males to senior nursing positions within Australia. However, since the mid-1970s there has been considerable
examination and analysis of this phenomenon in Britain and the U.S.A. Rapid advancement of males in nursing clearly does occur and this fact is widely mentioned in the nursing literature (Williams, 1989: 95; Dickenson, 1993: 283 and 303). Most authors suggest that males occupy about one third of the top managerial and educational nursing jobs in Britain (Oakley, 1984: 25; Hardie, 1987: 45; Short and Sharman, 1989b: 233). Gaze in 1987 stated that while men formed 8.6% of British nurses, they held 50.25% of chief nurse adviser posts and 57.8% of Director of Nurse Education posts (Gaze, 1987: 25). There are no comparable figures for Australia, and while this disproportion is possibly not so great, there is still general agreement that males rapidly advance up the career structure to the point that "where nurses once tended to be indirectly dominated by men in the medical profession ... present day nursing sees a growing domination of male nurse managers." (Austin, 1977: 113).

The reasons given for this advancement are various. It is argued that males are more likely to be mature age entrants into nursing 25 who have a clearer expectation of where they want to go in nursing and hence plan ahead and seize opportunities (Williams, 1973: 520; Streubert, 1994: 29). Males prefer to specialise in nursing areas such as special care nursing 26 or nurse education rather than remain generalists, and tend to seek advancement rather than continue with basic bedside nursing (Godfrey, 1979: 81-95; Villeneuve, 1994: 220). A survey of male nursing students in an Australian hospital in 1982 showed that the majority believed that 'getting ahead' in life was important (Dowdell, 1982: 167). Males are more career minded and apply for senior positions in greater numbers, it is suggested, because they are more confident (Nuttall, 1983: 11; Chua and Clegg, 1990: 157). The rigid nature of the health care hierarchy disadvantages females because it does not take into account broken and part-time career patterns for mothers, while married female nurses lack job mobility because they are usually geographically tied to their husband's job (Nuttall, 1983: 10). A study by Hardy in 1987 found that while the majority of male nursing leaders were married, 33 out of 36 female

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25 Perhaps this may be because they are males and consequently they are not encouraged towards nursing as a career while still in high school, but several years into the workforce they review their career pathway. Certainly with hospital based training, they were paid (low) wages during their career change, which made such a work move not totally unattractive.

26 Just as (male) doctors seem preoccupied with technological 'cure' of the patient, so do male nurses; while female nurses seem to gravitate to low technology 'care' of the patient.
nursing leaders were unmarried, so that it would seem that marriage restricts female nursing career opportunities (Hardy, 1987: 36). Similarly, a broken work pattern means that it takes, on average, an extra decade for female nurses with children to reach the same seniority level as male nurses (Gaze, 1987: 26). Finally, it is suggested that the interview panels for senior nursing positions are more likely to be impressed by the masculine qualities of male applicants, such as authoritativeness, which are deemed more suited to administrative posts (Nuttall, 1983: 11).

The monopolisation of senior positions by males is not unique to nursing. It has been commented upon in a number of other semi professions such as teaching and social work. Once almost exclusively female occupations, the increasing entry of males has seen them gravitate to the top. Sociologists describe this as a consequence of attempts by these occupations to move towards the masculine professional model (Short and Sharman, 1989b: 233-234). Males in these semi-professions seem to find it easier to meet the perceived criteria of professionalisation. Hearn states that administrative ideology tends to be male orientated and as a consequence "the semi-professions can be seen as one relatively easy route by which men can reach managerial positions" (Hearn, 1982: 195).

The total number of men in nursing remains small. It is seen as highly desirable to significantly increase the proportion of men entering nursing. The Briggs Report of 1972 was one of the earliest official calls for a deliberate effort to increase the numbers of male nurses (Skevington and Dawkes, 1988: 49). In times of nursing shortages it makes sense to double the potential market from which to draw nursing students to include both females and males, and it has been claimed that "men are more likely to remain in nursing, once trained, than their female counterparts ... the training of a male nurse is a good investment." (Brown and Stones, 1971: 53).

A number of nursing writers have also strongly expressed the desire to attract more males into nursing. A recent survey of heads of nursing courses in Australia showed that most felt that nursing was disadvantaged by a predominantly female membership and that encouraging more males into nursing was highly desirable (Speedy, 1990: 71). The stated reasons have little to do with increasing the range of applicants for nursing, or a belief that
males have traditionally been denied the right to care for the ill through the medium of nursing. Rather, they describe the benefits to be gained by nurses and nursing through the increased presence of males. It has been argued that in order to attract more males and as a consequence of having more males, nurse salaries would have to increase, to the benefit of all existing nurses. The implication is that most males would not work for the traditionally low wages that nurses receive, and that, once in nursing, males would be vocal and politically active in seeking to increase their pay (Gaze, 1987: 27; Streubert, 1994: 30). Studies suggest that male nurses are more militant than female nurses and would not be as hesitant to take action to improve their work conditions (Gray, 1989:147; Miller and Dodson, 1976: 44).

Similarly, it is argued that more males would increase the status of nursing, both because it would no longer be stereotyped as a female occupation, and because males would increase the professionalism of nursing as they would refuse to play a subservient role to doctors (Dachlet, 1978: 37). Typical of statements appearing in the nursing literature is, "Nursing needs to lose its association with femaleness in order to achieve full professional status ... male nurses are more likely to emphasise the professional status of nurses than are female nurses" (Rosen and Jones, 1972: 493-494). Not all nurses are in agreement with this trend which depicts men as the liberators of nursing. They claim that "it is unseemly to have come all this way as a collective force, especially as a force of women, only to yield the task of equalising the status of nursing and medicine to the smallest fraction of that force - men" (Wheeler, 1991: 29).

Males are also said to contribute more to better staff relationships (versus good nurse-patient relationships which are perceived as more responsive to 'femaleness'). Stein et al. in 1990 claimed that at least part of the nurse-doctor game had changed away from the male dominance and female passivity stereotypes due to the presence of more male nurses (Stein et al. 1990: 23). Anecdotal evidence of better communications and relationships between male nurses and doctors (both male and female) is widely reported in the nursing literature. Examples include, "I find that most doctors do not speak to me the way they would to a female nurse", and, "The staff on clinical units allowed me greater autonomy in the care of patients."
They tended to identify me as a member of their own group as well as a student" ("The nurse-doctor game", 1991: 61; Cias, 1982: 276).

Nurses saw that the way to attract more males to undertake nurse training was to distance nursing from the stereotype of poor pay and conditions, but, even more importantly, from the rigid hospital hierarchy with its images of the regimentation and uniformity of nurses. It was argued that the way to attract males was to move basic nurse education into the tertiary education sector where nurses would just be like any other student and would not be exposed to the same socialisation process that occurred in hospital training (Muecke and Srisuphan, 1989: 643; Speedy, 1990: 71). This assumption is widespread and is typified by the statement that "tertiary training has also made the profession of nursing more popular to men" (Southward, 1990: 45). There is a variation on this theme which places an even greater emphasis on the connection of males with university education. Cadd, for example, contends that "... the very progression being applauded (the beginning of trial tertiary courses in nursing) has only come since males have been allowed to nurse in any significant numbers" (Cadd, 1979: 5).

Hence, scattered throughout the nursing literature are the assumptions that more men in nursing would lead to improved pay and conditions; increased status for nursing; increased professionalism; and improved staff relationships, especially those between nurses and doctors. One important way to achieve these benefits was to make nurse training more attractive to men by moving it into the tertiary education sector. The occupational development of nursing has suffered from its association with femaleness. Male nurses are seen as an essential component in the professionalisation of nursing.

4.4. Nursing Uniforms

There is a plethora of articles in nursing journals concerned with the subject of nurses' uniforms - changes in uniforms, their history, the advantages and disadvantages of differing styles and their effects upon nurses and patients. This exaggerated concern was also apparent among nurse academics in the early years of the transfer of basic nurse education to the tertiary sector in this state, with considerable time and effort being expended on the topic of
clinical uniforms for staff and students. This preoccupation with nursing uniforms is motivated by the professional aspirations of nursing.

Again this concern may be traced back to the influential role of Florence Nightingale. Prior to Nightingalism there were two types of female hospital nurses: religious nurses - nuns - who wore a particular type of clothing which conveyed an image of respect, cleanliness and servitude, and a second group of untrained, uncaring lower class women who could not find any other suitable type of employment and whose nursing care was considered as poor as their standard of dress (Muff, 1982: 397).

Nightingale in organising her nurses to care for sick soldiers in the Crimea was obviously strongly influenced by her previous experience with the religious nurses at Kaiserwerth and by the need to fit into the military bureaucracy. Not surprisingly, she required uniformity in dress among her nurses. The result was the strong paramilitary and religious appearance of nursing uniforms, complete with badges, belts and headwear (veils). This appearance was duplicated in the Nightingale nursing schools in England and hence worldwide. In many ways, nursing uniforms were similar in appearance to that of Victorian parlour maids (Tiffany, 1987: 40). This, it is claimed, served both to emphasise the subservience of nurses to the military and civilian doctors, and to encourage the middle class to enter hospital, where it was just like home and they could rely on the conscientious care of the nursing staff (Kalisch and Kalisch, 1985: 888). It is also suggested that uniforms suppressed the sexuality of the nurse; that they obscured obvious sexual characteristics and turned nurses into the ‘third gender’, making nursing a much more acceptable occupation for unmarried Victorian women (Maggs, 1983: 197).

There was little change in nursing uniforms till after the Second World War. Nurses were proud of their uniforms and what small changes did occur were usually initiated by hospital laundries, such as reducing non-essentials like sleeve ruffles which were difficult to launder (Bamford and Sparrow, 1990: 48). From the 1960’s onwards, nurses in some small, specialised areas began to challenge the usefulness of nursing uniforms which were said to set up barriers which impeded nurse-patient relationships (Jones, 1980: 108). In some paediatric, psychiatric and mental retardation units nurses began either to wear street clothing or colourful,
distinctive smocks (in paediatrics) in order to break down the separateness of nurses and patients. Overseas in nurse administration and nurse education, though not nearly as common in Australia, there was also a move away from uniforms (Nightingale, 1983:23). Males, who previously had largely been confined to working in mental hospitals, had never had the same tradition regarding uniforms (Jones, 1980: 107). They were entering general nursing in larger numbers and their uniforms were designed for practicality rather than tradition.

Many arguments have been presented for the need for nursing uniforms at the bedside. The overt argument relates to cleanliness and prevention of transmission of infection (Bamford and Sparrow, 1990: 48). For years nurses could not wear uniforms outside the hospital because of the concern that they might transfer infection on their uniforms into and out of the hospital. However, studies show no difference between cross-infection rates with uniform or mufti. Rather, uniforms are thought to serve a number of other purposes.

It is argued that uniforms enable patients to easily identify nurses (Franzoli, 1985: 1108). However, studies have shown conflicting results. While some surveys suggest that patients think that the main reason nurses wear uniforms is for ease of identification, other surveys suggest that this is perceived as a minor role for uniforms and that uniforms serve a number of other more important sociological roles (Bamford and Sparrow, 1990: 46; Blackmore and Crock, 1990: 15; Joseph and Alex, 1972: 730). For the novice nurse, uniforms aid in the bonding process - the formation of a group identity. Changes in uniform with progression through the nursing hierarchy, even such minor things as the addition of year stripes during training, serve as 'rites of passage', establishing loyalty to the group. Differences in uniform amongst nurses (year stripes, badges, buckles, epaulets and different coloured uniforms) reflect different status levels amongst nurses. Importantly, the uniform establishes authority over the patient, giving the nurse power of control. It can also act as a symbol for the nurse to hide behind, giving the nurse anonymity if so desired so that s/he is no longer an individual, 'the nurse', but rather, 'a nurse' (Martin et al. 1986: 33). Whatever the reasons for the retention of nursing uniforms, studies have shown that patients prefer to be cared for by nurses in traditional white/pastel uniforms and that nurses, especially student nurses, prefer to wear these traditional uniforms (Franzoli, 1985: 1110; Muff, 1982: 401).
Tertiary based nursing represents a significant shift in the wearing of uniforms. Uniforms are worn only in appropriate clinical settings and never on campus. Student uniforms are immediately seen to be different from traditional nursing uniforms. There is no conformity of dress among tertiary institutions, and there has been a surprisingly large number of changes in student uniforms since 1985. Student uniforms have used colours not traditionally associated with nursing, such as apricot and plum, and in some cases have adopted colours (navy and white) and styles associated with nursing administration. Females can wear pants or culottes and males can wear shorts in summer. There is no differentiation between years, such as year stripes, even though ward staff complain that it makes it difficult to know where students are in their course and hence what they can do on the wards.

Perhaps the most interesting change is in the uniforms worn, or not worn, by nurse academics when, and if, they are on clinical supervision on the wards. Where they do wear uniforms, their clothing options include such items as culottes and shorts and their colouring tends to reflect that of nursing administration. Increasingly though, nurse lecturers are being given the option of, and are encouraged to wear, civilian dress with a white lab coat. This reflects an American trend which, not surprisingly, seeks to mimic the dress of most doctors in hospitals (Martin et al. 1986: 33). Nursing literature speaks of "power dressing", of the need to dress professionally (i.e., like a doctor) (Rosenfeld and Plax, 1977: 24). Traditional nursing uniforms are said to suggest a non-autonomous person because they reflect uniformity. Nurses dressed this way "lack authority apparel" (Muff, 1982: 400). In order to identify with the professional group they would like most to emulate, nurse academics prefer to wear lab coats over mufti in the clinical setting. It is argued that professionals do not wear uniforms (though surely lawyers in court have their own uniforms). However, surveys suggest that patients still prefer to be cared for by nurses in traditional uniforms, rather than nurses in more modern uniforms such as pants for females, or by nurses in mufti and lab coats (Mangum, 1991: 129). Then again, nurse academics usually have little to do with direct patient care when on clinical supervision, so patient preferences are of minor significance. White coats are seen as more authoritative, though patients are more distanced and less likely to talk with nurses wearing them (Tiffany, 1987: 40).
Interestingly, one study in which general ward staff ceased wearing their uniforms found that nurses altered their perception of their place in the health care team (Sparrow, 1991: 120). Lack of uniform increased their assertiveness with doctors, and doctors appeared more willing to listen. A strong suggestion emerges that uniforms reinforce both subservience amongst nurses and doctors' dominant behaviours towards nurses.

Changes in tertiary education nursing uniforms reflect a desire to be seen to be separate from the hospital setting. They have blurred the status rankings among nurses and between nurses and doctors. Rejection of uniforms by nurse academics is a manifestation of nursing's revolt against its traditional image. Nurse academics can appear more like medical doctors, reflecting their aspiration towards this profession's status. The dropping of, or at least significant changes to, nurse uniforms is said to present a more professional image (Nightingale, 1983: 23). It is a small action which may or may not have the desired effect, but it represents change that was only really possible away from the hospital setting.

4.5. Changing Nursing Titles

Changes in nursing titles over time reflect changes in nurses' attitudes towards themselves. Registered nurses used to be known as 'sisters', reflecting nursing's religious origins. They were addressed as such, for example, Sr. M. Jones, were documented under this title and were referred to by this title in the nursing literature. When males began to appear in small numbers in the general nursing population from about the 1970s onwards, they could not really be known as 'sisters', and instead were known as 'misters'. At about the same time, the predominantly American nursing literature recorded many changes. Possibly under the increasing influence of the feminist movement which sought to disassociate nursing from 'femaleness', and possibly in order to emphasise a new, increasing 'professionalism' of nursing, qualified nurses were no longer sisters but rather were registered nurses or R.N.s. Likewise, nursing aides or enrolled nursing aides became enrolled nurses or E.N.s, and the connotation of being mere aides or assistants was lost.

27 Doctors are known by the title of 'Dr', but eminent specialist doctors traditionally have been elevated to the designation of 'mister' - a kind of reverse snobbery within the health care system.
The nursing literature now referred to the registered nurse or the professional nurse, and documents were now signed 'M. Jones, R.N.'. Similarly, as part of the increasing bureaucratisation of nursing, ward charge sisters have become Nurse Unit Managers (N.U.M.s), and matrons have become Directors of Nursing (D.O.N.s). During their hospital training, trainees were known as nursing students, presumably with the emphasis on the 'nursing' component of their designation. They were nurses first and students second. Within the tertiary education system these entrants into nursing are known as student nurses - with the emphasis now being reversed to highlight the 'student' component of their title so that they are seen as students first who just happen to be enrolled in a nursing course.

There has also been an increasing emphasis on credentials, so that where once Australian nursing journals would have spoken of 'Sr...', now his/her full nursing qualifications would be listed. Our example has become, M. Jones, R.G.N., R.M.N., B.A., F.C.N.A. standing for registered general nurse, registered midwifery nurse, bachelor of arts, Fellow of the College of Nursing, Australia. This highlighting of credentials is part of the professionalisation process whereby would-be professionals emphasise their qualifications, and, with more and better qualifications, comes a perceived increase in status. More recently, there have been proposals by nursing organisations in the U.S.A. that "... the title of the professional nurse shall be Registered Professional Nurse (RPN)" (Velsor-Friedrich and Hackbarth, 1990: 131).

There has also been a number of changes in the titles of those who teach nurses. Up until the Second World War, student nurses were taught by experienced registered nurses who were simply referred to as sisters like everyone else. In the late 1940s a new category of sister-tutor was created to describe nurses specialising in nurse education. This simply showed that they were involved in the teaching of nurses and there was no increase in status associated with the title (Gillam, 1969: 255). During the 1970s a name change occurred to nurse teacher. Again, this was partly due to the disproportionate numbers of male registered nurses moving into nurse education who required an alternate title to sister-tutor. It might also be suggested that there was an increased prestige to be seen to be involved in the more 'professional' pursuit of teaching, as opposed to the poorly paid, long suffering nursing. However, during this time
there was a growing public dissatisfaction with the performance of school teachers and a probable lowering of their public status. About 1980, there was another name change to nurse educator, which sounded more authoritative.

With the transfer to the tertiary education sector, the hospital based nurse educators suddenly became nurse academics or nurse lecturers, or more significantly, lecturers in nursing or nursing studies. The emphasis no longer falls on nursing, but rather on tertiary lecturing. This represents a significant change in title with a strong public association with prestigious tertiary institutions. Within the tertiary hierarchy, there are opportunities for nurse lecturers to advance to positions of senior lecturer, associate professor, professor, Head of Department of Nursing and Dean of the Faculty of Nursing. These positions and their associated titles did not exist under the old hospital based system of nurse training. Changes in positional titles within nurse education represent increases in status (and salary and conditions) among nursing peers, alter relationships with other tertiary academics and influence the general public's perceptions of nurses involved in education.

4.6. The Image of Nursing

For many years there has been concern among nurse leaders about the public image of nursing. Nursing work is usually seen as inherently women's work. The Australian Nurses Federation has emphasised the need to change the image of the nurse from the feminine, Victorian stereotype perpetuated by the media (Editorial, 1984: 5). Editorials in influential American journals rail against the 'false' image of nursing displayed on television - "all nursing believes that the profession will be harmed if the same images depicted in the movie ('Nightingales') are part of the series" - while praising the positive image of the nurse in such series as "China Beach" where the lead character has "courage, compassion and confidence" (Nation's R.N.s rally', 1989: 861 and 874; Wagner, 1989: 5).

Nursing's lay handmaiden image has been described as "the ghost of the Crimea", retarding the growth of updated images of nursing (Hodges, 1988: 50). The Briggs Report of 1972 in Britain said that "nursing retains an inherited image which belongs in the late nineteenth century" (Salvage, 1983: 14). This subservient image cannot entirely be blamed upon a
deliberate, but unfortunate, strategy of Nightingale's. As English nurses spread the new nursing throughout the world, it remained necessary to gain medical and public support by maintaining an exaggerated Victorian era stereotype in which they were feminine and hence passive, submissive, unassertive and dependent on the father figure of the doctor. Because they were female and nursing was seen as an instinctual, maternal ability, and because they did not wish to antagonise the medical profession, little emphasis was placed on intelligence or academic preparation of nurses. By the time it was possible to alter the image it was too firmly entrenched and nurses had come to believe it themselves. The idea was developed that nurses were 'born not made' and this myth was continued to be perpetuated so that as late as the 1970's in Britain a Department of Health recruitment advertisement could make the claim that "the best nurses have the essential qualifications before they go to school" (Salvage, 1983: 13).

The main concern about the image of nurses is directed at the public perception of nurses, but also of concern are: nurses' own self-image of nursing and nurses; the way doctors, and to a lesser extent other health care providers, perceive and hence interact with nurses; and, importantly, the expectations of students commencing their nurse education. An understanding of these concerns about popular nursing stereotypes throws light on the nurse leadership's own image of nurses, of what they want it to be and what steps they are taking to try to alter existing images.

Nurse academics express concern about the various images of nursing because they are deemed to restrict the ability of nursing both to develop as a profession and to attract the resources for nurses to develop and practise as independent health care providers. This affects the status, authority, remuneration and bargaining powers of nursing. The popular image depicts nursing as a practice discipline - a hands on art. This is seen to have retarded the development of nursing theory because female nurses were deemed to lack the analytical skills needed to conduct research to validate theories (Muff, 1982: 147). Because nursing is perceived as not needing the possession of scientific knowledge it requires less funding for its education than does the more intellectual medicine (Williams, 1992a: 3s). Legislators, influenced by negative images of nursing, withhold appropriate funding for nurse education and restrict the
extent to which nurses can act as independent practitioners. It is argued that if you can alter the public image of nursing than you can redress the above problems.

It is also claimed that misleading public stereotypes of nurses and ideas about the functions of nurses give false expectations to many entering nursing (Cohen, 1981: 13; Begany, 1994: 30). Many intelligent people who would be of benefit to nursing do not consider nursing as a viable occupation, or, if they did enter hospital training, they soon dropped out because of lack of stimulation and the rigidity of the training system. Nowadays many who are drawn to nursing are unhappy with the academic side of nursing because they did not expect such an emphasis on theory. Many others are not ready for the harsh reality of nursing and the sheer hard work. Entrants display the values and attitudes of the lay public rather than those of a profession. They need to be socialised during their tertiary education towards the images of the modern nurse said to be held as desirable by nurse academics. For example, nurse academics imagine that the newly graduated nurse should have a commitment to continuing education, though this is by no means proven, and it seems more likely that new graduates are more concerned with adjusting to bedside nursing and earning a wage.

There is also concern that the 'more realistic' image of the nurse that is beginning to be displayed by the media depicts nurses not as first class nurses, but, rather, as second class doctors (Muff, 1982: 143). That is, they display nurses in high technology situations such as the Intensive Care Unit (I.C.U.) or Accident and Emergency, performing tasks more usually associated with medicine, but fail to depict nurses in holistic and caring situations (which is the direction in which the nurse leadership wants nursing to advance) (Aber and Hawkins, 1992: 289).

The present day public image encompasses a cluster of stereotypes about nurses which tend to have in common the attribution of a lack of effective power among nurses. There are three main images of nurses (Salvage, 1983: 13; Muff, 1982: 139; Schweitzer, 1994: 88-89). Firstly, there is the traditional angel image, with the nurse as a faithful servant, not too bright, but who does not complain and is willing to make sacrifices. Then there are the 'bad' stereotypes of the naughty nurse, or exploited sexpot, and finally the battle-axe dragon or hard nosed despot images. All these images are distortions of reality and like all stereotypes fail to
display the full complexity of any group of people. Added to these main stereotypes are two new groupings - the male nurse who is homosexual, and the militant nurse (Villeneuve, 1994: 220). The latter has gained much attention, such as in Australia during the nursing strikes and rallies of the late 1970’s and 1980’s, because the image is so incongruent with the entrenched images of self-sacrificing nurses (Lupton and Najman, 1989: 243).

Such images of nursing are truly transcultural. Studies of people’s perceptions of occupations in many different countries equate nursing with femininity and a helping orientation, while medicine is perceived as masculine with an achievement orientation and a higher educational level (Austin et al. 1985: 236; Kaler, 1989: 85-89). Hence, the idea that, "The public stereotypes nurses as temperature takers with small brains and big hearts" (Keddy et al. 1986: 752). It should be noted that the public still respects nurses. A Canadian study showed that the profession/occupation with the 'best' public image was nursing, while nursing's 'prestige' rating was high (though not as high as medicine's) at 3.59 on a 1-5 scale (Davies, 1989: 21; Austin et al. 1985: 232). But what the image of nursing most lacks is what nurse academics most want for nursing - power, authority and autonomy. In particular, the majority of the public continues to believe that nurses should first consult with the doctor before initiating any care - the antithesis of an autonomous role for nurses (Wright and Dorsey, 1994: 35).

The stereotypical images have been created and maintained by the media's presentation of nurses (Tattam, 1994: 32-34). Kalisch and Kalisch and Muff have exhaustively analysed how nurses have been and currently are represented in the movies, on television, in books and in children's books and games (Kalisch and Kalisch, 1982a: 264-270; Kalisch and Kalisch, 1982c: 605-611; Muff, 1982: 113). By far the most common depiction of a nurse is as a single, white, childless female under 35 years of age, subservient and in a hospital setting (Hodges, 1988: 98). Nurse educators argue that this image has not progressed with the changes that have occurred with increasing nurse educational preparation and the changing makeup of nurses.

Doctors have their own images of nurses. In general they see nurses as handmaidens, as assistants rather than as colleagues (Austin et al. 1985: 223). Nurses argue
that doctors, and to a lesser extent other health care workers, do not understand the capabilities of nurses and underrate their valuable contributions to patient care. Nurses generally do not see themselves as subservient and see a partnership with doctors as important, but this is not what is happening (Heenan, 1991: 26).

Entrants to nursing, because most of their exposure to nursing comes from the media, normally have a lay view of nurses and nursing. Left unchallenged, such views would have strong influences on their educational and occupational lives. With tertiary based nurse education, the views held by nurse academics become of increasing importance. They claim to see nurses as professionals with a knowledge base and an appropriate theoretical understanding to practise with authority and autonomy in an independent role. The move to the tertiary sector is critical to the establishment and maintenance of this ideal image. The popular representation of nursing is essentially non-professional and needs to be altered as part of the professionalisation process.

4.7. Socialisation of Nurses

An appropriate socialisation of its students is essential to the professionalisation of nursing. Socialisation consists of both formal and informal processes or sets of activities by means of which a person gains an appropriate cultural and subcultural orientation, disposition and behaviour in order to function as a member of a particular group (Ahmadi, 1987: 108; Doheny, 1982: 174). Professional socialisation is a form of adult socialisation involving multidimensional activity by which a person gains a specific body of knowledge and skills, forms an occupational identity and internalises the values and norms of that profession (Betz, 1985: 13). It is the means by which a professional culture is transmitted. In the case of nursing, it is perhaps more appropriate to speak of occupational socialisation, especially in the hospital setting, because use of the term 'professional' is problematic as applied to nursing.

During occupational socialisation the new entrant exchanges the lay stereotype of the occupational role for one held by those with whom s/he interacts. There is a discontinuity with the past and commitment to a new ideology, with the establishment of new social bonds with his/her peers. For nurses occupational socialisation begins with their education and the
values that they adopt at this early stage are very important in shaping their subsequent
behaviour as Registered Nurses. There are two distinctly different forms of nurse education -
hospital apprenticeship training and tertiary education. Batey argues that the different milieus
result in a particularly undesirable occupational socialisation in the former and a much more
'professional' socialisation in the latter (Batey, 1969: 4). For nursing, the socialisation of new
entrants that occurs in the tertiary setting is essential for the adoption of professional attitudes
and behaviours that will advance the cause of nursing. Opposed to this, the socialisation of
student nurses in the old hospital training, Batey argues, inculcated subservience and did much
to retard the professionalisation of nursing.

4.7.(i). Hospital Socialisation of Nurses

In the old New South Wales hospital based nurse training system, student nurses
underwent a three year apprenticeship as paid workers in which they alternated study blocks
with work on the wards. Applicants for nurse training normally had to undergo a panel
interview involving senior nurses from education and administration. A commonly asked
question would be, "Why do you want to do nursing?". Wondrak suggested that occupational
socialisation began at this point, with the interviewers culling out those applicants who did not
meet the interviewers' expectations of what should motivate a person's desire to be a nurse
(Wondrak, 1989: 58). The acceptable responses would involve an element of altruism: a desire
to care for the sick, and, by implication, to put the needs of others before oneself.

Successful applicants commenced their training with a Preliminary Training School
(P.T.S.) of up to six weeks duration before starting work on the wards. The P.T.S. had a high
attrition rate, as it was a time of weeding out students with unsuitable learning behaviour and
attitudes. Neophytes were obliged to wear uniforms, were taught in a formalised classroom,
were strictly regulated during their eight hour study block day, having to clock on and clock
off, and were inundated with significant amounts of information to be learnt and skills mastered
before being let loose on the wards. Students were highly regimented with no room for student
initiative or individuality (Meissner, 1986: 52). New recruits were seen as "initiates who have
to be moulded into a system" (Mackay, 1989: 16). Those students who could not fit into this
authoritarian model were most likely to drop out or to fail academically because of lack of sufficient motivation to study for their many exams. Divestiture of student identity and individuality was encouraged to ensure conformity, in order to meet institutional needs (Bradby, 1990: 1222).

Nurse training school syllabi were set by the N.E.B. and were based largely on the supplying and retention of knowledge with little cognitive skills development and had as their ultimate goal the passing of the N.R.B. state registration exam consisting of two three-hour multiple choice question papers which were predominantly knowledge based. Nurse training was based on meeting the needs of the hospitals for useful workers who could reliably implement patient care as determined by the doctors - in other words, a service ideology (Bottorff and D'Cruz, 1985: 10).

The information supplied in the nursing schools was based on a modified medical model, with an emphasis on the gaining of proficiency in particular practical procedures of use on the wards. The nursing content was almost an afterthought in the curricula and little emphasis was placed on nurse initiative. There was an emphasis on rote learning with prescriptive knowledge and formalised problem solving. Nurse training schools established a formalised, authoritarian relationship with their students. Obedience, conformity, hard work and lack of initiative were fostered. The knowledge conveyed supported the medical model of illness and served to reinforce the dependence of the nurse on the doctor and add to the stature of the doctors. It has been suggested that hospital nurse training schools were "reminiscent of a nineteenth century teachers' training college" (Holloway and Penson, 1987: 238).

While nurse training schools did little if anything to alter the concept of nurse as handmaiden, training on the wards did even less for nurse independence. Nurse teachers generally had minimal interaction with students on the wards because either they were teaching in other study blocks or they were involved in supervising a number of students across a number of wards and shifts. The relationship between nurse teachers and ward staff was, at best, neutral. Common attitudes were that 'those who can do, those who can't teach', that nurses moved into teaching because they did not want to work at the bedside with patients and that students were taught in the school the 'proper way' to do procedures and on the wards they
learnt the 'real way' to do them (Fawcett and McQueen, 1994: 264-271). On the wards most of
the learning by students came from informal teaching by R.N.s, more senior nurses and even
enrolled nurses (Wyatt, 1978: 265-266). Because most of their three year training was spent on
the wards, students adopted ward staff as their role models, if for no other reason than to
survive the traumas of working on the wards. Occupational role identity by students has been
seen to occur within about six to ten months of commencing hospital based training (Bradby,
1990: 1220).

Hospital nursing is a status-rigid hierarchy with orders issued from the top down,
and student nurses on the bottom. Obedience is expected and there is little room or need for
nurse initiative. Most nursing activities are routine and laid out in procedure manuals. Events
outside the norm require consultation with, or intervention by, doctors. Students learn to obey
and to respect authority, especially medical authority. Studies have shown that new students on
the wards quickly learnt that their perceived worth by other nurses was based on technical
competence and that interpersonal communication skills and closeness with patients were
deemed unimportant or even wasteful of time (Brooker, 1978: 27). Students rapidly replaced
their humanistic skills with technical skills. Good nursing behaviour equates with speed and
busyness.

Nurse deference to doctors is demonstrated by the fact that, if a patient and a doctor
both speak to a nurse at the same time, the nurse will inevitably answer the doctor first and not
the patient (Muff, 1982: 203). The aura of medical wisdom was further enhanced by the fact
that senior doctors seldom spoke to student nurses on the wards but, rather, sought information
and issued orders through the R.N.s. This extreme social separation further enhanced the
mystique and superiority of the doctors. The main interaction between student nurses and
doctors occurred when doctors lectured to nurses on their areas of expertise. These were formal
lectures with no student input and were often highly technical and of dubious usefulness to the
students.

Nurses gained sufficient knowledge from their training and hands-on experience so
that, with most work being routine, there was little incentive to gain further knowledge because
it was hard to see its practical value. Only if an experienced R.N. chose to specialise in, say,
coronary care nursing, would the nurse undertake a short, post registration certificate course, typically 6 month duration conducted by the College of Nursing, which emphasised specific and practical skills. During their hospital training, nurses came to see nursing as more bureaucratic than professional, with little need for nurses to be creative, original or flexible (Roberts, 1984: 19). The newly registered nurse having survived the system was now prepared to fit back into the existing system and act as a role model for new student nurses, thus completing the circle. Hospital based nurse training resulted in a non professional socialisation of nurses.

4.7.(ii). Tertiary Based Socialisation of Nurses

It is claimed that tertiary based basic nurse education will break this cycle and lead to a different, more desirable socialisation of nursing students which they should then transfer to their working life and, ideally, will have a positive influence upon hospital trained R.N.s.

Because nurse education now occurs in universities it is possible that student entry expectations may be different from those for hospital training (Murray and Chambers, 1990: 1099-1105). Within a university setting, students may expect their nurse education to be more academic with the acquisition of knowledge and learning skills assuming a higher priority. The concern, most often expressed by certificate R.N.s, is that university educated nurses will lack clinical skills, lack a hands-on ability, and will be more concerned with theory than 'actual nursing care' (Submission from the Australian Council of Deans of Nursing, 1993: 2). With different entry expectations, more males might be encouraged to enter nursing, as it is supposed that a university degree would be more attractive to them. It has been assumed by many nurse academics that the entry expectations and behaviours of tertiary entrants might be such that there is a commitment to the educational ethos of continuing education, research and questioning behaviour.

Tertiary based nurse education, located away from hospitals, and independent of hospital service needs, has been able to adopt a much more flexible approach to student learning. Tertiary courses are comprehensive, with nursing content effectively reduced in the area of medical-surgical nursing, and much more emphasis placed than previously on
psychiatric, developmental disability, maternity, and community nursing (Basic Nurse Education: Guidelines, 1984: 2-3). Courses on nursing history, ethics, theory and research can be incorporated. The social sciences of sociology and psychology are given more emphasis (Nurse Education in N.S.W., 1984: 2). With no state registration examination focusing course content, much more curriculum versatility is possible. The result is that the biomedical model of illness can be largely abandoned in favour of various nursing models based on the concept of holism, with an expansion of content from a largely biological to a bio-psycho-social basis. Sociologically the effect should be to reduce the student nurses’s overwhelming respect for the medical model of health care and hence reduce their subservience to doctors. Medical care and nursing care should become separate entities. Nurse academics such as Cohen argue that students should get a much more rounded education with the tertiary learning qualities of inquisitiveness, questioning attitudes and initiative instilled in them (Cohen, 1981).

Nurse education in the tertiary sector is less authoritarian, with no uniforms on campus, less formalised organisation of the students' work/study days and more flexible teaching methods. Because students will have a much longer exposure to nurse lecturers, they will serve as their role models and, of course, nurse lecturers are meant to display more 'professional' behaviours and attitudes (Weller, 1988: 179-184). On clinical practicum students are supernumerary and under supervision (Basic Nurse Education, 1984: 3-4). As opposed to the delivery of repetitious service tasks, there should be less pressures on students in the wards and more room for individuality and more time for learning. Qualifying this is a reduced number of clinical hours in various ward areas (due to a conflict between balancing theory and clinical hours and the high budgetary costs of clinical supervision). There is also an awkward academic to student ratio, so that the majority of clinical supervision is conducted by non-lecturing/non-university clinical supervisors with, in reality, much of the clinical experience on a 1 to 1, or 2 to 1 student-to-registered nurse basis. It is possible that a significant proportion of occupational socialisation of student nurses during their formal educational period still actually occurs on the wards, where they learn about 'real' nursing (Bottorff and D’Cruz, 1985: 11).

Nevertheless, the expectation is that this change of educational setting and philosophy will facilitate the integration of professional role behaviours in these student nurses.
Cohen in her 1981 book *The Nurse's Quest for a Professional Identity* describes the four goals of 'professional' socialisation as:

1. The learning of theory, facts and skills;
2. The internalisation of the professional culture;
3. Development of a personally and professionally acceptable role;
4. Integration of this role into daily life.


Cohen's work has been influential in convincing many nurse leaders that tertiary socialisation of student nurses will foster increased self concept in the new graduates who will assume, over time, a leadership role within nursing (Joseph, 1985: 22). The aim is to produce students with an exit culture which incorporates autonomy, assertiveness, accountability, self directed continuous learning and nursing care focused on the patient's interests - all deemed aspects of professional identity (Mauksch, 1984: 58; *Submission from the Australian Council of Deans of Nursing*, 1993: 2).

The nursing literature regularly presents these conclusions as proven, and there appears to be a strong, widespread belief in nurse academia supporting these ideas. However, the few large scale studies of professional behaviour amongst (American) tertiary graduates compared to hospital graduates (trained in community colleges attached to hospitals in the American system) give ambiguous results. Some studies measuring autonomous behaviour and the nurse's professional orientation scale demonstrate more professional attitudes from university graduates (Meleis and Farrell, 1974: 162-167; Huck and Sandler, 1979: 39). Other studies of the Cohen's developmental model fail to show that students internalise the behaviours they are supposedly exposed to in the tertiary setting (McCain, 1985: 180-186; Hupcey, 1990: 196-201). However, it is the supportive results that are most commonly (and selectively) quoted in the nursing literature.

It is unclear whether tertiary educated nursing students incorporate the professional attitudes that their university education is supposed to give them. What has been established is that as newly registered nurses, tertiary graduates experience 'reality shock' when entering the workplace (Wilson and Startup, 1991: 1478-1486; Talotta, 1990: 111-115; Frisch, 1987: 25-
First coined by Kramer in 1974, in this context, the term refers to the conflict graduate nurses experience between their expectations from their university education and the real world situation in hospital wards. Because no extensive research has been done, it is unclear to what extent new graduates are resocialised in the hospital setting away from the 'professional' ideology to the existing hospital 'occupational' ideology. At the present time in New South Wales, this problem of resocialisation is possibly compounded by the fact that most new graduates enter the public hospital system on an initial twelve month or even three month contract. Depending on their suitability, i.e., their usefulness to the hospital, the contracts of these graduates can be let expire or made permanent. It is not unreasonable to suppose that those graduates who fit in, or quickly adopt the existing nursing attitudes at their hospital, are far more likely to retain their jobs than those who might be considered rebellious or disruptive or unreliable.

It should be noted that the nursing literature also clearly discusses the fact that tertiary based nurse education can and should be used to resocialise hospital trained R.N.s professionally as they upgrade their credentials from certificate to baccalaureate or post-graduate qualifications (Cragg, 1991: 256; Lynn, 1989: 232-237). The running of conversion courses is perceived as an opportunity to reeducate large numbers of older, hospital trained R.N.s towards a professional ethos.

Whether or not the education of nurses in a more liberal setting, away from the control of the medical profession and hospital bureaucracy, has a positive long-term effect on occupational attitudes of nurses is arguable (and unproven at this time). It is also unclear whether the majority of R.N.s (certainly in Australia) are all that concerned about the type of socialisation that was instilled in them during their training. What is important is that the concept of a desirable tertiary socialisation is widely believed to be true in the nursing literature and is presented to nurses as one of the reasons for the need to transfer nurse education to the tertiary sector.
4.8. Conclusion

Many of the issues discussed in this chapter appear routinely in the nursing literature. They help to explain part of the reasoning given for the push for tertiary based nurse education. The nursing literature when writing about nurse-doctor relationships, male and female health care workers and nursing socialisation, reflects many of the commonly held beliefs of nurses about nursing’s role and position in the current health care system. While many of these beliefs are generalisations or lack empirical evidence or are only part of the true explanation or depict a specific (and presumably biased) viewpoint, nevertheless, they help to illustrate the motivations of many nurses for changes to the existing nurse’s role.

Chapter 6, The Overt Reasons for the Transfer and Chapter 7, The Covert Reasons for the Transfer will evaluate the importance of these beliefs - whether they form a part of the educational rationale for transfer or whether they are rhetorical arguments which serve to obscure the real issues. Thus, for example, socialisation of nursing students in a tertiary education setting is used as an overt argument for the transfer of nurse education because such a setting is said to produce nursing graduates who are more innovative, adaptable and questioning, and hence deliver a better standard of patient care. A covert reason for the transfer is the nursing desire to socialise nursing students into professional behaviours, including an expectation of collegiality with doctors. Finally, there is a hidden issue involving the geographical separation of nurse education from hospitals and doctors, which means that nurse academics no longer have to interact with the medical profession and are free to pursue their own interests. Hence, many of the stated rationales for changes to nurse education, which, on the face of it, seem to be straightforward educational arguments, in fact, may serve a number of unstated ends.
Chapter 5

The New Nursing Technology: A Professionalisation Strategy

This chapter examines the components of the new technology of nurse education. It discusses the changes in technological emphasis from those existing in the old hospital based nurse training. It includes an examination of nursing theories and the nursing process, which highlight the differences between the old paramedical model of nursing and the new holistic nursing. The new nursing technology de-emphasises the equipment component of health care technology while emphasising the technique, the ways of delivering nursing care. This chapter describes how this changed emphasis is part of a professionalisation process and introduces a number of problems and inconsistencies with this strategy.

5.1. Introduction

Historically, nursing and nurse education have been subordinate to medicine. As medical knowledge grew and the use of technical equipment increased in hospitals, the medical profession encouraged an expansion of nurse education so that nurses would better be able to understand what was happening to the doctors' patients and be more proficient in delivering patient care. Progressively doctors abandoned procedures and equipment to the care of nurses. In order to be useful assistants to doctors and to supply the needed services in hospitals, nurses had to be adequately trained in paramedical knowledge. Doctors rate nurses' technical competence as much more important than their ability to provide emotional support (Oakley, 1984: 26). In the hospital setting, through their training, nurses have had to adopt a medical approach to patient care, to become proficient with 'high technology' and to communicate in medical terminology.

However, in the last ten to twenty years the nursing leadership and nursing literature began seriously to question the appropriateness of this type of nursing care. Concern was expressed that too great an emphasis on equipment dehumanised patient care, that the patient was lost amongst the machines, and that there was too much emphasis on 'cure' as opposed to quality of life, i.e., 'care' (Brewer, 1983: 97; Paterson and Crawford, 1994: 164-
This negative view of the dominant role of 'cure' in traditional health care may be taken to the point where the doctor is presented as a threat to the well-being of the patient with the nurse having a protective function (Turner, 1987: 153). There was increasing agitation by the nursing leadership to deemphasise the hardware (the equipment) with a reemphasis on a new software (the relationship between nurse and patient). High technology was rejected in favour of a high touch (low technology) nursing care emphasis. While medicine is based on the use of tools, the new nursing is to be based on the use of self-listening, teaching, guiding, supporting and just being there (Masson, 1985: 72). Medical care is presented as technocratic with too great a reliance on mechanistic technology, while it is claimed that the new nursing uses an ecological framework (harmonious with nature and self-reliant), based on new nursing techniques - a new way of providing nursing care (Allen and Hall, 1988: 33). Nursing "must balance care of the patient against the technology of medicine" (Hailstone, 1990: 19).

Rejection of paramedical ideology for a distinctly different nursing ideology and nursing terminology is presented as clarifying the separateness, the uniqueness of nursing, and assists the drive for professionalism (Tartaglia, 1985: 34). The technology of the new nursing permits the "assertion that nursing is parallel rather than subsidiary to medicine" (Gamer, 1979: 109). It is, in other words, a professionalisation strategy. It is therefore necessary to examine the new nursing technology and the new approaches to nursing care inherent in this technology. The following sections examine how tertiary based nurse education differs from the old hospital based nurse training in basic philosophy, language, knowledge, technique and application.

5.2. The Rejected Paramedical Model of Nursing

The ideological indoctrination of hospital nurses began with their hospital based nurse training. Hospital training had a medical emphasis which highlighted the use of equipment, an understanding of the medical concept of illness and the ability to use medical/technical jargon (Armidale and New England Hospital, 1980: 2-6; Western Suburbs Hospital, 1977: 3-5). Nurse education curricula were determined by the N.E.B. which was controlled by the doctors and the health care bureaucracy. Nursing students had the ultimate
goal of passing the N.R.B. general training state registration examination which had a medical/technical emphasis.

The 1,000 hour general nurse training syllabus gave little time to 'support strands' (N.S.W. Gazette, 1978). Students were given sufficient hours of lectures on basic anatomy and physiology to appreciate the disease process - few hours, however, were given to behavioural subjects such as sociology and psychology. Even less time was given to nursing history, nursing theory and nursing ethics. The bulk of hours was given over to the types of nursing to be encountered in general hospitals (N.S.W. Gazette, 1978). There were few hours for community nursing and the bare minimum of hours given to psychiatric nursing, which was seen as a specialist certificate course. However, it is not uncommon to encounter patients in general hospitals with behavioural problems in addition to their physical difficulties. Education was directed towards the perceived service needs of hospitals and the ability to care for the physical (biological) disabilities of patients, with little concern for their psychosocial problems. Nurses, like most doctors, were trained to recognise and to treat the physical needs of the patients, but were ill equipped to begin to assess or to meet the common psychosocial problems of patients.

Nurse teaching reflected a medical specialisation format. Apart from medical and surgical nursing there were many specialist areas taught such as ophthalmic, E.N.T. and orthopaedic nursing. The classification of these nursing areas reflected medical specialities and often had little to do with what the nurse would encounter during his/her training. For example, ophthalmology and ophthalmic nursing are highly specialised and little knowledge of practical benefit was likely to be gained by the student from much of what was taught. Nurse education had a biological approach based on the medical model of a pathophysiological condition causing an illness which needed to be cured. Diseases were examined in a methodical way by body systems - a Cartesian perspective which separates the body from the mind and soul. For example, each of the body systems such as respiratory, cardiovascular and integumentary would be examined in turn. Within each body system there would be a discussion of the common diseases, some examples of classical diseases and mention of some interesting, but often rare, diseases.
If we look at diseases of the endocrine system, the commonly occurring conditions of diabetes and altered thyroid function are appropriate for nurses to learn. However, Addison's disease, a condition affecting the adrenal cortex, and its complication of Addisonian Crisis were also taught. This condition is very rare, only cared for in specialised units, and hence unseen by student nurses, and probably not seen by most nurses in their whole working life. There is no distinctly different nursing care involved with this disease and from a nursing perspective it is an uninteresting disease. However, from a medical viewpoint it is very interesting because of the assessment and testing involved. Yet, it was always taught in the nursing schools because it formed a case study option in the state registration examination (Illawarra School of Nursing, 1982: 22). An understanding of Addison's disease was a waste of the limited lecture hours available during nurse training. Yet, such was the medical domination of nursing courses that its teaching assumed an undeserved emphasis. University based nursing courses do not discuss Addison's disease.

Presentation of individual diseases also followed the medical model (Nicholl, 1986: 355). Sufficient pathology was taught in order for the nursing students to appreciate what had gone wrong with the patient's body. Then signs and symptoms were presented in order to determine the actual disease, along with differential diagnoses. Yet, it is doctors who diagnose diseases, not nurses. There was significant discussion of pathology testing - altered biochemistry, haematology, serology and radiology. Next, the conservative (medical) and interventionist (surgical) care and options were presented, along with the pharmacological treatments and their side effects and interactions. Finally, nursing care was discussed, almost as an afterthought, and usually consisting of less than half the time allocated to the disease (Illawarra School of Nursing, 1982: 17; Whiteside, 1970; The Lippincott Manual of Nursing Practice, 1982). A discussion of potential complications or prognoses would complete a nurse's study of the topic.

The way individual diseases were taught was a simplified model of the way they were taught in medical education and reflected the same sequencing and much of the same emphasis. A small amount of nursing care was then added to this simplified model. Perhaps this approach is not surprising, since originally all medical-surgical nursing lectures were given
by doctors (Draper, 1990: 362). It has been argued that doctors spoonfed nurses a simplified
version of medical knowledge because doctors traditionally portrayed nurses as incapable of
rational learning and judgement, largely because they were females (Johnstone, 1994: 125-
131). As qualified nurse teachers began to appear, they assumed the teaching of the non
specialised, 'med-surg' nursing. Having themselves been trained in hospital schools to this
format, and their nurse education training not being significantly different in its approach, they
perpetuated this presentation. Doctors often continued to guest lecture in their speciality, such
as paediatrics and neurology (Western Suburbs Hospital, 1978; Illawarra School of Nursing,
1982). Thus, lectures either had virtually no nursing in their content, or they presented what the
doctor wanted the nurses to do for him in the hospital.

Work on the wards reinforced teaching. Students quickly learnt that increased
status came with technical competence - the mastery of nursing procedures and the ability to
handle equipment such as E.C.G. machines (Melia, 1983: 28). If they were to become a useful
member of the nursing team and to be of benefit to the ward, students needed to learn quickly
what was meant by a patient's medical condition and its implications for medical and nursing
care. For instance, to know that a patient had a right pneumothorax (a medical diagnosis)
should have told the experienced nurse much about the probable medical interventions and
supportive nursing care.

Equally important, when student nurses first entered the wards they were very
confused by the medical terminology, abbreviations, and acronyms that they encountered in
written notes and on handover reports. Words like 'nocte', 'bd' and 'C.O.A.D.' are all medical
jargon that nurses have adopted. They are a useful shorthand for conveying much information
quickly, give the nurse a knowledge superiority over the patient who has little idea what these
terms mean and bond together the nursing and medical staff. Rapid adoption of medical
terminology and phraseology is important for the student nurse. If the nurse understands the
above language s/he becomes more useful because s/he can usually anticipate the doctor's
requirements.

Hospital based nurse training enthusiastically embraced the biomedical model of
disease (Brown and Seddon, 1996: 31-32). Nursing care on the wards, by emphasising
technical competence and deemphasising emotive interaction between nurse and patient, reinforced this model. Opposed to this, the new university based nurse education utilises a humanistic model of nurse-patient interaction, which requires a new language of nursing (Roy and Andrews, 1991: xvii-xx).

5.3. The New Holistic Model of Nursing

The biomedical model of health care has been strongly criticised for its purely biological perspective (Engel, 1977: 129-136; Holden, 1990: 223-224). According to it people become sick because they have a dysfunction of a particular organ or body system - they have a disease. Medically determined health care is directed at curing this disease. The advantage of this approach is that it narrows the focus of intervention significantly by dividing the body into a large number of small sections, and concentrating just on the affected section(s). The disadvantage is that it becomes impersonal and uncaring, with a tendency to ignore the broader subjective experiences and practical difficulties faced by the patient.

Holism is concerned with the complete individual. It does not separate the person into separate compartments but looks at the whole person in that particular person’s context. The term holism is derived from the Greek word meaning 'whole' (Holden, 1990: 229). It is presented in the new nursing technology as the fundamental philosophical formulation for professional nursing care. The new nursing denounces the diagnostic reductionism of the biomedical model and proselytises holistic care. Holism sees the individual as more than the sum of the parts. Individuals are in constant interaction with their environment and 'significant others'. In line with increasing public concerns over environmental issues, nursing continues to popularise its activities by adopting a strong environmental perspective, and, in retrospect, Florence Nightingale is presented as nursing's first environmental theorist (Kozier et al. 1991: 66; Phipps et al. 1991: 36-37; Gropper, 1990: 30-33). Hence, the University of Wollongong nursing curriculum speaks of "caring globally", "ecologically responsible behaviour", and the "environmental dimensions" of patient care (University of Wollongong, 1993: 5-8). Thus dysfunction of a particular system is not confined to that specific locality, but impacts on many other parts of the individual and his/her relationship with the outside world. Similarly the
N.S.W. Nurses' Association emphasises environmental health issues stating that "Nurses should be socially aware and politically active in relation to environmental issues" ("Policy on nursing and the environment", 1996: 29).

The new nursing literature condemns the biomedical model for focusing almost exclusively on biological systems. Holism, by contrast, looks at biopsychosocial functions. In one formulation it sees the individual as having four interacting modes - biological, self-concept, role function and interdependence (Roy and Andrews, 1991: 15-18). Total patient care involves consideration of all these modes in all their complexities. For example, if a patient has a severe kidney disease a number of biological systems will be affected. Hospitalisation and knowledge of the disease diagnosis will alter the way the patient feels about his/herself (self-concept). The patient's role within the family will alter while in hospital, and possibly after discharge. If ill enough, the patient will become much more dependent on the nurses and others to meet physical and other needs. A biological problem can have many psychological and social ramifications. It is argued that medicine concentrates on the first while nursing encompasses the totality.

Biomedicine sees illness as a disease, requiring intervention to effect a cure. With an ageing population, there is relatively less acute illness which is amenable to the traditional medical model of cure. Holism is presented as being far more compatible with the increasing incidence of chronic illness which requires both care and greater patient involvement in his/her own treatment (Staunton, 1987a: 3; Turner, 1987: 8-9; Donnelly, 1993: 1-7). Holism sees illness as a maladjustment to stimuli, with the patient needing assistance to readjust to a state of wellness. A holistic approach to patient care puts the emphasis on the individual for his/her own care (Alfaro, 1990: 91-93). The nursing role is to assist as necessary. If the patient is totally dependent, say due to unconsciousness, then the nurse takes over the total care, including decision making. As the patient regains independence, control of the patient's care becomes his/her responsibility. The nurse must inform, involve and defer to the patient in decision making. The nurse's role is to assist, to guide the patient to make appropriate decisions about care. In the biomedical model the patient is passive, the recipient of care. In the holistic model the patient is active, involved in his/her own care.
Holism provides a framework for nursing's uniqueness. It justifies nursing moving into psychosocial aspects of patient care. Nursing's uniqueness lies in its ability to bring together all these separate concerns into a coherent whole (holism) (Nicholl, 1986: 117-122). It requires a closer and better communication between nurse and patient because the nurse needs to know about the whole patient, his/her feelings, beliefs, doubts and because the patient takes responsibility for his/her own care. In order to make responsible decisions the patient and family need to be educated by the nurse. If the patient is to be protected while reliant on others, the nurse must act as a patient advocate, supporting what is best for the patient. With an emphasis on wellness the nurse has an important function in prevention of illness, particularly through individual, family and community education.

Holism is a key word in nursing literature, yet there is wide variation in its supposed application to patient care (Sarkis and Skoner, 1987: 61; Barnum, 1987: 27). An analysis of a number of Australian tertiary nursing curricula showed consistent support for the concept of holism in the official discourses, but holism was singularly lacking in the actual nursing subject descriptions (Bruni, 1990: 100-108; Brown and Seddon, 1996: 30-35). Holism may be a key concept in Australian nurse education because it is both necessary for course approval by other nurses and serves to separate tertiary nurse education from medicine and the old hospital based nurse training, yet most nurse academics are unsure how to apply it in their teaching or clinical practice (Hall and Allan, 1994: 112).

Traditionally, 'nurses have not been free to nurse', or free to utilise their knowledge or skills autonomously (Maas, 1973: 238; Johnstone, 1994: 125). Holism implies that there are many nursing actions which require no medical input. Holistic nursing has distinct functions independent of and interdependent with medicine, and is not just a dependent implementation of medical orders. The largely unclaimed areas of patient education, patient advocacy and health promotion become the domain of nursing. Nursing sets boundaries, defining its areas of responsibility and expertise, and by making itself distinct from medicine, it supports a team approach to patient care with nurse-doctor collegiality rather than nursing subordination. It permits an integrated approach to patient care and allows the patient's health issues to serve as the primary designator of the team leadership role versus the traditional
medical leadership role (Sarkis and Skoner, 1987: 63; Forbes and Fitzsimons, 1993: 2). Holism can serve as the basis for collaborative practice between nurses, doctors and other health care providers (Jones, 1994: 1-11).

The medical profession is unhappy with this philosophy (Staunton, 1987c: 2-3). It contradicts the way doctors were taught and the way they interact with patients. It smacks of alternative medicine (Berliner and Salmon, 1979: 31; Richards, 1991: 205). Doctors are unclear what the term holism means and how it alters nursing care and the role of the nurse. They suspect nurses of expanding their role into new areas. It has been claimed that nursing models have incorporated holism in direct reaction to the medical model of health care (Wilcox, 1987: 70). The concept of the holistic human gives nursing a unique perspective and the ability to build a unique body of knowledge. Traditionally, the nurse was seen as acting as a health generalist with a little bit of knowledge about a lot of other disciplines, but not a lot about any one of them, and performing as an (inferior) 'substitute' to these specialists (Stevens, 1984: 241). For example, nurses know a little about medicine, physiotherapy, radiology, nutrition and social work and can perform in these areas when needed. However, if a person is greater than the sum of all his/her individual parts, then nursing can claim its own unique domain, with its own unique knowledge base - one of the criteria for a profession. Holism is an attempt to legitimate to society and nursing's 'peers' in medicine what it is that is unique that 'professional' nursing does (Kobert and Folan, 1993: 308).

5.4. Nursing Theory and Nursing Theorists

Nursing theories are important because they are ways of looking at and organising nursing care in a completely different approach to that traditionally used by nurses in the hospital setting. The word theory is derived from the Greek word for vision (The Concise Oxford Dictionary, 1990: 1266). A theory should provide a vision of the way in which nurses should practice. Rather than relying on tradition, habit, prescriptive protocol or intuition a nursing theory should enable systematic and logical examination of phenomena that is explanatory and predictive, and hence lead to appropriate nursing actions (George, 1985: 1-13). Because each encounter with a patient is different, it is no longer desirable to treat each patient
identically, but rather it becomes increasingly possible to individualise patient care. Individualisation is a central premise of the new holistic nursing. By contrast with medicine, which is said to treat all similar patients the same (for example, all appendectomies are generally treated the same), holism involves more interaction with the patient to individualise the care and it requires the nurse to use his/her knowledge to choose the best care options rather than blindly following the same prescription. The nursing literature claims that nursing theory enables nurses to make informed decisions (clinical judgements) about their interventions on a case by case basis (Jennings, 1987: 63-69). The ability to make clinical judgements is an important component of the indeterminacy of the professions.

There are many different nurse theorists with different perspectives on how individuals respond to the environment (including other individuals). These models are not complete, are subject to modification and some are more useful with certain categories of patients than with others. Differences in applicability probably reflect the starting point of the theorist and the context within which the model was developed. If a model of nursing care was developed amidst psychiatric patients it might emphasise psychosocial needs and deemphasise biological needs. Such a model would have limited applicability to maternity patients. The multitude of nursing theories reflects the short time span since their initial development. There has been little time to find and demonstrate commonalities among theories to form a single, universal model. Such a model may not be possible because of the differences among patients (Mandelbaum, 1991: 53-55).

If we accept Florence Nightingale as the earliest nurse theorist, then it may be argued that she perceived that the function of the nurse was to control the patient's environment to aid the patient in his/her own recovery (Chapman, 1985: 7; McCann Flynn and Hackel, 1990: 5). Her concepts of cleanliness, asepsis and adequate nutrition were more advanced than the medical ideas of the time. The opportunity to test, to authenticate and to expand her theory of nursing was compromised however by the concurrent locking of nursing into a rigid implementation of medical orders which discouraged questioning and innovation (Brown and Seddon, 1996: 31-32).
It was not till the late 1950's in the U.S.A. that nurse academics began to examine why nurses intervened in certain ways, and found no logical approach to nursing actions (Huttman, 1985: 34-39). A number of these early nurse investigators then developed theoretical frameworks to help guide nursing actions. There are many different early nurse theorists including Abdellah (nursing problems), Henderson (basic needs), King (goal attainment theory), Levine (conservation principles) and Peplau (psychodynamic nursing) (George, 1985: 320-322; Fawcett and Carino, 1989: 2-3). Many of the early nurse theorists were not holists, but subsequently their theories have either been adapted to holism or rejected as simplistic and outdated. Later theorists such as Leininger (transcultural care theory) and Roy (adaptation theory) hold the concept of holism as a central premise (Kozier and Erb, 1988: 5).

An indepth analysis of the numerous nurse theories, with their differing concepts of the nature of patient problems and the role of the nurse is not necessary here. The key point is that adoption of one or more of these theories for teaching nursing, patient care and research has some important consequences. Nursing theory allows for the organisation of unique nursing knowledge, for verification of this knowledge, for further research and the examination of nursing actions. This theoretical stance demarcates nursing’s knowledge base and demonstrates its distinctive expertness - a condition of professionalisation. Hence, nursing theorists can claim that "theorists such as Roy and Johnston increased nurses' awareness of the need for a conceptual basis for practice and of the need to establish nursing as an independent profession with its own body of knowledge" (Perry, 1985: 35-36). However, Freidson comments that aspiring professions run the risk that "If there is no systematic body of theory, it is created for the purpose of being able to say there is" (Freidson, 1970a: 80). Thus, there must be some doubt as to whether nursing theories have proliferated in order to quantify or to describe what it is that nurses do, or whether nursing theories are created primarily to demarcate nursing from medicine.

Nurse theory helps to mark out the boundaries of nursing, separating its actions from those of other health occupations (Short et al. 1993: 58). For example, the American Nurses' Association Social Policy Statement (1980) included theory as one of the defining
characteristics of nursing (Jennings, 1987: 64). A distinctive area of knowledge and expertise serves as a justification for autonomous behaviour - another condition of professionalisation.

The use of nursing theories also supports the claim for the existence of nursing science, even though their use could be seen to contradict the emphasis in nurse education on holistic matters. A certain prestige comes with being a scientific discipline and the sciences are closely associated with universities. This concern is seen within many nursing departments in tertiary institutions. There is considerable debate as to whether nursing should be associated more with arts, education or science faculties. This aspiration for closeness with the sciences is best seen in the U.S.A. where nursing graduates are awarded a Bachelor of Science (Nursing), (B.S.N.). The position in Australia is more flexible. Initially graduates were awarded a Diploma of Applied Science (Nursing), (D.A.S.(N)), or some similar wording. When the basic qualification was upgraded, it became a Bachelor of Nursing, (B.N.), because it was felt that the emphasis should be placed on nursing. Since then, the science association has come back in favour with, for example, a Master of Science (Midwifery), (M.Sc.(Midwifery)).

5.5. The Nursing Process

If holism is the distinctive philosophy of nursing, and nursing theory is the framework for nursing care, then the nursing process is the way in which nursing actions are carried out. It has many similarities with the processes of medical and scientific method. In particular, its similarity to scientific methodology is emphasised in the nursing literature, so that it is said that "the nursing process is the application of scientific problem solving to nursing care" (Marriner, 1983: 1). The nursing process is seen as the mechanism which links nursing to science. It has taken the medical approach to intervention and changed the terminology, and borrowed the format of scientific method to highlight the scientific basis for nursing actions.

In determining what is wrong with a patient and deciding upon the appropriate interventions, medicine utilises a specific sequence of events. Nursing has chosen the same systematic approach, but with different names:

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28 This also has funding implications as science students tend to be better funded than arts or education students.
In this respect, nursing has borrowed heavily from the profession to which it most aspires - medicine. Doctors are responsible for their patients from the initial examination to the final evaluation prior to discharge. Similarly, the nurse is responsible for Total Patient Care (TPC), (that is, total independent nursing care), from the initial patient assessment, using the nursing process, to the final nursing evaluation at the completion of nursing care. Traditionally, nurses have been taught few assessment skills - how to take T.P.R. and blood pressures, plus some simple visual observations. More complex assessment skills, such as the interpretation and significance of E.C.G.s and cardiac monitors, were taught on the job as the situation warranted, such as working in a Coronary Care Unit.

The nursing process requires a much more comprehensive assessment of the patient (Jarvis, 1992: 3-13). The nurse is in competition with the doctor regarding physical assessment of the patient and there is probably a much greater emphasis on psychosocial concerns in the nursing assessment because of more emphasis on nurse-patient communication. The nursing process emphasises that nursing is as thorough and as skilful as medicine, plus it expands it to include the neglected social and psychological areas of patient care. The new nurse needs to be more knowledgable, more skilful, more systematic, more thorough in assessment of the patient. In some ways the nurse becomes a mini-doctor, and in other ways is also concerned with more areas of assessment than the traditional medical approach. Because nurses cannot
order pathology testing (though they should be able to interpret the results) there is a greater emphasis on low technology, hands-on assessment and talking with and listening to the patient.

The nursing process serves to separate technique from technology (i.e., equipment). The mechanical technology of medical diagnosis includes equipment for taking X-rays, blood specimens and various invasive procedures for specimen collection. Doctors, as much for fear of possible litigation for making the wrong diagnosis, rely increasingly on test results to make and confirm diagnoses (and especially to eliminate alternative, but uncommon, differential diagnoses) (Reiser, 1978: 163-165). Nursing, probably because it cannot initiate pathology testing and because of fewer concerns about litigation, is not particularly concerned with test results. Rather, it is concerned with new (for nurses) techniques of assessment involving physical assessment (look and touch) and verbal assessment (asking and listening) - a low technology, new nursing technique approach.

Using the nursing process, the nurse can then make some purely nursing diagnoses (identification of problems) which should be independent of any medical concerns. The nursing process can be used to exclude doctors from nursing, to establish nursing autonomy and to set the boundaries of independent nursing care (Wright, 1985: 34; Short and Sharman, 1987: 197).

To some nursing authors it is almost anathema to suggest that some medical interventions can determine nursing actions and impact on nursing diagnoses (Carpenito, 1993: xxv-xxxi). This is part of the conflict between the dependency of hospital nursing and the ideal of independent nursing practice.

The difference between nursing and medicine is emphasised by formally recognising the desirability of involving the patient in setting his/her own achievable goals or outcomes and the appropriate nursing actions to achieve this. The patient is meant to be actively involved (if at all possible) in his/her own care. The nurse's role is to consult with the patient, to ensure that desired outcomes are realistic, to encourage the patient to do as much for him/herself as is possible and safe, to individualise care and only to intervene as necessary. The nurse constantly re-evaluates the success or otherwise of the nursing care plan and, if necessary, further consults with the patient to adjust the desired patient outcomes. This is in sharp contrast to the passive role of the patient within traditional medicine.
The nursing process has not only adopted the medical process for its own purposes but has also given it a distinctly nursing terminology, which appears to confuse doctors and others, and hence excludes them from nursing concerns. It gives a uniqueness to the nursing methodology and emphasises the nursing concern of nurse-patient communication, and through that identification of psychosocial problems. Combining the nursing process with most nursing theories promotes a holistic identification and treatment of patient problems. According to Tierney when nurses understand and use the nursing process, "They are conscious of the fact that doctors do not know how to nurse, never having been trained to do so, and therefore doctors cannot tell them how to do it" (Tierney, 1984: 837). The nursing process has become so important to modern nursing that in the U.S.A. the Joint Commission on Accreditation of Hospitals requires nurses to document their work using the nursing process (McHugh, 1987: 51). In practice in most hospital settings, there would be neither the time nor opportunities to fully implement the nursing process on every patient. Rather, it is an educational ideal illustrating the uniqueness of nursing, or possibly could be used in a small number of nursing settings (to be discussed later in this chapter).

The nursing process is also meant to highlight the similarities with conventional understandings of scientific method (Marriner, 1983: 1). Information is gathered, a hypothesis is proposed, more information is gathered and the hypothesis is tested. If invalid a new hypothesis is generated. With the nursing process comprehensive patient information is gathered, a desired outcome is proposed, actions are implemented to achieve this outcome and the achievability of the desired outcome is evaluated as necessary. This analogy is widely supported in the nursing literature (Leddy and Pepper, 1985: 75-92; Rapley and Robertson, 1990: 233-236). While it is debatable whether or not scientific method is a true reflection of what scientists do, this is incidental to the fact that the nursing process is claimed to mimic the idea of scientific method and it is perceived to give a scientific respectability and rationality to what nurses do (Lynch et al. 1983: 205-238). To advocate the use of the nursing process brings nursing into closer association with the sciences. Use of a scientific method-like approach to patient care is seen to justify the concept of nursing science, nursing research and the development of nursing knowledge. The nursing process is represented as helping to bring
together the duality of the new nursing, by combining humanism or holism with science through the use of scientific method.

5.6. The Reorientation of Nursing Literature

Changes in nursing literature over the last decade or so in both textbooks and journals, the majority of both originating in the U.S.A., reflect this changing emphasis in nursing. Textbook titles used to refer to 'Medical-Surgical Nursing', which emphasised the medical disciplines of medicine and surgery (Cook, 1991: 1464; Willis, 1994: 47-48). Typical examples of this were the commonly used Australian nursing texts by J. E. Whiteside entitled *Surgical Nursing* and *Medical Nursing* (Whiteside, 1967; Whiteside, 1970). These days textbook titles refer to 'Adult Health Nursing', eliminating the association with hospital medicine and surgery, and emphasising health rather than illness. There is more emphasis on community nursing, health education and prevention. Similarly, pathophysiology texts are being written by nurses for nurses with the assumption that nurses need to have a much greater knowledge about disease processes. In both types of texts, chapters have moved to a multisystem discussion of disease concepts such as stress and adaptation, neoplasia and altered nutritional status (Kozier et al. 1991; Porth, 1990). This is a fundamental break with the traditional medical single body system approach. Nursing students may find the complexity of dealing with multisystems confusing, but what is important is that it represents a distinct difference between nursing and medical texts. Most nursing texts have at least introductory chapters on nursing theories and the nursing process and utilise this process in discussing nursing care.

Nursing journals have increased significantly in numbers (perhaps in response to the need for greater numbers of nurse academics to publish). Titles of new nursing journals reflect the changing emphasis within nursing - *Advances in Nursing Science, Nurse Practitioner, Nursing Diagnosis, Holistic Nursing Practice* and *Australian Journal of Advanced Nursing*. The journal *Nursing Research* was first published in 1952 and in the next 20 years the percentage of articles on the nursing process and human behaviour (psychosocial concerns) rose from 12% to 36%, reflecting the increasing emphasis on these areas (Nicholl, 1986: 73).
Retrospective analysis of American nursing textbooks and nursing curricula show that when American nursing first entered universities extensively in the 1970's these texts and curricula were initially formatted on the existing hospital based system of the biomedical model of nursing care (Sohn, 1991: 209). This was at least partly due to the fact that there were several different, coexistent localities for nurse education (universities, colleges and hospitals) and all graduates had to sit common state registration examinations, which retained a medical/surgical nursing emphasis. This emphasis changed significantly over time as nursing theories and the nursing process were adopted. Australian nurse education did not significantly enter the tertiary sector until 1985 onwards. Because the majority of nursing textbooks used in Australia are American (probably due to the economic difficulties in producing competitive Australian textbooks), and because of the predominance of American journals, the concepts of the new nursing expressed in these more recent writings have heavily influenced contemporary Australian nurse education. Also, graduates from the New South Wales tertiary nursing courses have been granted automatic state registration and have not had to sit the existing state registration examination, with its medical/surgical nursing emphasis, so undergraduate textbooks can be utilised which use alternate terminologies and different approaches to patient care.

5.7. Nursing Diagnosis

The change in nursing terminology to which doctors in hospitals most often object is nursing diagnosis. A nursing diagnosis is "an actual or potential health problem that focuses upon the holistic human response of an individual or group, and that nurses are responsible and accountable for identifying and treating independently" (Alfaro, 1990: 54). The key words in this definition are "holistic", "responsible", "accountable", "identifying" and "treating independently". Holistic care of the patient requires independent and accountable nursing care, i.e., professional nursing care.

The concept of a nursing diagnosis arose from the concern that nursing language was both imprecise and borrowed, and thus failed to communicate to other occupations the uniqueness of nursing. Both Wilensky and Brown have argued that an occupation has difficulty
in claiming a monopoly of knowledge and skills essential for professionalism while its
tonguage contains "a vocabulary which is familiar to everyone" (Wilensky, 1964: 148; Brown,
1986: 36). Hudson goes further and claims that so much of a profession depends upon
language that the professions could not exist otherwise and that aspiring professions base their
language upon precedent professions (Hudson, 1978: 38; Brown, 1986: 38). Spicer writes that
the specialised vocabulary is a vital part of the mechanism of social separation" (Spicer, 1971:
799). Language is intertwined with the creation of professional authority and it follows that to
create a professional nursing it is necessary to create a unique nursing language (Brown, 1986:
40). In the case of nursing the nursing process is a variation of a theme based upon both the
medical process and scientific method, while the developing nursing jargon, largely consisting
of nursing diagnoses, is sufficiently different from both lay and medical language to illustrate
the developing professional separateness of nursing from the other health occupations.

In 1973 the North American Nursing Diagnosis Association (NANDA) met in "an
attempt... to initiate the process of preparing an organised, logical, comprehensive system for
classifying those health problems or health states diagnosed by nurses and treated by means of
nursing interventions" (Taylor-Loughran, 1990: 71). While there was some concern over the
similarity of the term nursing diagnosis to that of medical diagnosis, it was felt that this title was
basic to professional nursing (Ziegler, 1986: 12). Meeting every two years, the Association
approves new nursing diagnoses. There are now several hundred nursing diagnoses
(Carpenito, 1993: ix-xii). This represents only a small fraction of the probable final number.
Currently one of the major concerns is that it is easy to identify many patient problems for
which there are no suitable nursing diagnoses yet available. It becomes necessary to try to
identify a problem under an awkward, and not very suitable, nursing diagnosis, or formulate a
new, temporary nursing diagnosis, or continue to use a medical label.

Nursing diagnoses are seen as a system for classifying phenomena, which is part
of the requirement of a science (Nicholl, 1986: 289-290). They serve as a direction and focus
for nursing research and the development of nursing science (Taylor-Loughran, 1990: 71).
They can be grouped into different taxonomies to highlight similarities between diagnoses
Fawcett and Carino, 1989: 3-4). For example, the 1988 NANDA list of nursing diagnoses can be ordered by Gordan's Functional Health Patterns into the following groupings:

* Health Perception - Health Management.
* Nutritional - Metabolic.
* Elimination.
* Activity - Exercise.
* Sleep - Rest.
* Cognitive - Perceptual.
* Self-Perception/Self-Concept.
* Role - Relationship.
* Sexuality - Reproductive.
* Value - Belief.

(Alfaro, 1990: 42).

Such groupings illustrate some of the distinctive domains of nursing practice (Short and Sharman, 1989b: 226-227). Within the Role - Relationship pattern are nursing diagnoses of parental role conflict, defensive coping, altered family processes, dysfunctional grieving, impaired social interaction and social isolation. Other health occupations, especially medicine, are perceived as having largely ignored these problems so they become the unique responsibility of nursing, irrespective of whether nurses know what these nursing diagnoses mean, or how to individualise the care of such problems.29

Other nursing diagnoses have a degree of overlap with medical diagnoses. For instance, under the Activity - Exercise pattern is a nursing diagnosis of ineffective breathing pattern. While it is descriptive, the trouble with this nursing diagnosis is that, by itself, it covers

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29 Nursing diagnoses are listed in an awkward wording for computerisation purposes, in a way which most people find confusing - for example, "coping, ineffective family: compromised". Indeed, nurses complain that they find nursing diagnoses and the terminology of nursing theories confusing and awkward as evidenced by the statement that: "Why nurses must be 'afflicted' with baroque nursing theories couched in stilted pseudo-intellectual jargon ... Who, besides academic luminaries, benefits from this blizzard of inflated words?" (Smith, 1981: 83).
a number of possible underlying physiological problems, all with different treatments. Medical diagnoses compatible with this nursing diagnosis include acute and chronic asthma, various respiratory depressions, emphysema and Chronic Obstructive Lung Disease (C.O.L.D.). Any one of these medical diagnoses would indicate the underlying problem and hence suggest appropriate medical and nursing treatment. In order to narrow down what is meant by this nursing diagnosis, and determine appropriate nursing actions, it is necessary to apply a modifier such as "ineffective breathing pattern as evidenced by ...". One such possibility might be, "... acute onset of expiratory wheeze", which would suggest an acute asthma attack. It is obviously much simpler to use the medical diagnosis of "acute asthma attack" than the nursing diagnosis of "ineffective breathing pattern as evidenced by acute onset of expiratory wheeze".

Some nursing authors contend that certain nursing diagnoses remain purely the domain of nursing even when others use them. For example, they perceive that "sensory deprivation", which was a nursing diagnosis long before it became of interest to doctors, remains within nursing even if used as a medical diagnosis - somewhat of a form reversal with medicine seemingly borrowing from nursing (Stevens, 1984: 108).

Nursing diagnoses are long and unwieldy to use, are time consuming to communicate (it is much easier to say C.O.L.D. than an equivalent, unambiguous nursing diagnosis) and are often confusing. They are useful for computerisation and for nursing research, and definitely confuse doctors and serve to separate nursing from medicine. The problem is that most nurses do not like them (Tartaglia, 1985: 34). Australian nursing students and R.N.s first became widely exposed to nursing diagnoses with the transfer of nurse education to the tertiary sector from 1985 onwards, and not surprisingly found them incomprehensible and long winded (MacRae, 1988: 12; "Comfort state", 1989: 36).

In the U.S.A. nursing diagnoses have been used to determine the costing of nursing care within hospitals (Mehmert, 1987: 948). This has important implications for funding within hospitals, as nursing care is difficult to quantify and is usually inadequately and inappropriately funded. Nursing diagnoses have also been presented in the U.S.A. as the basis for direct governmental reimbursement/payment to independent nurse practitioners (Mittelstadt, 1993: 43 and 47-49). The use of nursing diagnoses not only has financial implications, but also

5.8. Nursing Science/Nursing Research/Nursing Knowledge

Historically, nursing care was based on trial and error procedures, leading to "tried and true" methods with meagre scientific rationales (Crow, 1981:1). Many of the common sense nursing actions such as second hourly pressure area care for immobile patients, including the rubbing of dependent areas with soap and water, were given untested pseudo-scientific rationales (Smith and Lew, 1976: 107). In recent years, upon testing, such actions are claimed to have no scientific basis, to be useless, to be harmful and wasteful of nursing time (Kozier et al. 1991: 848-849; Stow, 1996: 2). There are enormous areas of traditional nursing practice, as well as new areas of nursing practice, which are acknowledged as being untouched by research (Rapley and Robertson, 1990: 233). Until recently what little clinical nursing research that was conducted, was performed largely by non nursing scientists (Ziegler, 1986: 15).

Professional nursing practice needs to be justified by a scientific rationale (Vincent, 1984: 22-37). The new nursing needs a body of knowledge, grounded in nursing, that develops and is validated through nursing research (Lerheim, 1991: 73-78; Bramwell, 1985: 45). Such scientific foundations would promote the concept of independent nursing practice, because discrete knowledge exclusive to nursing is seen by nurses as a basis for power (Chinn et al. 1987: 20). Beginning in the 1960's in the U.S.A., nurse academics began to promote nursing science and by the 1980's they began to claim that nursing science had begun to emerge (Jennings, 1986: 506). However, nursing research methods fit uneasily into the scientific medical model, and Judy Waters describes Australian nursing research as having "taken off somewhat at a tangent and ... trying to tease out the metaphysical nature of nursing" (Bagnall, 1994: 44-45). Examination of the metaphysical nature of nursing is very much at odds with expounding a scientific rationale for nursing practice. There is a conflict between what nursing writes and what nursing (research) does.

Nursing science supposedly utilises different nursing theories (paradigms) to direct inquiry towards an understanding of health phenomena and hence gather a body of nursing
knowledge which can be used to validate these theories, form new theories and direct nursing care (Elhart, 1978: 48-54). Nursing diagnoses form an appropriate classification system for this knowledge and the nursing process enables this knowledge to be used. The label of nursing science elevates nursing to the same scientific level as medicine, yet serves to demonstrate its distinctness from medicine because of its uniquely different theories and language. In claiming a scientific basis nursing associates itself with university learning, yet presents itself as distinct from such sciences as physiology, psychology and sociology (Roberts, 1980: 33-34; Duespohl, 1983: 4-5).

Nursing research can be taught and conducted by qualified nurse researchers investigating the validity of nursing theories and nursing actions. The nursing knowledge so gained is not only obtained by nurses themselves and is highly useful to the further development of nursing science, but it can also be of most use to nurses themselves. For instance, in researching pain medical research concentrates on treating pain through drugs and invasive techniques. Nursing research, by contrast, concentrates on the largely ignored areas of patient perceptions and responses to pain, and non-invasive pain therapies such as positioning, massage and relaxation. In so doing nursing builds up its own discrete area of knowledge, presumably little researched and of little interest to conventional medicine. The nursing administration of analgesics stronger than paracetamol requires a medical medication order and places nurses in a dependent position to doctors. However, non analgesic pain prevention and pain relief techniques can be nurse initiated and are independent nursing actions.

The feminine stereotyping of nurses has attributed to them a number of allegedly non scientific traits such as intuition and emotion (Meleis, 1984: 41). The linking of nursing with science is seen as a way to alter this image to one more traditionally associated with science and to lay claim to attributes such as independence, autonomy and intelligence, which are also professional stereotypes (Jennings, 1986: 506-507). Thus, Florence Nightingale may be presented as the first nursing scientist because of her alleged use of an analytical approach to collecting health care data (Lerham, 1991: 73). An increasing preoccupation with science in

30 Recently, controversy has arisen over some nurses, American nursing schools and nursing textbooks advocating the use of 'therapeutic touch' for pain relief as it has been labelled 'pseudo science' (Jaroff, 1994: 70-71).
nursing is consistent with an increasing societal interest in science and technological change (Hamilton, 1984: 41-48). This emphasis overrode an initial setback when in the early years of tertiary based nurse education in New South Wales many nursing students failed science support subjects (Thorp, 1990: 15; Lumby, 1991: 18).

As yet, nursing science, nursing research and nursing knowledge are in their infancy, but the terms are regularly used in nursing literature and nursing curricula. Non nurses still give little credence to the idea of a discrete collection of nursing knowledge, so that, "It is far from an acknowledgment that nursing possesses a unique body of knowledge ... In many cases, the courts have not challenged the ability of a physician to testify on the adequacy of nursing care" (Murphy, 1987: 13). Nevertheless, an alleged scientific basis, with an emphasis on research by academics and postgraduate students, and the promotion of purely nursing knowledge are all represented as indispensable to the claim of a professional status for modern nursing. In tertiary institutions kudos comes with research grants and nurse academics, along with all other academics, are encouraged to conduct research (Melland, 1995: 71). In 1988 the Federal Minister for Community Services and Health established the Centre for Nursing Research in Adelaide "in recognition of research as integral to nurse education and practice" (A Professional Commitment, 1988: 4), while in the U.S.A. the National Institute of Health’s Center for Nursing Research was recently funded with a budget of forty million dollars (Sharp, 1991: 22). However, it is claimed that nurses' efforts to improve their professional standing in Australia through research have been limited by a reluctance to provide adequate competitive funding for nursing research (Bagnall, 1994: 44; Connolly, 1994: 8).

Postgraduate studies normally have a research component. Traditionally, much PG nursing research has concentrated on education, sociology and psychology related to various aspects of health care. Emphasising nursing science significantly broadens and encourages research opportunities for PG nursing students into areas of assessment and interventions involved in the delivery of nursing care (Position Paper, 1994).

Nurse academics in Australia remain apologetic about the quality, quantity and usefulness of nursing research in this country offering excuses such as "... a spokesperson said that research was flourishing in Australia despite (emphasis added) the scholarly focus on nursing being less than 10-years old" ("Nursing research", 1994: 6). Similarly, there are appeals for nurses to publicise their research more because "... nurses are producing a lot of valuable work that is not currently available to the wider ... community" ("Hidden treasures", 1993: 4).
5.9. Primary Nursing and the Independent Nurse Practitioner

The preceding changes to nursing terminology and technique seem to be directed towards the concepts of primary nursing and independent nursing practice (Bowers, 1989: 14). However, in Australian hospital wards there appears to be little time, opportunity or inclination to implement the nursing process. A general shortage of R.N.s on the wards (due to financial constraints), a heavy patient load and rigid, medically dominated protocols make nursing innovation difficult.

What types of nursing is the nursing process most suitable for? It seems to be most applicable to two extremes of nursing, which in this country contain small numbers of nurses. Primary nursing is a form of hospital nursing in which a nurse is responsible for a patient on a twenty-four hour basis throughout the patient's hospital stay (Bowman and Carter, 1990: 39). Just as a Visiting Medical Officer has overall responsibility for the medical care of the patient and directs the actions of other junior doctors, so the primary nurse has the autonomy, accountability and authority to direct the actions of other junior nurses. The primary nurse is meant to be highly knowledgable, an expert in his/her area and ideally, to possess post-graduate qualifications.33

At first glance, the new category of nurse created recently in New South Wales, the Clinical Nurse Specialist, might appear to fit this description. In reality, due to financial constraints, only one clinical nurse specialist is designated to each ward. S/he is normally the longest serving nurse, acting as a second-in-charge to the nurse unit manager and sometimes has a role in continuing education on the wards. The clinical nurse specialist probably does not have a tertiary degree, may very well not be the most clinically competent and knowledgable nurse on the ward and is usually rostered to handle the paperwork on the opposite shifts to the nurse unit manager. The position becomes an administrative one, is a reward for long service and minimises the additional costs by granting a pay rise to the most senior and most expensive nurse already on the ward. These constraints combined with the fact that most clinical nurse

33 There are now calls for advanced practice nurses, who fit the criteria of primary nurses, to possess at least a master's degree in nursing (Sharp, 1992: 28).
specialists were hospital trained mean that the nursing process and primary nursing are unlikely to be utilised.

The areas where the equivalent to primary nursing and the nursing process are most likely to be used in the hospital setting are the high-tech areas of nursing such as I.C.U. and Accident and Emergency. This appears paradoxical because the new nursing seems to support a low technology emphasis, but it is in high technology areas that experienced nurses seemingly have the most autonomy in decision making, though within specific set protocols. Nurse-patient ratios are usually one-to-one or one-to-two, so the nurse spends more time with the patient and has greater opportunity to implement a variety of nursing actions. On the general wards there are usually too many conflicting demands on the nurse's time for more than the delivery of the bare minimum of physical care for all the patients. There is seldom time to do justice to the psychosocial nursing diagnoses, because traditionally a 'good' nurse should not sit and talk to the patient, but rather, should be seen to be busy all the time delivering physical care. Nurses in high-tech areas have been taught many basic medical assessments and interventions, and hospital protocols normally permit them to implement routine procedures, such as tracheostomy care, that general wards nurses are not permitted to do at all, or that require them first to seek medical permission or guidance, or that they are uncomfortable about doing because of the infrequency of the procedures.

There are a number of physiological nursing diagnoses which are most applicable to nurse specialist areas. The trouble with a nursing diagnosis such as 'altered breathing pattern' on the general wards is that the nurses cannot carry out many nursing interventions before they intrude on the medical domain, and medicine takes precedence over nursing in the hospital setting. So, these nursing diagnoses are arguably of little use to the general nurse. However, in I.C.U. for example, there are many more nursing interventions permissible from these physiological nursing diagnoses because the doctors have delegated more tasks to the nurses. Because of this apparent increase in autonomy and accountability such nurses are sometimes referred to in the nursing literature as professional practice nurses.

It is debatable whether these nurses are 'professional' as their increased autonomy is largely illusory with medicine maintaining its hegemony over them (Ovretveit, 1985: 76-79;
Eaton and Webb, 1979: 69-84; Larkin, 1981: 15-30; Freidson, 1984: 14). It is more a case of the doctors allowing their 'assistants' to do more, to take over those basic interventions which they do not have the time for, or the inclination to do any more. Thus, while a former NSW Health Minister, Ron Phillips, speaks of emergent nurse practitioners "working collaboratively with doctors", what is actually happening is that these nurses are taking over the less urgent and less glamorous medical tasks, freeing the doctors to concentrate on the more serious hospital patients, while still enabling the doctors to retain supervision of the nurses' interventions (Patty, 1994: 9). These high-tech nurses are allowed more initiative, but it is still the medical profession that is regulating the limits of nursing care (Bernzweig, 1975; Fiesta, 1991: 28-29; Howells, 1992: 8-13; Bond and Bond, 1986: 179).

Primary nursing, or professional nursing, which utilises the nursing process, is only really feasible in the existing hospital system in very specialised nursing units, where very few nurses work. The other nurses most able to utilise the nursing process are nurse practitioners. They work in the community, originally separated from doctors, but increasingly these days, especially in the U.S.A., as members of medical clinics (Bolger et al. 1988: 34). Nurse practitioners originated in the U.S.A. around 1965 to fill the health care gap resulting from an uneven distribution of doctors which created a shortage of primary health care providers (in this context, a shortage of local doctors) amongst the chronically ill, rural, urban poor and paediatric population (Briggs, 1990: 31).

The original concept of nurse practitioners in the U.S.A. was both to provide greater access to health care and to lower the costs of providing such care (Hupcey, 1993: 181; Booth, 1981: 110-113; Trnobranski, 1994: 135-136). Studies have shown nurse practitioners to have been both successful in delivering effective health care and to be cost effective (Hupcey, 1993: 181; Greenfield et al. 1978: 298, 305-309). In recent years increasing litigation insurance premiums have caused many rural doctors to give up obstetrics, while many obstetrician specialists are no longer willing to be involved in actual deliveries. This has created increased opportunities for midwifery specialist nurses in the total number of patients and the types of nursing care that they can deliver.34 By 1980 there were already 13,000 active nurse

34 This represents an interesting reversal of the suppression of midwives by doctors at the end of the last century.
practitioners in the U.S.A. (Richman, 1987: 110). The demand for nurse practitioners in the U.S.A. by the year 2000 is estimated to outstrip supply by a factor of three to one (Gioiella, 1993: 254). The shortage of community doctors in Australia has never been as great as in the U.S.A. Opportunities for an expanded role for nurses in the community have probably never been as great in Australia except in very unpopular localities such as remote aboriginal health care.\textsuperscript{35}

Nurse practitioners in the U.S.A. are depicted as usually functioning independently of medical practitioners. The achievement of independent nursing practice is seen by nurses as an important component of professionalisation. It opens the way for recognition of increasing autonomy in nursing, and legal recognition of an independent role for nursing, so that, "It [The Nursing Profession Act of 1984, Alberta, Canada] ... was important to recognise nursing in legislation as an independent profession" (Storch, 1984: 51). Because such nurses were not competing with doctors the medical profession had few objections. However, this type of nursing was and still is in something of a legal grey area. Most governmental legislation specifically prohibits nurses from making medical diagnoses. In reality these nurse practitioners had to make diagnoses because there was no one else to make them. While some nurse practitioners have been prosecuted for practising unlicensed medicine, in general doctors were willing to leave things as they existed ("Missouri charges R.N", 1991: 11). These nurse practitioners were actually acting as mini-doctors in many instances. It has been estimated that nurse practitioners could undertake without difficulty about two-thirds of the work normally allocated to general practitioners (Maggs, 1987: 168). The U.S. Department of Health and Human Services equated one nurse practitioner in a primary health care setting as equal to one-half of a doctor (Masson, 1985: 71).

Many nurse academics objected to this abrogation of nursing by nurse practitioners in favour of a pseudo-medical role (Briggs, 1990: 31).\textsuperscript{36} Debate occurred in America in the

\textsuperscript{35} The introduction and promotion of courses in aboriginal health for aborigines has meant that the drastic need for registered nurses in even these localities may be reduced.

\textsuperscript{36} In recent years there has developed in the U.S.A., and to a lesser extent in Australia, a shortage of contracted junior doctors (RMOs) in general hospitals. This shortage has resulted in nurse practitioners being contracted to do "medical workups" and other routine medical tasks, though some nurses claim that these nurses still maintain a holistic care perspective (Mallison, 1993: 7).
1960s as to whether these new nurse practitioners who were making, in effect, medical
diagnoses were in fact nurses at all, but rather pseudo-doctors. This is no longer seen as a
problem as nurse academics argue that a good Master of Nursing preparation enables modern
nurse practitioners to utilise a nursing framework and nursing theory to make nursing
diagnoses based on a holistic approach and focusing on wellness (Gioiella, 1993: 254). As the
shortage of doctors in the U.S.A. was reduced the medical profession began to object to the
infringement of their role by these nurse practitioners (Hupcey, 1993: 185; Zammuto et al.
benefits, and means of control, of incorporating nurse practitioners into their practices to do
such activities as preliminary assessment of the patient, collection of simple tests and the
follow-up of patients. The doctors benefited because their clinics could see more patients and
the nurse practitioners were assured of a fixed salary. There is some concern over doctors
claiming reimbursement for work actually performed by salaried nurse practitioners (Ott, 1989:
186). In working for and under the direction of doctors, these nurse practitioners have lost their
independent role and reverted to doctors' assistants.

It seems likely that concern over the above issues has accelerated interest in the
formulation of nursing diagnoses and usage of the nursing process. By using nursing
diagnoses nurse practitioners legally are no longer making medical diagnoses. The medical
profession has had a long history of concern over other occupations impinging upon its areas of
control of the provision of services. For example, the Australian Medical Association stated
that, "It is not in the public's interest that definitive diagnosis or treatment of illness, injury or
disability should be undertaken for any patient without the direct involvement of a medical
nurses to circumvent legal restrictions placed in their way by the medical profession.

The emphasis on psychosocial problems amongst existing nursing diagnoses is
ideally suited for community based nursing where the nurse practitioner is in a one-to-one
relationship with the patient, or patient's family, in the patient's home, or in a nursing clinic,
and adequate time exists to talk with the patient in order to identify psychosocial problems. A
study of nurse practitioners and G.P.s in a collaborative practice demonstrated that during their
interviews with patients the nurses were significantly more concerned with psychosocial issues than were the doctors (Campbell, 1990: 1359).

Most importantly, it is said that the establishment of nursing diagnoses opens the way to argue for direct financial reimbursement for nursing services. Nursing diagnoses are distinct from medical diagnoses, yet in the community setting can involve many of the same interventions. As a new category for reimbursement it should be possible for government and health funds to reimburse nurse practitioners significantly less than doctors for providing virtually the same services in many instances. Since nurse practitioner salaries are only about 25% that of salaried doctors in community clinics, there should be no shortage of interested nurses willing to work for direct financial reimbursement or increased salaries (Campbell-Heider and Pollock, 1987: 424). Studies have shown that American nurse practitioners are most unhappy with their salaries, which are lower than those of newly graduated doctors, while most happy with their increased autonomy compared to their other (typically hospital based) nursing colleagues (Hupcey, 1993, 181; Koebel et al. 1991, 43-56; Tri, 1991: 46-55). These entrepreneurial nurse practitioners/consultants would make more money, while the costs to the health care services could be reduced.

By 1990 in the U.S.A. over 20,000 registered nurses (nurse practitioners and other specialist registered nurses) had set up their own nursing businesses with better pay and conditions compared to nurses still working within the traditional health care systems ("Prognosis looks good for nursing's entrepreneurs", 1990: 34; Soehren and Schumann, 1994: 123-127). The main difference between these nurse practitioners and doctors is that nurses cannot prescribe drugs (Poulton, 1994: 81-84). There is agitation by nurses to have limited rights to prescribe in particular circumstances - a suggestion vigorously opposed by doctors (Carlisle, 1990: 26-28; "The role and function ...", 1992: 11; Morris, 1994: 30-32; Baker and Naphine, 1994: 35-37; Staunton, 1994c: 42). However, in Australia nurses in Family Planning Clinics have for many years supplied follow-up courses of the contraceptive pill after an initial medical consultation, while some individual American states have legislated for independent nurse practitioners to prescribe medications including, in a few states, controlled substances (Pearson, 1993: 24).
The situation for independent nurse practitioners in New South Wales is somewhat different to that in the U.S.A. While N.S.W. has community nurses who often function without medical supervision, their knowledge base is usually only sufficient to carry out the simplest of procedures. They are much like hospital nurses transferred out into the community. Most problems out of the ordinary need to be referred to a doctor. They have no special assessment skills which makes it difficult to make diagnoses (nursing or medical). A number of postgraduate courses in community nursing are beginning to be offered by universities and these courses include significant assessment components. However, intake numbers are limited in comparison to the existing numbers of community nurses, let alone the potential numbers, if this type of nursing was to be encouraged.

In 1991 the New South Wales Nurses' Association made a submission to the state government to establish the role of independent nurse practitioner, and New South Wales Department of Health reports have recommended an expanded role for nurse practitioners (Staunton, 1991: 11; Spilsted, 1993: 25-26.). At present in Australia, the accepted working definition of a nurse practitioner is "a registered nurse with appropriate accreditation who practices within the professional role. S/he has autonomy within the work setting and the freedom to make decisions consistent with his/her scope of practice, and the freedom to act on those decisions" (Parkes and Spilsted, 1993: 21). Freidson states that, "To attain the autonomy of a profession, the paramedical occupation must control a fairly discrete area of work that can be separated from the main body of medicine and that can be practiced without routine contact with or dependence on medicine" (Freidson, 1970a: 69). The emergence of nurse practitioners, utilising the nursing process in an independent role in the community setting, can be seen as an attempt to achieve this professional end. Jan Stow, Director of Nursing Services, Westmead Community Health Services, Sydney, acknowledges that "Those nurses who choose to follow the professional role of the autonomous practitioner challenge a widely held view of nursing as responsive only to the direction of others and establish a new agenda for change" (Stow, 1996: 3).
In 1992 the state and federal governments proposed the establishment of privately run nursing clinics to treat minor ailments, on the grounds that such clinics were thought to be much cheaper to run (Bonham, 1992: 3). At this time the nearest Australia has to independent nurse practitioners are a small number of midwives who are eligible for Medicare provider numbers (Willis, 1990: 105; Bonham, 1992: 3). They tend to be involved in home births because of resistance by doctors and hospital bureaucracies to their being granted clinical privileging (that is, the right to use hospital services) (Sherwood, 1991: 52). This process of exclusion of independent midwives, involving the denial of hospital usage, can be perceived as a medical strategy to deny these midwives 'official' legitimacy as professional health care providers (Willis, 1979: 32).

Much of what is being taught in nurse education seems to be aimed at achieving primary nursing and independent nurse practice, but such are the constraints of the existing health care system in N.S.W. that what is being taught can only be truly utilised by a small proportion of the total nursing population. Graduates of tertiary nursing courses, when they begin their working life as general nurses on the wards, are confronted by a theory-practice gap. Certificate nurses doing conversion courses immediately recognise the conflict between what nurse academics are teaching and the reality of the actual working environment. It can be argued that you have to start somewhere to educate or reeducate nurses to the new nursing if change is ever to be achieved. Yet, nurses and nurse academics seem to be unable to reach a suitable compromise between the ideal that is taught and the actuality of the work situation. Even if nurses do have difficulty in accepting the new nursing (nursing theories and the nursing process), the one unquestionable consequence of promoting primary nursing and independent nursing practice is to further demonstrate the separation between the old subservient nursing and the new autonomous nursing being promoted by nurse academics and the nursing leadership.

5.10. The Patient as Client

Medicine and traditional nursing refer to the ill person as a 'patient'. However, in the last decade the nursing literature has taken to referring to the patient as a 'client', or less commonly as the individual, child, adolescent, adult or elderly (Sohn, 1991: 211). The term
patient is viewed as having negative connotations. Sociologically, a patient, because s/he has taken on the 'sick role', appears inferior to and dependent upon nurses and doctors, whereas the new nursing literature argues that the nurse and client should be equals (Lopez, 1979: 60-65). A new term was needed to show the new relationship between sick people and the nurse - a relationship in which, theoretically, the sick person takes an active role in his/her own care and the nurse helps as appropriate.

Equally important, professionals such as lawyers and architects refer to the people they deal with and who pay for their services as clients. By adopting the term client nursing emphasises its new, responsible, professional relationship with the sick and further illustrates its divergence from the medical model with its medical terminology. A 1992 working paper on nursing from the New South Wales Department of Health spoke of the focus of nursing as care of "customers" (Structural Efficiency Program, 1992: 3). This term, while lacking professional connotations, does reflect the changing attitude of nursing, emphasising that nursing is providing a service and that 'customer rights' do exist.

5.11. Conclusion

The nursing literature and tertiary based nurse education seek to dissociate nursing from the traditional emphasis on a high technology, biomedical model, aping of medical knowledge, procedures and terminology. Instead they promote 'high touch-low tech' nursing, with distinct independent nursing procedures based on increased patient assessment, including thorough verbal assessment of long neglected psychosocial problems and the creation of a new nursing jargon. This new nursing technology highlights the proposed separation of nursing and medicine, and serves to unite the nursing 'profession' by giving nurses a unique language and approach to health care. The result is meant to be the emergence of a new nursing culture. This is best understood as a professionalisation strategy.

The new nursing technology seeks to give a scientific rationale for nursing care. This is aimed at putting nursing on the same scientific basis as medicine and is consistent with the perceived close association of scientific research and teaching with the university based
professions. However, the notion of a science of nursing rests uneasily with the central nursing premise of holism, which, generally, is seen as non-scientific. This incompatibility of the two major themes of the new nursing highlights the inconsistencies of its rhetoric.

The old hospital-based nurse training and its resultant nursing practice had a low indeterminacy/technicality ratio because it was commonly perceived by the general public and other health care occupations that there was little that was unique about nursing knowledge and judgement. Nursing knowledge and practice were seen as involving a combination of simplified medical knowledge and common sense. As a consequence, there was little social distance (status difference) between nurses and their patients. The development of a new nursing technology seeks to give a mystique to what nurses do by creating an esoteric nursing knowledge base, specialised terminology and a scientific rationale for nursing care through application of the nursing process. Nursing care would become more indeterminate because outsiders could no longer do what it is that nurses do. This would increase the nurses' power over their patients and alter nurses' relationships with other health care providers, especially doctors. Because of its uniqueness, nursing would be empowered in its relationships with others and be recognised as more professional. However, the problem remains that nursing has still to convince others that the new nursing technology is both useful and unique. There are inconsistencies in the nursing rhetoric with the holistic emphasis on active patient involvement in his/her care at odds with attempts to increase nursing's indeterminacy through promotion of an esoteric knowledge base and professional nursing judgement which require minimisation of patient involvement in decision making.

Thus, this chapter has discussed the variety of, somewhat conflicting, changes to nurse education which were, and still are, promoted and implemented with the transfer of basic nurse education to the tertiary sector. The rationales advanced in the nursing literature for these professionalisation strategies are, at best, dubious. Rationales for specific changes to the technology of nurse education have been advanced in isolation of one another so that, for example, inconsistencies and conflicts arise between, on the one hand, the promotion of scientific nursing and, on the other hand, the equally strong promotion of a non-scientific holistic emphasis to nursing care. Similarly, the development of nursing theories as the
foundations for an esoteric knowledge base for nursing represents a very superficial and misleading approach to the process of professionalisation. The significant changes to the how and what that is taught in basic nurse education lack coherency and consistency in both their rationales and implementation.
Chapter 6

The Overt Arguments for the Tertiary Transfer of Basic Nurse Education in New South Wales

In examining the reasons for the transfer of basic nurse education to the tertiary sector a number of issues need to be discussed. There were several reasons given for this transfer including the formal arguments for such a change presented to the government and its various educational committees. There were also informal arguments, not used with the government, but freely discussed in the nursing literature and at nursing conferences, employed to justify this stance and to try to persuade the majority of nurses to support the need for change. Finally, there were some hidden reasons, not openly discussed, but which had a strong influence on the nursing leadership, especially among nurse educators.

This chapter examines the overt arguments presented by nurses for the need to transfer nurse education to the tertiary sector. It includes both the formal arguments presented by various nursing bodies to the governmental and educational committees and the detailed and extensive discussions that occurred in the nursing literature. It is also necessary to discuss the government's reasons for accepting the change - not only the stated acknowledgments but also the unstated financial and political reasons. The other interested parties were the educational experts and the C.A.E.s who had input into the various advisory reports on nurse education.

6.1. Changing Attitudes to Nurse Education

Between 1966 and 1983 there were many reports, both government and non-government, and many workshops on the desired future of nurse education in this N.S.W. With the publication of the 1966 W.H.O. Report many people began to seriously question the adequacy of the existing hospital training of nurses. The W.H.O.'s recommendation for an absorption of the education of nurses into the higher education system in a manner similar to that of other professions was too radical for the thinking of most Australian nurses and governments. The 1967 Matrons' Report, for example, while acknowledging the inadequacies of the then 242 hours of nursing lectures during training, was adamantly opposed to a transfer
to the higher education sector, and instead recommended improvements in the existing hospital based training.

The state government supported this view, firstly by increasing nurse education hours to 720, establishing regional schools of nursing while closing down many smaller hospital schools, and then announcing the 1,000 hour syllabus. Equally important was the provision by the government of a formal tertiary education program to improve the teaching qualifications of nurse teachers, since the quality of what was taught suffered from the fact that, "The only subjects that can be taught by someone with no qualifications other than basic registration are first aid and practice of nursing" (Partridge, 1983: 30). Meanwhile, from the early 1970s, the attitudes of the nursing leadership altered to encompass the desire for tertiary based nurse education. The arguments presented for change and the reasons for these changing attitudes require examination.

6.2. Nursing's Stated Reasons for the Transfer

In the Australian nursing literature and in their presentations to the various advisory committees, the leaders of the state and federal nursing organisations gave three major groupings of stated reasons for the need for the transfer of basic nurse education out of the hospital system. These groupings may be summarised as follows:

1. The inadequacies of hospital based nurse training compared to tertiary based education;
2. The inappropriate use of student nurses on the hospital wards, to the detriment of both their training and patient care;
3. The cost advantages in tertiary based nurse education compared to any further upgrading of hospital based nurse training.


Each of these groupings of arguments will be examined in turn.

6.3.(i). The Inadequacies of Hospital Based Training

Nurses in New South Wales argued that the existing hospital based nurse training, with its biomedical focus, was too medically orientated and too narrow in its approach. Student nurses had to pass the state N.R.B. examination at the end of their training in order to register.
This examination had a multiple choice question format concentrating on medical concerns. Most of the questions required a simple recall of knowledge and the few deductive questions were hampered by the very limitations of multiple choice questioning. The consequence was that this examination drove the student nurses’ theoretical study during their final twelve months of training, just at the time when they should have been integrating their isolated bits of learning into a coherent whole. Students in their final year of training had typically become disillusioned with their training and were only concerned with 'getting through' and passing their N.R.B. examination (Bolton, 1981: 35).

The syllabus was knowledge based and medically dominated, and that is what it produced - nurses with some degree of proficiency in these narrow areas. Any increase in theory hours under the existing hospital training system would in all likelihood be incorporated back into the existing approach. Radical change was unlikely to occur for a number of reasons including medical influence on the N.E.B. and the fact that most nurse educators had been taught under the same system and would most likely be content to continue with the same approach to teaching.

The nursing literature argued that nurse training was aimed at making nurses 'reasonably safe' in the hospital setting and had nothing to do with teaching them desirable 'professional' skills (Goals in Nursing Education, 1976: 2-3; Hicks, 1981: 714). The literature also claimed that hospital trained nurses worked well only in a predictable environment (Rush, 1991: 121). This was not surprising because they trained on hospital wards where most nursing actions were governed by set protocols, where little occurred outside the ordinary and little nursing initiative was required. Take these nurses outside the normal acute hospital ward setting, whether it be to a busy Accident and Emergency unit which required some nursing initiative, or community nursing or geriatric nursing, and these registered nurses initially had great difficulty in adapting. Presented with new patient problems, hospital trained nurses supposedly could not function properly. They were said to have difficulty in adapting to new situations when they only had previous experiences to fall back on. It was argued that nurse training stifled nurse initiative and original thinking, dampened enthusiasm and discouraged questioning while encouraging conservative and conforming
behaviour (Delacour, 1988: 20). One study showed a decrease in critical thinking ability amongst student nurses in their final year of hospital training compared to their entry behaviour (Richards, 1977: 90).

The theory component of hospital training often bore little relationship to what nurses did on the wards. The knowledge gained from study blocks was not widely used or integrated into their ward experiences. The 1969 Matrons' Report found that only 4 of the 96 schools of nursing in this state were up to minimal standards in the knowledge actually taught (Report of the Committee, 1969: 27). Much of the learning of student nurses and junior registered nurses actually came while on the wards (Report of the NEB on the Future Development of Nurse Education, 1974: 8). An Australian survey of what nurses actually did in hospitals concluded that, "This type of knowledge and relevant skills frequently may be absent from the nursing curriculum ... The range of nursing responsibilities is extensive and extends beyond the activities that some might believe appropriate" (Wilson and Najman, 1982: 33). Nurses were learning much of their useful knowledge on the job and were being let down by an inadequate theoretical study. So, even though the existing biomedical emphasis of hospital nurse training seemed to support the service needs of the medical profession and the hospitals, in fact, it appeared to be of limited use at the bedside. Caldwell-Smith, the Director, Division of Nursing, Health Commission of NSW stated that either a large increase in study block hours was needed to give a wider, more relevant knowledge base to nurses, or a radical departure from the existing system was called for (Caldwell-Smith, 1980: 14).

Perhaps one of the reasons that much of the knowledge being taught was of so little use to the nurses on the wards was that nurse educators and nurse education were isolated from what was happening on the wards. The composition of the N.E.B. was physically and intellectually separated from events at the bedside (Gillam, 1969: 257). For many years nurse educators had very little to do with actual supervision of students on the wards and had little recent experience and exposure to 'knowledge of most worth' to ward nurses.

Equally important, the technological knowledge explosion meant that much of what nurse educators were teaching soon became obsolete. Nurse educators would spend some time teaching the implications and nursing considerations of a particular diagnostic test, only to
have it superseded within a short period. Nurse educators were often teaching something that
had already been changed in the hospitals, or the knowledge that the student gained could be
outdated before completion of his/her training. The nursing syllabus concentrated on the giving
of knowledge, which ran the risk of soon becoming outmoded, rather than on teaching the
student how to use general principles to arrive at answers, on how to learn to learn.

Even for knowledge which retained its validity there were serious questions about
how long nurses retained what they had been taught. As Bevis argued: "Another difficult
problem for the information-orientated curriculum is that for many years learning psychologists
have demonstrated definitively that less than 25 percent of content material 'learned' is available
for recall in two years, unless it is used and reinforced regularly or organised around
meaningful life processes" (Bevis, 1973: 12). Once registered, the nurse was only likely to
work in several nursing areas (e.g., medical and paediatric wards) during the next few years
and much of what s/he had been taught about diseases and interventions not relevant to these
areas would soon be forgotten.

In acknowledging the speed and scope of technological change in the secondary
and tertiary health care settings (hospitals and high technology units within acute care
hospitals), the nursing literature presented two arguments related to the inadequacies of hospital
based training. The first was that traditional hospital training was failing to keep pace with
technological change. The outmoded techniques of the knowledge based nursing curriculum
could not hope to keep up with the changes in health care (Report of the Committee, 1980a:
119). The way to produce technically competent registered nurses, who would be able to more
easily learn about and adapt to new health care technologies and new modes of patient care, was
through a basic educational system which taught student nurses how to find and use new
knowledge, which instilled in them an enthusiasm for continuing education (to become lifelong
learners) and hence to have the desire and ability to find out things for themselves, and the
willingness and capability to practice in conditions of constant change (McDonald, 1994: 6).
These technically competent nurses would be of exceptional benefit to the medical profession
and the hospital system. As new nursing fields opened up they would be ready to accept these
new challenges. The production of technically versatile nurses was greatly restricted by the
The existing training system because versatility or adaptability was not encouraged (Brewer, 1983: 96-104).

The second argument maintained the opposite - there was too great an emphasis on technology within the existing health care system and as a result the patients were being lost amongst the machines. Patient care, both medical and nursing, was becoming dehumanised. For instance, in coronary care units (C.C.U.s) it was pointless for all the staff to be competent in their understanding of and ability to use all the high technology equipment and invasive procedures if the poor heart attack victim was so frightened by all the hustle and bustle and flashing lights that he literally frightened himself to death because his acute anxiety sent his blood pressure soaring and put too much strain on his already damaged heart. In such an environment it is all too easy to neglect the patient, to see him as just a slab of meat to be connected to the machines, and for the staff to be oblivious of his very real anxieties and those of his family (Reiser, 1978: 220-221). If the patient's anxiety was noticed at all, the technological response was to give the patient an intravenous injection of an antianxiety drug such as morphine to effectively sedate him (Luckmann and Sorensen, 1974: 672). Meanwhile, the worried relatives were largely ignored in the waiting room.

It was claimed that this was exactly what doctors were doing, and to a lesser extent, those nurse specialists who were enamoured with high technology (Reiser, 1978: 220). Patient care, and the concerns of 'significant others', would be improved (with, in this example, possibly better survival rates and shortened hospitalisation) if only the nurses were educated to recognise and respond to the psychosocial aspects of patient hospitalisation. While the location discussed was a high technology unit, the psychosocial problems of patients were being largely ignored across the whole hospital setting. Here was a badly neglected area of patient care that nurses should be taught to treat in order to give patients the complete health care that they deserved. An emphasis on 'cure' was not enough. It also had to embrace 'care'. The existing hospital training system did not have sufficient hours or the ability to do justice to a comprehensive biopsychosocial nursing curriculum (Report of Committee, 1970: 12; Bolton,

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37 Relevant nursing diagnoses for this situation include "fear", "anxiety", and "powerlessness".
38 I have deliberately used masculine language here because of the predominance of male heart attack victims.
1981: 34-36). A new educational setting was needed which would maintain the 'scientific basis' of nursing, while integrating it with a greatly expanded social sciences (psychology and sociology) strand.

Not surprisingly, hospital based nurse training taught nurses how to function within the acute hospital setting. There was little emphasis on community nursing and public health education and prevention (Western Suburbs Hospital, 1978; Armidale and New England Hospital, 1980). Australia's health care systems in all states and territories were geared to secondary and tertiary health care (in hospitals), and these institutions have always employed the bulk of nurses in running these 'sickness services' rather than health services. In the 1970s, W.H.O. embraced the concept of primary health care (that is, community based health services) as the means of achieving 'health for all' by the year 2000 (Primary Health Care, 1978). Primary care deemphasises curative care in hospitals and emphasises self-reliance and self-determination in health matters. In 1979 the International Council of Nurses (I.C.N.) confirmed nursing's commitment to primary health care (The Role of Nursing, 1979). If Australian nurses were to meet this challenge, then there had to be an increasing emphasis on community nursing, public health education and the prevention of illness.

Again, hospital training could not cope with this changed emphasis without a vast increase in theory hours, a greatly increased student nurse placement in the community and a rejection of the medical domination of nurse education which streamed student learning towards the support of hospital services. The reason why the government should support this changed direction for nurse education was that "The most powerful outside force at work on all health care systems is economic pressure for cost containment...(and)...The World Health Organisation has acknowledged that nursing will play the leading role in primary health care" (Clay, 1988: 75-76). A more efficient, less expensive health care system for New South Wales would result from nurses leading the way in the adoption of primary health care, but the appropriate education of nurses was not feasible unless nurses abandoned hospital based training (Report of the Committee, 1980a: 119-120).

For many years there has been a critical shortage of nurses in countries such as the U.S.A. and Britain (Hanson and Patchett, 1986: 26). This shortage was attributed to a
combination of decreased enrolments in nursing courses, an increased attrition rate of student
nurses during their training and an exodus of trained nurses out of nursing into alternate
employment or home duties (Short et al. 1993: 177-178). This trend was not nearly as
worrisome in N.S.W. with cyclic episodes of too many newly registered nurses entering the
job market at times of temporary shortages of employment vacancies (often because of annual
hospital cutbacks due to budgetary overspending) (Carroll and Dwyer, 1987: 17-21).

However, there was concern about several potential problems. Wastage rates of
student nurses in Australian training hospitals were as high as 23.4%, with the loss of money
and resources unprofitably spent on their aborted training (Report of Committee, 1970: 8 and
28; Neill and Barclay, 1989: 5). Work and training conditions were their main reasons for
abandoning their training. Once registered, about half these registered nurses would quit
nursing within a few years with no intention of returning to their occupation (Kelly and Bye,
1990: 11). This represented a considerable loss of experienced nursing talent which constantly
had to be replaced by training new nurses for three years, followed by several more years in
which they refined their nursing skills as junior registered nurses. There was also the worry
that eventually Australian teenage girls might follow the overseas trend and abandon entry into
the traditional female employment of nursing in favour of the expanding study and job
opportunities for females in non traditional occupations.

Hospital based nurse training was represented as unsatisfactory because it placed
considerable strain on students due to shift work and the study block system (Report of the
N.E.B. on the Future Development of Nurse Education, 1974: 8; Booker and Rouhiamen,
1981: 41-43). Having lectures and examinations crammed into a four week study block placed
enormous pressures on students to gain and then regurgitate knowledge over a relatively short
period of time. In the period leading up to their final external state registration N.R.B.
examination, there were difficulties for students in trying to combine shift work and study. A
more reasonable approach to academic studies would be available in the tertiary education
sector.

In 1973 the control of nurse training in N.S.W. was transferred from the Minister
for Health to the Minister for Education, but all the costs of training still came from the hospital
budgets. There was a philosophical argument that health dollars should be spent on health care and not on the education of nurses (Palmer, 1983: 37). The cost of teacher education was not paid for by individual schools, but from the tertiary education budget, and so should be the case for nurse education.

6.3.(ii). The Benefits of Tertiary Based Training

Educational philosophy would suggest that it is undesirable to educate a single group of students in isolation, as it tends to restrict the breadth of their learning and narrows their outlook (Dunlop, 1974: 53). It is also unwise to educate employees under the control of their employers because the employers have a restricted perspective on what needs to be taught. They want education to be directed at meeting their immediate needs and often fail to appreciate the long term advantages of a workforce with a wider, more general education (Duke, 1975: 38). In times of rapid technological change it is far better to teach students how to learn for themselves than to try to teach them knowledge and skills that rapidly become outdated.

Hospital based student nurses working and training on the wards are prone to concentrate far too much on learning a step by step procedural approach to nursing skills needed at that particular time and place, and are poorly prepared to adapt to new demands and skills because they have learnt to work on the basis of set hospital protocols rather than by flexible general principles.

Nurse education was the last form of 'semi professional' study to move into the mainstream of education in multidisciplinary educational institutions. What could be considered the nearest occupational group to nurses, namely teachers (a female dominated semi profession), had abandoned teacher training in single discipline teachers' colleges in favour of conversion and amalgamation into C.A.E.s, with disparate vocations studying together. The theoretical training of teachers had long been geographically separated from their ultimate employers, the schools, with provision for regular student teacher practical sessions where the student teacher was supernumerary to the regular teaching staff and was supposedly under close and constant supervision. Similarly, the theoretical education of medical students, the other occupational group that most nurses relate to and most aspire towards, had for a long time been separated from hospitals. It was only appropriate that nurse education should follow suit.
It was argued that if nurse education was based in the tertiary education sector it would permit a much more liberal education of nurses (Goals in Nursing Education, 1976: 3). Student nurses would be exposed to a wide range of subjects, studied in greater depth than was previously permitted - most notably psychology, sociology and ethics. More hours and a closer integration of the biosciences and the social sciences would help to demonstrate to the nursing students the relevance of these subjects to nursing care. A comprehensive nursing syllabus would allocate more time to non medical/surgical nursing areas of care such as geriatric, psychiatric, developmental disability and community health nursing (N.S.W. Government Gazette, 1978; University of Wollongong, 1986: 30-32). The narrowed bias of hospital based training would be replaced by a widened perspective across the spectrum of nursing activities.

Because of the need for specific support strands of study and the large number of different types of nursing to be studied in three years, the nursing syllabus was very prescribed with virtually no student choice in subjects to be studied. However, it was felt that nursing students would benefit from a liberal study or elective course(s), usually in their first or second year of study, which had no relationship whatsoever to their nursing studies (Basic Nurse Education: Guidelines, 1984: 3; Armidale C.A.E., 1984: 52-65). A non nursing elective would encourage the independence of nursing students, expose them to the influence of non nursing students and academics and encourage their integration with tertiary institutional life. Typically 12 credit points out of the 48 credit points for the year would be put aside for liberal studies (Catholic College of Education, 1984: 36; University of Wollongong, 1986: 117).

In the support strands of introductory bioscience, psychology and sociology it was argued that the nursing students would amalgamate with the existing first year courses and would integrate fully with other tertiary students doing these courses, having the same lectures, tutorial groups and assignments (University of Wollongong, 1986: 117). Early exposure to other non nursing students and academics would help to foster their recognition that they were students first and nurses second, and aid their adoption of tertiary styles of learning which encouraged independence and self learning. Because student nurses would be taking subjects in common with non nurses they would come to recognise alternative views and approaches to what they were learning; that there are, for example, many different sociological perspectives.
relevant to health care. The result would be nursing students who were more aware of individuality and differing views, and, as a consequence, would not see nursing and health issues in black and white, with only one correct viewpoint. They would come to recognise that patients have the right to see health care concerns and issues differently from doctors and nurses.

There were shortages of nurses in New South Wales in the late 1970s and early 1980s. The way proposed to overcome these problems was to move nurse education into the tertiary sector ("1158 tertiary nurses ...", 1988: 24). It was thought that such a move would help to maintain female interest in nursing as a career, would attract more males into nursing and might entice more mature age students, especially females with families (Neill and Barclay, 1989: 4-11). In particular, mature age entrants were known to do well academically and they and males to be more likely to remain in nursing (Jones, 1986: 32-33). Similarly, it was felt that tertiary graduates, having spent three years in obtaining their credential and with opportunities to upgrade their tertiary qualifications, would be more likely to remain in nursing and not leave after several years working as a registered nurse. A more experienced and better qualified workforce would result.

Separating the demands of study and work and having nursing students as supernumerary on the wards would help to reduce the dropout rate of students. The possession of tertiary degrees, especially postgraduate qualifications, reflecting the attainment of particular 'useful' skills would form part of the parcel of factors contributing towards new career paths for bedside nurses, thus helping to enhance the attractiveness of nursing as a continuing career.

The central emerging theme in nurse education, deriving from the U.S.A., was the concept of total patient care (T.P.C.), involving the nurse looking after all the biopsychosocial aspects of patient care. Hospital based nurse training and hospital based nursing care were largely confined to the biological aspects of patient care (reflecting the medical emphasis within nursing care). If nurses in this country were going to successfully implement total patient care

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39 Originally hospital nurses had provided for those "activities of daily living" that the ill patient couldn't meet himself. Over time they had increasingly taken on delegated technical tasks, to the detriment of basic care of the patient (Freidson, 1970b: 64). A nursing educational emphasis on T.P.C. would promote a return to nursing's holistic origins of patient care and serve to distance nursing from the medical cure model (Gardner, 1989: 317).
then they would need a much more comprehensive grounding in areas not adequately covered in existing nursing curricula. Tertiary based nurse education would permit more study of such areas as sociology, psychology, ethics, nursing theories and nursing assessment. This would culminate in an improved ability for tertiary nurse graduates to make clinical nursing decisions which are central to the concept of total patient care.

Total patient care is represented as a more desirable form of clinical nursing than task allocation or team nursing, as it permits a better quality of nursing care which by its very nature must be more desirable for the patient. It is important not to ignore the psychosocial consequences of illness because they can be of as much concern to the patient and 'significant others' as the purely physical manifestations. Opportunities to learn T.P.C. in the hospital environment were too limited. Only in tertiary education institutions would nursing students learn how to implement T.P.C. When these university graduates entered the work force they would then be able to implement this concept in their patient care, bringing about a gradual but steady improvement in patient care within the hospital setting.

It has been suggested that during the remainder of this century there would be two important changes to health care involving more high technology treatment of acutely ill patients (tertiary health care) and a concurrent movement of the less ill patients out of the acute hospitals and back into the community setting, with its emphasis on primary health care (Cary, 1988: 341; Hill and Ragg, 1994: 30). As a consequence, nurses would need to be able to function in one of these two extremes of nursing care, either in high technology areas or in community nursing.

Tertiary based nurse education would instil the thorough grounding in the sciences needed for working in high technology nursing areas, while supernumerary clinical experiences would enable suitable supervised learning experiences without the risks of nursing students directly caring for very ill patients outside their depth of knowledge and understanding. Tertiary based nurse education would also permit a more complete grounding in primary health care, involving low technology assessment skills, expanded patient education, more comprehensive communication skills and community nursing theory (The New South Wales Institute of Technology, 1984: 10-12). Graduates of such tertiary courses would be better suited for the
changing expectations of modern health care than nurses trained within the narrow confines of the general wards of the acute care hospitals.

One of the major claims made by the nursing leadership was that tertiary educated nurses would be much more versatile and useful members of the health care team, leading to real benefits in the quality of patient care. Graduates of the 'new nursing' would display originality, creativity, insight, innovation, and would be decision makers (Spicker and Gadow, 1980: 20). They would be actively involved in decision making about patient care, rather than just passive implementors of medical decisions and hospital protocols.

Surprisingly, there was little valid research into the supposed superiority of tertiary education nursing graduates over hospital trained nurses. What few studies had been reported in the literature, especially the U.S.A. and Australia, were equivocal (Brooke, 1985: 1-5; Parkes, 1984b: 177-182). Very few nursing writers have commented upon this disparity between the higher educational goal of excellence and the lack of supporting evidence for such amongst graduates of nursing. One such author who did is Thomson who said that: "If however, after 20 years of investment in higher education for nursing, the evidence of this superior quality (of graduates) is not so much absent as sparse and unconvincing, then the discipline might be well advised to re-examine its purpose and to differentiate between short-term political expediency and long-term wisdom" (Thomson, 1987: 21).

Despite the fact that these few studies showed no clear-cut superiority of tertiary educated nurses, this was ignored in the argument for the expansion of tertiary based nurse education. Instead the unsubstantiated claims of important nurse theorists and writers such as Rogers and Johnson for the superiority of baccalaureate level nurses were taken and accepted as fact by most nurses and non nurses (Bullough and Bullough, 1984: 58).

Until the changeover in nurse education in 1985, New South Wales nurses were being trained in hospitals via a 3 year certificate course. Seemingly strong arguments were submitted for a transfer of basic nurse education to the tertiary education system. But the question remained open as to whether nurses should be transferred to the T.A.F.E. system with training leading to the awarding of an associate diploma, or into the C.A.E.s leading to a diploma award.
The view of the nursing leadership was that T.A.F.E. was involved in 'technical' training, with a hands-on approach which involved a partial apprenticeship (Editorial, 1971: 3). As such it failed to foster the attitudes and skills of critical thinking now deemed essential for nurses. The C.A.E.s, on the other hand, were involved in 'professional' education as evidenced by the presence of teacher education in these institutions. Study leading to the awarding of a tertiary diploma at the UG2 level at a C.A.E. would "provide both breadth of education and comprehensive nursing preparation" (Goals in Nursing Education, 1976: 37).

It was felt that the content of the existing 3 year nursing certificate and the expectations of nursing students were already too great for not only the awarding of a normal certificate but also for the awarding of an associate diploma. The amount, complexity and range of knowledge and skills required to be mastered by nursing students during their 3 years of training had consistently been increasing. The content and expectations were more consistent with the 3 year diploma award to be found in C.A.E.s (Goals in Nursing Education, 1976: 36-37). Such a level of study would be consistent with the American experience of tertiary nurse education.

There was initially little realistic expectation for the movement of nurse education into the universities or the awarding of a bachelor degree in nursing (Statement on Nursing Education, 1977: 2). The government was resistant to this move, presumably because of the increased educational costs of such a move. There were doubts about adequate numbers of entrants into nursing being able to meet the universities' entrance requirements and the universities did not want basic nurse education because it was too 'vocational' (Russell, 1990: 185). With the amalgamation of the C.A.E.s and the universities, however, nurse education achieved its move into the university system.

6.4. Student Nurses and Ward Duties

The concept of total patient care as the philosophical underpinning of the new nursing goes hand in hand with that of holism. Total patient care requires an intelligent, knowledgeable registered nurse who can utilise the nursing process (Alfaro, 1990: 2-11; Kozier et al, 1991: 164-170). This requires the nurse to possess significant interpersonal
communication skills, good patient assessment abilities, a high degree of knowledge and understanding of patient problems (not only physiological, but importantly also in the psychosocial areas), excellent planning skills and competence and dexterity in a wide range of nursing procedures. It was claimed that these abilities were only to be found in a thoroughly educated registered nurse who has been taught to use the nursing process, with its emphasis on the above activities (Patten, 1979: 36-38). This registered nurse would then have the total responsibility for the nursing care of the number of patients s/he had been allocated for that shift.

It was argued that student nurses, enrolled nurses, trainee enrolled nurses, nursing auxiliaries and even hospital trained registered nurses lack the education to do more than give lip service to the concept of total patient care (Lublin, 1985: 18-28). The theoretical knowledge base and, hence, understanding of patient problems would depend on where a student nurse was in his/her three years of apprenticeship training. Student seniority would equate with which nursing interventions had been taught and practised under some form of supervision, till it had been deemed that the student nurse had reached a level of competency satisfactory for 'mastery' of given nursing procedures. Junior nursing students would not have achieved mastery of many nursing procedures and were often incapable of delivering total patient care.

For example, it might be argued that it would be possible to take anyone off the street and in several days teach that person to give out medications, including injections, with reasonable speed and safety. This is obvious, because at home patients self-medicate, while newly diagnosed insulin dependent diabetics quickly learn the procedure for giving their own subcutaneous injections. However, it literally takes years for a nurse (or anyone else) to be taught and to learn from experience what lies beyond these simple actions. An extensive understanding of pharmacology is needed to appreciate the implications of the medications taken by a patient in relation to the patient's present condition and his/her care, and to be aware of potential drug interactions and side effects. It also takes considerable time and some guidance to learn to use the simple procedure of giving out medications as an opportunity for ongoing assessment and communication with the patient.
Also, it was argued that hospital trained registered nurses, with their educational emphasis on physiological problems and poorly taught communication skills, were deficient in their ability to provide the psychosocial (and hence total) care of patients (Report of the Committee, 1980b: 2). To be implemented properly, the concept of total patient care required all the nurses on a ward to be tertiary educated registered nurses, or certificate registered nurses who have been reeducated to the nursing process by tertiary based conversion courses. It was claimed that with a totally registered nurse ward workforce the standard of patient care would improve significantly. A wider range of patient concerns would be addressed appropriately by the nursing staff so that the patient's hospital stay would be more beneficial. It was possible, because the nursing care was better and more consistent, that the duration of hospitalisation might actually be reduced with concurrent cost savings, and that the patient's and family's perceptions of the standard of nursing care would be increased. While it was a central premise of the argument that total patient care delivered by only registered nurses improved patient care, there was surprisingly little research to support this claim. Only several small American studies had been conducted and were said to demonstrate these claims, but the evidence was by no means clearcut. These studies suggested that all-registered nursing staff in hospitals were feasible, and that they could increase the quality of care while decreasing the cost of patient care (Christman and Jelinek, 1967: 78-81; Ellis, 1978: 107-112).

The lack of research was not surprising, because an all-registered nurse workforce on a general ward, implementing total patient care, was more an ideal than reality due to the financial and bureaucratic difficulties in establishing such a unit for research purposes. Yet, there seemed to be a lack of enthusiasm for testing such a central premise. Instead it seemed that the supposedly high standard of nursing care to be found in the all RN, small and highly specialised units, such as Intensive Care Units, had been extrapolated to the argument for all RN general wards.

Probably only a small number of the nursing leadership here and overseas had believed that all RN general wards were achievable (Christman and Jelinek, 1967: 78-81). As a compromise, the majority of the nursing leadership wanted an all trained/qualified nursing staff on the wards (all registered nurses and enrolled nurses); that is, non-qualified student nurses
and trainee enrolled nurses to be removed from the paid workforce and direct involvement in
patient care except during supervised, supernumerary clinical experiences. Although enrolled
nurses could not deliver total patient care, the tertiary educated RN would be able to plan the
patient care and direct the activities of the enrolled nurse. The RN would implement total patient
care on his/her own patients, and then carry out that portion of total patient care (for example,
medications and complex dressings) that the enrolled nurse was not trained or permitted to do.

There are two issues here. The first was the desire for an all RN, or at least an all
trained nurse, workforce on the general wards which could efficiently implement the concept of
total patient care. Such a situation required the removal of student nurses from the bedside
because they lacked sufficient knowledge, skills and experience. Second, it was felt that student
nurses were wasted on the wards in giving direct patient care. Much of their training was spent
on the performance of repetitious tasks and there was little supervision of students on the
wards. Junior student nurses were often allocated simple task nursing, involving such activities
as bed making, showering and observation rounds because they had yet to be taught more
complex nursing procedures. They developed a task orientation to nursing care and later they
had difficulty appreciating and trying to implement any form of total patient care or primary
nursing care.

The majority of hospital nursing services in Australia were provided by student
nurses (Statement on Nursing Education, 1977: 16-20). The least qualified people were in the
most direct contact with the patients, performing the most numerous tasks. One observer
suggested that attention should be drawn "to the gigantic fraud at present being perpetrated on
the public, when people are led to believe that they are being cared for by 'nurses' when ill"
(Altschul, 1976: 3). Occasionally a nurse educator would visit the wards and supervise some
student nurses towards 'mastery' of the next set of nursing procedures, but such were the
demands on nurse educators that little time was available for individual observation and ward
teaching of student nurses.

It could be argued that the consequence of all this was that patients failed to receive
the appropriate nursing care that they deserved, because on any one shift they were likely to be
looked after by a number of nurses and hence missed out on total patient care as it was meant to
be delivered. Since no one nurse spent much time with any one patient, and the nurses were fully occupied completing their prescribed tasks, there was little time or incentive to talk to the patient and come to appreciate the patient's non obvious, non physical concerns and problems. Much of the student nurse's training was not actually training at all, but delivering basic, repetitious patient care - meeting the service needs of the hospital. It was not necessary to make thousands of beds to learn how to be proficient at making the variations on a hospital bed. The student nurse training was not even an apprenticeship training, because an apprenticeship implies that the trainee was taught and supervised by a 'trained craftsman'. In fact, many of the practical skills and the application of the knowledge base of junior student nurses came from more senior student nurses (Report of the NEB on the Future Development of Nurse Education, 1974: 8). Student nurses were taught by other student nurses, and hence their training was patchy, with significant variation in clinical experience between different hospitals (Delacour, 1986: 20).

The converse of the situation was that sometimes, rather than being involved in day in and day out repetitive, basic tasks, student nurses had to take on responsibilities for patient care that were beyond their capabilities, knowledge base and experience, and which raised a number of legal, ethical and patient safety concerns. From having very little responsibility as a junior student nurse on day duty, it was not uncommon, up until about 1980, to have two junior student nurses running a twenty to thirty bed ward on night shift. While student nurses always had an area supervisor - an experienced RN covering nursing administration - to refer to if needed, nevertheless the students had to take on enormous responsibilities. Night duty was perceived as a good opportunity to mature student nurses; an opportunity to take on those extra responsibilities and to be more involved in many aspects of patient care. On night duty student nurses could expect to be involved in a large 6 a.m. medication and injection round, without supervision, just at a time when physiologically the nurse was most tired and most likely to make errors (Gould, 1989: 61).

In the promotion of the case for the transfer of basic nurse education to the tertiary sector, hospital based training with student nurses working on the wards was presented as being entirely unsatisfactory (Delacour, 1986: 20). There was considerable variation between
hospitals in experience, expectations and standards of students' clinical exposure (Report of the NEB on the Future Development of Nurse Education, 1974: 8-9). Improper use was made of the students' time which should have been used for learning purposes. Often as not outside the classroom, students learned from other students, and learned from their mistakes. Often they could only perform nursing procedures by using a step by step protocol approach, without appreciating the significance and potential dangers of their actions, because they lacked both the knowledge base and reasoning skills to understand why they were doing what they did. Far better for student nurses to be removed from the workforce. In the tertiary setting, away from the medical and hospital bureaucratic influence and demands, they could be taught, practise and role play total patient care. There would be an emphasis on cognitive skills - reasoning skills. Rather than learning procedures by rote, students would be taught to use basic principles to work out for themselves sequences of actions to achieve a desired result in patient care.

The result would be that students would get a better education and patients would get a better nursing care from an all trained nursing staff. Michael Parry, Chairperson of the State Planning Group and Higher Education Board, indicated that the New South Wales government supported this belief, giving as one of its reasons for the transfer of nurse education out of hospitals as the desire to "improve patient care by having a more highly trained, more stable nursing workforce" (Parry, 1984: 8).

If students were removed from the bedside they would need to be replaced. Various estimates have been made as to the equivalence of registered nurses and student nurses with, for example, eight registered nurses being able to replace ten student nurses (Report of the Committee, 1980a: 89). There is a wide range in the estimates of how many trained nursing staff are needed to replace student nurses on the wards - a lot depends on whether you want to maintain the ability to carry out a set number of tasks or to actually attempt to 'improve' patient care through the implementation of total patient care.

While no actual formula was agreed upon with the New South Wales Department of Health for the replacement of student nurses in hospital, there seemed to be an assumption on the part of nurses that the majority of the reallocated nursing positions would be held by
registered nurses (Report of the NEB on the Future Development of Nurse Education, 1974: 10 and 12). There would be more registered nurses on each ward and hence increased opportunity to move away from task allocation or team nursing towards something closer to primary nursing care, involving total patient care, resulting in an improvement in patient care. Because there would be more RN positions available on the wards there would be jobs available for the newly graduated, tertiary educated registered nurses in the state hospitals. Having been educated in the concepts of holism, the nursing process and total patient care, these new graduates would then bring these ideas and abilities into the hospital system and help to change the existing system.

6.5. Costs of Nurse Education

It was difficult to quantify accurately the costs of the three year training of nurses under the hospital system. There was no discrete health care budget allocation for nurse training (Report of the N.E.B. on the Future Development of Nurse Education, 1974: 8). Rather, the costs of running hospital schools of nursing came out of the individual hospital budgets. Nursing schools were dependent upon the philanthropy of the hospitals' nursing and general administrations. The problem was not much clearer with the regional schools of nursing. It was not possible to give a definite cost to train a RN, but rather a range of costs depending on the criteria used.

A N.E.B. report in 1977 estimated that it would cost between $8,153 and $12,350 over three years with a 1,000 hour study block release to train a RN in the state hospitals (The Cost of Hospital Based Nurse Training, 1977: 73). A 1980 report estimated that it would cost about $3,900 per annum to train a RN in the C.A.E. system. Add to this an averaged T.E.A.S. allowance of $656, and the annual recurrent cost was thought to be $4,556, or a total cost of $13,500 (1980 dollars) to train a RN in the C.A.E. system (Report of the Committee, 1980a: 98). This figure was comparable to the 1977 figures for hospital training. A break even point had been reached with the 1,000 hour syllabus with 25 weeks of study block release. Any increase in the theory hours of hospital based nurse training, plus any further catchup increases in the wages of student nurses, would make it increasingly cheaper to introduce tertiary based nurse education. The above cost estimates were based upon replacing student nurses with a
largely RN workforce with relatively few ENs. A shift in the balance towards more (cheaper) ENs and less (expensive) registered nurses would make even greater savings to the state government.

There was general agreement that the 1,000 hour syllabus was inadequate and would need to be significantly improved to at least match the 1,600 hour Victorian general nursing syllabus. The main recommendation was to exceed this figure: "The resource documents suggested that in order to meet the wide range of objectives, students would need an increased allowance of 1,850 hours to be spent in the school of nursing and, or working in clinical settings at the behest of the school of nursing, rather than as indicated by the service needs of the hospital" (Report of the Committee, 1980b: 2). No matter to what extent theory hours were increased, hospital based nurse training would become more expensive than nurse education in the tertiary education sector (Statement on Nursing Education, 1977: 17-18). After an initial one off expenditure for capital works, the state government would save money by paying for nurse education in C.A.E.s, and as a bonus would be likely to be able to reutilise the hospital nursing school buildings and nurses' homes.

6.6. The State Government’s Reasons for the Tertiary Transfer

In examining the state government’s reasons for announcing the transfer of basic nurse education to the tertiary sector from 1985 there are the stated, readily apparent reasons for this political change in attitude, but there are also reasons that were not acknowledged and perhaps not apparent at the time.

The late 1970s and early 1980s was a period of increasing nursing militancy in this state for better wages and improved working conditions (Pittman, 1985: 8; Russell, 1990: 137-169). In particular, student nurses were seen as very poorly paid workers with excessive mental and physical demands being placed upon them for little financial return. A 40 hour work week, shift work, patient care allocations similar to that of registered nurses and work practices such as placing junior student nurses incharge of wards on night duty with only the limited 'supervision' of the hospital night duty nursing supervisor were major expressed concerns of the nursing workforce. Increasingly, nurses were agitating for reform through rallies widely
reported in the media, work to rule activities and minimal staffing 'strikes'. Nurses won a number of significant improvements in wages and in conditions such as rostering (Hill and Tate, 1985: 9). However, the principal unresolved nursing concern related to nurse training.

This unprecedented nursing militancy won much public support and widespread media coverage. The state Labor government was looking for a quick and easy way to placate the remaining primary concern of the nursing occupation. The sudden, complete capitulation to the ideal of tertiary based nurse education could be seen as a major victory by the nursing leadership and it would go a long way to removing the last militant demands of the nurses. Such a concession by the state government would reduce the need and the ability of nurses to carry out politically embarrassing actions such as strikes (McCoppin and Gardner, 1994: 108-109). At the same time the state Labor government might be seen as scoring political points for its innovative thinking over the more conservative Liberal governed states and conservative coalition federal government.

This package of concessions regarding wages, conditions and, most importantly, nurse education, might also help to alleviate the politically embarrassing shortage of nurses in the public hospital system by producing a more reliable number of graduates entering the workforce each year and making it more desirable for registered nurses to stay within the public hospital sector (Gray, 1989: 93). As well, the state government in announcing its acceptance of tertiary based nurse education could claim that this move was consistent with the government's desire to enhance the public hospital system by having a better and more stable nursing workforce (Parry, 1984: 8). The government would be seen to be acknowledging the proposed benefits of an educationally better prepared nursing workforce whose knowledge base and adaptability would be more in line with that espoused by such recommendations as those of the Sax Report of 1979 and the W.H.O. Expert Committee on Nursing of 1966. The government acknowledged that moving nurse education into tertiary institutions where learning could occur in the presence of other groups of non nursing students would bring the education of nurses into line with that of many other comparable occupational groups such as teachers, physiotherapists, nutritionists and social workers (Media release, 1983).
While the majority of nurses in N.S.W. trained and worked in the 2nd Schedule hospital system (i.e., general, acute care public hospitals) there were also a number of other important hospital schedules. It has been suggested that the 5th Schedule hospital system, involving psychiatric and mental retardation (now known as developmental disability) care, had long been politically embarrassing to the state governments because of the more vocal militancy of these nurses compared to the general trained nurses (Moxon, 1984: 43; Brown, 1984: 40-41; Kokowski, 1987: 6-7). Transfer of basic nurse education to the tertiary sector would involve the establishment of a comprehensive nurse education syllabus encompassing both psychiatric and mental retardation nursing along with a number of other nursing areas, and the amalgamation of the existing nursing registers into a single comprehensive nursing register. Specialisation in psychiatric and mental retardation nursing would become postgraduate studies in tertiary education institutions rather than first or post registration certificates in specific hospitals. The numbers and power and militancy of the 5th Schedule nurses would rapidly disappear amongst the far more widespread 'general' nursing population.40

While the government has never acknowledged the financial benefits to be gained by the transfer of basic nurse education, it is not difficult to envisage that this could have been one of the major reasons for announcing such a move. The state government was faced with a rapidly rising cost of basic nurse training while studies had shown that it was cheaper to educate nurses in the C.A.E. system than in the hospital system. With one announcement, the state government could resolve the whole problem of hospital based nurse education and make significant cost savings. As events transpired, with the federal government's assumption of the tertiary educational costs of nursing from 1993, the state government was relieved of this ongoing cost and responsibility.

There is one other factor that may have been of importance in the state government's decision to move basic nurse education out of the hospitals. It has the potential to lead to significant cost savings but it is impossible to determine whether it consciously influenced the government's decision or developed as a consequence of the transfer. This factor is the cost of

40 Since then developmental disability nursing has almost disappeared as a nursing speciality with care of these patients increasingly occurring outside the traditional hospital environment and being delivered by specially trained (and non trained) and cheaper, non nurses.
replacing student nurses on the wards with an all trained workforce (i.e., a mixture of registered nurses and enrolled nurses). If far fewer registered nurses and/or an increased number of cheaper enrolled nurses (or even nursing auxiliaries) work at the bedside, replacing the care once given by student nurses, then savings can be made in the costs of nursing care in the state public hospitals. Whether the government in 1983 had this in mind as a hidden agenda, or whether it merely emerged from events is not readily apparent. The mechanisms by which this has occurred and the extent of it will be discussed in greater detail in Chapter 8, The Consequences of the Transfer.

For all the arguments presented by the nursing leadership for the shift of basic nurse education into tertiary institutions, it still required a political change of mind for the event to occur. It seems likely that these educational arguments had little effect on the government's will (perhaps because of the medical opposition to such a move). What seems more likely is that politically embarrassing nursing militancy and the high costs of hospital based nurse training were the major motivating factors for the state government to announce the transfer of nurse education.

6.7. The Role of the C.A.E.s

For reasons already presented, the C.A.E.s were the tertiary education institutions most likely to be involved in nurse education, both basic and postgraduate, if such a transfer was to occur. Representatives from the C.A.E.s on the various governmental advisory committees on nurse education had long been supporters of the transfer of basic nurse education out of the hospital system (Statement on Nursing Education, 1977: 6). While there were undoubtedly valid educational reasons for promoting such a move, there were also benefits to be gained by the C.A.E.s from such a transfer. Taking on the responsibility of the education of many thousands of nursing students would significantly increase the student populations of the C.A.E.s, especially amongst the smaller institutions. This would help to maintain their viability in the eyes of the government, would require the provision of additional resources such as buildings which could also be used by non nursing students, would require minimal adjustment on the part of most C.A.E.s which had a long history of comparable
teacher education, and would lead to increased status for various C.A.E.s through increased student numbers. The C.A.E.s would be significant beneficiaries from the transfer of nurse education.

6.8. Opposition to the Tertiary Transfer

If the nursing leadership in N.S.W. accepted the need to transfer basic nurse education to the tertiary sector, there was little general nursing support for dramatic changes from hospital based training. Many bedside registered nurses appeared to be either uninterested in the whole issue or were opposed to such a change, though not to the extent that they were willing to organise in order to oppose the nursing leadership's views (McCoppin and Gardner, 1994: 102-103). The possible reasons for the apathy of most registered nurses to changes in their training system are many. It was claimed that most registered nurses were unaware of the inadequacies of their training system - that they displayed "a marked lack of insight into the deficiencies of their own education" (Chittick, 1968: 12). In fact it has been said that many registered nurses "regarded the element of apprenticeship as a more important part of nurse training than (their) theoretical studies" (Baly, 1980: 318). Hospital trained nurses are conservative in their outlook and tend to wish to maintain the status quo (Herbert, 1983: 13-14). This was attributed to their apprenticeship style of training which produced a RN "who is restricted in outlook and resistant to change" (Report of the Committee, 1967: 37).

The apprenticeship system produced registered nurses who were obedient, disciplined, acquiescent to hospital protocols and lacking in a desire to change nursing practices. The concerns of the general registered nurse working at the bedside in the years leading up to the transfer of basic nurse education in 1985 can perhaps be typified by the statement that: "Only the exceptional professional (i.e., university educated North American nurse) ever reaches the standards we know to be routine throughout the New South Wales nursing profession ... The nursing hierarchy have been seduced by the dream of greater professional satisfaction and recognition they hope will come with a predominantly theoretically based training system and are ignoring what happens to patients when nurses stop nursing" (Cameron and Brown, 1984: 32). The nursing leadership have been described as professional
elitists who are materially orientated, as opposed to the proletarian bedside nurses (Draper, 1990: 361). As a consequence "the professionals are elitists, and are slowly distancing themselves from the generalists" (White, 1983: 239).

Despite the muted mumblings of at least some of the bedside nurses, there was increasing agreement amongst the nursing leadership for the transfer of basic nurse education to the tertiary sector. The vast majority of nurses in the state had, in fact, little say in the demands for the radical changes to nurse education (Melosh, 1982: 15; Kelly, 1991: 5; McCoppin and Gardner, 1994: 38-39). This is perhaps not so uncommon in any such situation where the demands for wide reaching change are initiated and cultivated by an elite vocal minority while the significantly larger majority goes largely unheard and unheeded because of its apathetic unconcern for change and its lack of a united voice (Freidson, 1970b: 21).

Non nurses were often very vocal in their resistance to fundamental change to nurse education. The medical profession in this country was very resistant for many years, and very successful, in its opposition to the movement of nurse education out of the hospital setting (Hazelton, 1990: 107-125). Doctors continue to be resistant to changes to nurse education stressing “... the value of the primary and traditional nursing role, which is deliverance of patient care at the bedside under the guidance of a doctor. That is the nurse’s traditional role and the role they do best” (Wertheimer, 1990: 11).

Doctors had a vested interest in maintaining the apprenticeship training of student nurses. Within the hospital sector doctors had a significant input into the context and direction of basic nurse training in such a way as to maintain an emphasis on nursing care in support of the medical treatment regime. The medical domination of the content of traditional nurse education reinforced the medical claim to authority over nurses based upon the doctors’ greater knowledge of ‘specific aetiology’ and disease processes within the body (Submission to Inquiry on Professional Issues in Nursing, 1987: 7; Brown and Seddon, 1996: 31). Changes to basic nurse education might represent a challenge to this authority.

The 3 year socialisation process that occurred during hospital training taught student nurses to be willing helpers of the hospital doctors. If nurses were to be taught and socialised away from the hospital setting then they might no longer be willing to fulfil their
traditional supportive role to medicine. Such concerns were also to be found amongst the health care industry: "The Hospitals' Association of New South Wales, fear that college basic nursing programmes will produce some abstract person ... (who is) indoctrinated with an attitude of mind that is in opposition to the welfare of the health service in general" (Parsons, 1978b: 9).

Much of the medical profession, health care bureaucracy and bedside nursing population did not consider that there was much theoretical knowledge in general nursing nor that there was any need to expand the theoretical component of nurse training while most of the useful learning by student nurses occurred at the bedside on the wards and not in the classroom. They argued that hospital training for nurses was desirable because nursing was "labour intensive: and much of the work requires only a low level of skill" (McEvoy, 1992: 40).

6.9. Conclusion

There were many seemingly good educational reasons given for an upgrading of basic nurse education in N.S.W. in the 1980s. These arguments formed the basis of the case presented by N.S.W. and Australian nursing bodies for the transfer of nurse training out of hospitals and into tertiary institutions. However, these arguments could have equally been used for changes to the existing hospital based nurse training, its transfer to the T.A.F.E. system, or a partial or gradual transfer to C.A.E.s.

The arguments presented represented identified deficiencies in hospital based nurse training. As such, they highlighted real problems which, sooner or later, needed to be addressed. All interested and informed parties, both nurses and non nurses, which included doctors, health care bureaucracy and government, recognised the need to expand nurse education, though there were obvious differences in viewpoint as to the extent of the needed expansion.

What is interesting is the way in which the nursing leadership tried to use this information to argue for very specific and radical changes to where, how and what would be taught in basic nurse education. These educational rationales were only the most obvious arguments for change and served to justify and camouflage other sets of nursing’s reasons for
change. In order to understand the nursing desire for a rapid and total transfer of nurse education to C.A.E.s it is necessary to look beyond the educational rationales and discuss the covert reasons of nurses for such change.
Chapter 7

Nursing's Covert Reasons for the Tertiary Transfer

While escalating costs and unfavourable media attention were more compelling reasons for the New South Wales government's endorsement of the tertiary transfer of nurse education, the nursing leadership in this country and overseas in its submissions to governmental bodies had put forward any number of seemingly good and valid educational reasons for this move. However, I argue that there was an equally important, if not more important, hidden agenda in the nursing leadership's agitation for this change. This hidden agenda takes two forms. First, there were arguments for change which did not appear in the official representations to the government and its advisory bodies, but which nurses occasionally discussed and which appeared in the nursing literature, sometimes discussed in-depth and sometimes only mentioned in passing. Second, there were important incentives for change which were not discussed in print at all (or hardly at all except as throw-away lines, presented almost as afterthoughts to the major arguments for change), but which become much more significant when the consequences of this major change in nurse education are examined, when the winners and losers of this change are discussed. These hidden arguments were concerned with the professionalisation of nursing, including both the strategies to achieve this and its proposed benefits.

7.1. Tertiary Socialisation Reexamined

While the benefits of tertiary based nurse socialisation versus the deficits of hospital based nurse socialisation were widely discussed and presented as arguments for a superior nurse education in the tertiary setting, these arguments went beyond the obvious. It was claimed that tertiary socialisation would lead to more flexible, adaptive, enthusiastic nurses who would be more comfortable in a changing health care environment (Report of the Committee, 1980a: 33-36; Spicker and Gadow, 1980: 20-22).

It would also remove the strong influence of the medical profession on student nurses which encouraged a subordinate role for nurses to the doctors and lead instead to
nursing students internalising those attributes of a professional culture which were seen by the nursing leadership to be essential to the professionalisation process. While these ideas were discussed in the nursing literature, they were never presented as part of the formal arguments for the move to the tertiary education sector. The nursing leadership sought an independent or at the very least a collegial interdependent role for nursing which would be different from the traditional dependent role of nursing to medicine. As long as nurse training occurred within the hospital setting, the power and influence of the medical profession would dominate the socialisation of student nurses both in the nursing schools and on the hospital wards.

Medicine had a predominant influence on the existing nursing curriculum. Tertiary based nurse education enabled nurse academics to significantly reduce this medical influence while promoting the independence of nurse education. Nursing students now have very little exposure to doctors during their 3 years of undergraduate study. Doctors were no longer wanted and were actively discouraged from offering their services as guest lecturers. Instead, the lectures were given by nurse academics in their areas of expertise or special interest. For example, where once neurological nursing would have required a number of lectures by a visiting neurosurgeon, in the new tertiary nursing syllabi a changing emphasis would decrease the total hours given to this area of nursing and concentrate just on nursing care, with only minimal background information given on the medical aspects of neurology. Outside lecturers were confined to nursing specialists such as diabetic nurse educators or community oncology nurses with occasional presentations by non nurses such as speech pathologists or physiotherapists.

The tertiary nursing syllabi placed less emphasis on the total number of hours on traditional medical and surgical nursing in the acute care hospital setting, and even within this topic there was a greatly increased emphasis on the psychosocial aspects of patient care (Illawarra School of Nursing, 1982: 5-6; Mitchell College of Advanced Education, 1984: 28-29). Even the title of medical/surgical nursing has been largely replaced with some alternate name such as acute care nursing or adult nursing (Armidale College of Advanced Education, 1984: 89). Similarly, the new nursing curricula no longer refer to 'illness' with its medical connotations. Instead the new nursing emphasis is on health, the promotion of health and

The nursing literature claims that all this cannot help but change nursing students' attitudes towards doctors. While from an educational perspective they should be more questioning, flexible and independent thinkers, which is supposedly better for patient care, these nursing students should more importantly no longer be in awe of the doctors. Lacking any extensive exposure to doctors during their tertiary education these nursing graduates should not have been socialised into a subordinate helping role to the doctors. Instead, they should be able to assume an independent practitioner role in which they are on equal terms with the doctors.41 As helpers, nurses are not professionals. As collegial members of professional health care teams they conform with a number of the attributes of a profession. This, I argue, is the primary reason for the nursing leadership desiring a different socialisation for nursing students - not socialisation towards better patient care as is the stated reason, but socialisation away from the influence of doctors towards so-called professional attributes.

7.2. Encouragement of Professional Attributes

In Chapter 2, What is a Profession? the traits of a profession used by nursing were discussed. They consist of:-

1. A distinct body of specialised knowledge;
2. Authority and autonomy;
3. A professional culture;
4. A code of ethics.

Removed from the domination of medicine within the hospital system it was argued that nursing students would be socialised within a setting in which they would adopt a number

41 When discussing this in more detail in Chapter 8, Consequences of the Transfer I will claim that in reality this has not occurred, but rather that tertiary nursing graduates are resocialised back towards the existing norms when they enter the workforce.
of these attributes, including the willingness to display autonomous or independent behaviour and appropriate moral principles or ethical behaviour in the delivery of their nursing care (Ryan and McKenna, 1994: 114-123).

In the hospital setting the role models for student nurses were the registered nurses who were said not to display professional attitudes. The traditional registered nurses on the hospital wards are not autonomous practitioners and lack the so-called attributes of a professional culture (Raymond, 1988: 6). In the tertiary setting the nursing students' role models are supposed to be the nurse academics (Weller, 1988: 179). Entrants into nursing would commence their tertiary education with non professional attitudes, but by graduation they should have adopted, via their nursing lecturers, important professional attitudes (Murray and Chambers, 1990: 1099-1105).

Nurse academics are meant to display autonomous behaviour because their knowledge base and understanding of modern nursing practice should enable them to teach and practise nursing in an independent manner. They are separated from the restrictive protocols of hospital nursing and the nursing departments and faculties should be encouraging them to implement innovative nursing practices (Catholic College of Education Sydney, 1984: 17-18). Their behaviour should provide a role model for their students, while the nurse academics should actively encourage their students to be independent thinkers, to experiment and to take responsibility for their own actions (Charles Sturt University, 1989: 21-22).

In the tertiary setting the way in which nurse academics teach should not be the traditional format of rote learning with the accumulation of facts. Rather, nursing students should be challenged in their education, leading to the production of creative, reasoning, independent thinkers who utilise group support and are confident and enthusiastic enough to pursue ongoing (postgraduate) education (University of Wollongong, 1993: 13, 17). The nursing literature argues that these attitudes are major components of a professional culture (Doheny, 1982: 180-181; Lublin, 1985: 22-24). Additionally, the tertiary setting more readily permits the widespread educational utilisation of the developing nursing jargon of the nursing diagnosis and the nursing process which tends to bind together these nursing graduates and separate them from the non initiated medical profession.
Similarly, formal courses in nursing ethics would help to develop an appropriate attitude and code of behaviour in nursing students towards patients and other members of the health care team which are consistent with the perceived professional code of ethics (Chaska, 1978: 17; University of Wollongong, 1986: 62-63). Nursing courses go well beyond this and see aspects of ethics in particular, relating to patient rights and patient advocacy, as unclaimed areas of health care and seek to establish a nursing claim to expertise in this area - expanding and setting a particular boundary for nursing domination in this aspect of patient care (Bandman, 1984: 483-487; Mason et al. 1991: 72-73).

7.3. Other Professional Traits and Tertiary Education

A unique body of knowledge acquired through a number of years of study (especially at an advanced or postgraduate level) and the authority derived from this knowledge can only realistically be attained in the tertiary educational setting. Tertiary academics have the education, time, facilities, opportunities and encouragement to actively develop, pursue, research and experiment with purely nursing knowledge. Development and testing of nursing theories, new nursing diagnoses and the nursing process have come via nurse academics. Nursing research which can lead to new, distinctly nursing knowledge is only actively encouraged in tertiary educational institutions. Rather than rely on the traditional knowledge of others, especially that of medicine, nursing leaders argue that nursing needs to generate its own exclusive knowledge base. Judith Lumby, Professor of Surgical Nursing at The University Of Sydney, explicitly demonstrated this desire for nursing's demarcation from medicine when she said: "We are trying to telegraph to people that we are not some offshoot from medicine, that we are looking at human and clinical matters quite differently ... We are on about what it is to be human" (Bagnall, 1994: 44). This new nursing knowledge then needs to be taught to the new entrants into nursing in such a way that they accept and utilise this knowledge in their everyday worklife. This serves to separate their knowledge base and nursing actions from both the hospital trained registered nurses and the doctors.

Additional study at the postgraduate level was encouraged so that an even greater familiarity with and utilisation of this purely nursing knowledge occurs. This attitude is clearly
displayed by nursing calls for the bachelor degree as the minimum requirement for 'professional' nursing, and more recent calls from the U.S.A. for at least a Master's of Nursing as the requirement for entry into a second nursing register, or second license, for the independent nurse practitioner, clinical nurse specialist, nurse midwife and nurse anaesthetist ('Policy on nurse education', 1996: 28-29; Sharp, 1992: 28; Leigh and Frauman, 1990: 134-138; McBeth et al. 1993: 45-47). In particular, the N.S.W. Nurses' Association claims that the independent nurse practitioner with many years of study of unique nursing knowledge (to at least a Master's level) would be displaying a unique expertise (Staunton, 1991:11; Stow, 1996: 2). This nurse, because of his/her independent practice, would by definition, be self-directed and directly accountable to his/her patients - that is, s/he would have the authority attribute of a profession (Mundinger, 1980: 152).

7.4. The Boundaries of Nursing

Another major component of the hidden agenda of the nursing leadership which was occasionally discussed in the nursing literature was the need to establish and protect nursing's boundaries or occupational territories or task domains or areas of demarcation (Gieryn, 1983: 781; Daly and Willis, 1989: 1152). By this I mean the formation of distinct areas of nursing responsibility and leadership which were either exclusive areas of nursing work or else areas in which nursing would take a leadership role and direct the actions of other health care workers. Such actions were deemed necessary for two reasons. First, it would inhibit the encroachment of other health care providers into what were previously seen as activities belonging to nurses ('Policy on role boundaries in personal care', 1996: 17; Wilson and Najman, 1982: 31; Tartaglia, 1985: 34; Staunton, 1987a: 3). Second, it would develop unique nursing areas outside the control of medicine and the other health care occupations (MacRae, 1988: 13). Such areas would help to justify the unique 'professional' role of nursing. Instead of appearing to take bits of knowledge from many different disciplines and carrying out health care activities which had considerable input from a number of other occupations, nursing would now professionally demonstrate and control its own unique specialised knowledge base and activities (Melia, 1983: 28-30).
The emergence of modern nursing in the late nineteenth century was associated with nursing activities not too dissimilar to those carried out by domestic servants. When doctors began to perceive the benefits of this routine patient care in freeing up their valuable time, coupled with the reliable and disciplined nature of these nurses, they progressively gave up the more mundane medical procedures. Nurses were happy to take on these discarded activities while giving up activities such as ward cleaning, and preparing and serving patient meals because they were now too busy and these were no longer deemed true nursing activities. Although still enamoured by the ideal of total patient care some hospitals and their nurses have progressed to the nurses giving up such mundane and 'unprofessional' activities as making patient beds, and showering and shaving patients ('Statement on non-nursing duties', 1981: 38-39). Willis refers to this phenomenon of discarding unwanted activities as 'pass-the-task' (Willis, 1994: 14).

However other activities that not only have been lost from nursing's primary delivery domain, but which are now generally perceived as having become too specialised for nurses, are seen by the nursing leadership as more worrisome occurrences ('Policy on nursing and nursing care', 1996: 22; Pittman, 1985: 8). Nurses having accepted the recording of E.C.G.s when it was discarded by the doctors, have in turn lost this activity to specially trained E.C.G. technicians who bring their own highly technical and expensive machines to the patient's bedside in hospital. Not only would the registered nurse be unable to use these machines properly because of lack of training, but the nurse would also lack the experience and knowledge base needed to interpret subtle abnormalities.42

Similarly, for many years registered nurses were the only health care providers with the basic knowledge and time to discuss and teach about dietary problems with hospitalised patients. As nutritional concerns have gained prominence and knowledge about diet has

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42 E.C.G. technicians are not expected to be able to interpret E.C.G. recordings, a task left to the cardiologist, but familiarity with the testing usually gives them knowledge of the significance of the subtle changes in the electrical conduction of the heart. Interestingly, since E.C.G. technicians only work office hours Monday to Friday, urgent E.C.G. traces are done by the registered nurses using older, less complex machines and many registered nurses would be able to interpret any gross, potentially dangerous abnormalities of cardiac conduction.
expanded, hospitals have responded by introducing trained nutritionists to advise and educate the patients. This component of patient education has also been lost by nurses.

Not too many years ago, physiotherapists were relatively rare and the routine teaching and application of the various types of physiotherapy were performed by both trained and student nurses. As physiotherapy has become a complex discipline in its own right and physiotherapist numbers have increased, this area has been lost by nurses. Nowadays physiotherapists do the initial assessment of the hospital patient, determine the appropriate type of physiotherapy needed and any safeguards required, educate the patient, perform the physiotherapy and evaluate the results, all on their own initiative or on referral from the doctor. This tends to occur during office hours so that the bulk of the actual physiotherapy needs to be performed by the nursing staff. There is still some degree of confusion and conflict over who initiates and takes responsibility for physiotherapy on hospital patients.

These represent procedures which were once nursing’s responsibility and have been lost to other health care workers, with nursing input being perceived to play a subordinate role. Yet, under the concept of total patient care, the nurse would like to retain responsibility for such things as a test performed on the ward (E.C.G. recording), patient education (about diet) and interventions (physiotherapy) on the ward. These losses are perceived as representing an erosion of nursing responsibility (Staunton, 1987b: 2; Brann, 1980: 29).

In America, though not yet in Australia, doctors have argued that the acute shortage of nurses and "organised nursing’s emphasis on 'autonomous professional status' ... [taking] nurses away from the bedside” could be alleviated by the introduction of auxiliary health care providers (trained under a medically determined syllabus) (Service, 1988: 7; Lindeman, 1989: 70). This proposal would see anaesthetic nurses replaced by (cheaper) anaesthetic technicians and 'routine' (nursing) care provided by registered care technologists, leaving the registered nurses as "hands-off" managers (Lindeman, 1989: 70-73). Such proposals are strongly rejected by the nursing leadership as being contrary to the best interests of the patients who are best served by qualified nurses providing total patient care (Vidovich, 1989: 9; Palmer, 1989: 28-29; Pilkington, 1989: 22-28).
This could greatly reduce the need for and numbers of registered nurses and could greatly reduce the power and role of registered nurses by putting them in competition with another group of providers of direct hands-on patient care. Preventing erosion of the unique domain of nursing has become a pressing issue. Not only must nursing protect itself against the encroachment of other health care providers, but it must also resist attempts by medicine to use others to challenge nursing's new role.

The N.S.W. Nurses' Association perceives that one way of achieving this protection is to provide a sufficient knowledge base so that nurses can claim that they are up-to-date providers of health care in particular areas and are best suited to make the appropriate and correct judgements in patient care (Staunton, 1987b: 2-3). This process is similar to the way in which the development of scientific medicine at the turn of the century is seen as a major justification of attempts by medicine to control competition in health care delivery by claiming cognitive authority (recognition by others of credibility and expertise in a particular field) over all matters related to illness (Sadler, 1978: 186; Richards, 1991: 202-204). Additionally, the nursing process, total patient care and the concept of holism have supposedly been shown to be the best, and perhaps the most cost-effective, way of providing health care. Tertiary credentialling, the university setting and nursing research to validate the new nursing care are all represented as essential to support nursing's fight for its domain. For instance, while control of patient nutrition and physiotherapy may have been usurped in the hospital setting, in the community and home setting an 'appropriately' credentialled community nurse specialist could be seen to be more than adequately prepared to educate about nutrition and implement and evaluate physiotherapy.

Issues of protecting boundaries in nursing also relate to the separation of registered nurses and enrolled nurses (or professional nurses versus technical nurses). In justifying the unique role of the tertiary educated professional registered nurses it becomes important to clearly separate their role from the far less adequately prepared enrolled nurses. Encroachment by enrolled nurses of activities said rightly to belong to registered nurses is seen as needing to be resisted ('Policy on nurse education', 1996: 28-29). This issue will be discussed in more detail later in the chapter.
Not only do nurses need to prevent encroachment by others but they also perceive the need to both demonstrate their separateness from medicine and to expand their own occupational domination into unclaimed areas of health care. The movement of nurse education out of the hospital and away from medical domination permits the development of nursing curricula in tertiary institutions which reject the medical biological model of illness in favour of a biopsychosocial model of health. Nursing is deliberately emphasising the psychosocial aspects of health care precisely because nursing claims that medicine has traditionally ignored this area.

This opens up whole new areas of patient care for which medicine is said to lack the knowledge base, strategies for intervention and interest, while nursing possesses all these. It serves to demonstrate that nursing is not an inferior form of medicine with a role confined to the support of medical care, but is a distinct occupational entity with different concerns and areas of responsibility which are different to and may be demarcated from medicine. A reduced emphasis on the traditional medical/surgical nursing, which is associated with medicine, and an increased emphasis on such areas as community and geriatric nursing, which are associated with very few doctors, again demonstrates the attempted break with medicine. These underresourced but growing areas of community care and geriatrics are thought to offer great opportunities for an expansion of independent nursing practice.

Likewise, the nursing leadership has long been aware of the growing attention being given to the reporting of medical malpractice. It has decided that medicine has comparatively underemphasised ethics in health care delivery (Folta, 1973: 19-23). This difference between medicine and nursing is demonstrated by the traditional medical preoccupation with preserving life at all costs while for decades nursing has emphasised the quality of life and the dignity of dying. Tertiary based nurse education has greatly expanded the time and emphasis placed on nursing ethics and is trying to promote nursing's role in patient advocacy with nurses promoting and protecting the welfare of the patient over, for example, the possibility of iatrogenic disease (Ardidale College of Advanced Education, 1987b: 123-126; Wollongong Calendar, 1993: 338).
If nursing can establish a clear and distinct role for itself with its own particular and exclusive knowledge base and implementation of health care, then it can claim a separate role for itself in the health care team. Nurses would be recognised as independent health care providers with an acknowledged valuable input into patient care and an equality with other providers (though perhaps what is desired is an equality with the doctors and a superiority to other health care workers such as physiotherapists and social workers). One of the components of the attribute model of a profession is a recognised unique provision of a valuable service to the community. Equality in the health care team would be an acknowledgment of this and this equality can best be obtained and maintained through tertiary based nurse education.

7.5. Increased Status and Increased Remuneration

The nursing literature makes much of the need to increase the lowly status and pay of nursing and nurses, largely through the mechanism of tertiary based nurse education and the attainment of postgraduate qualifications. Much is made of the "social, economic, political and symbolic rewards which should accrue to those labelled professional" (Bond and Bond, 1986: 283-284). Studies over several decades in a number of comparable Western countries such as Australia, Britain and the U.S.A. have consistently shown that the public accords nursing a lower occupational standing or ranking than medicine (and a lower ranking than a number of other health care occupations).

Congalton, reporting on the social standing of various occupations in Australia in the 1960s, consistently scored doctors a high 1.61 or an A1 rating while trained nurses scored a lower 3.87 or B3 and trainee (i.e., student) nurses rated a lower C4 (Congalton, 1962: 12-15; Congalton, 1969: 146-157; Congalton, 1976b: 90). Such public rankings of occupational status are similar in both the U.S.A. and Britain (Treiman, 1977: 236-239; Bond and Bond, 1986: 62). Daniel's 1980s survey of occupational prestige in Australia also showed that physiotherapists (3.2), social workers (3.5), speech therapists (3.5) and occupational therapists (3.6) had all attained greater prestige than registered nurses (3.8) (Daniel, 1983: 112-116).

Commentators have noted that occupational prestige correlates strongly with gender so that, for example, "'Nurse' was placed in a cluster that also included ballet dancer, teacher
and child care worker ... the first of 3 clusters of essentially female occupations" (Pittman, 1985: 29). When comparing the health care occupations, the three male dominated occupations of medical specialist, general practitioner of medicine and dentist are rated higher than all the female dominated health care occupations (Daniel, 1983: 112-116).

While looking at the rankings of occupational prestige it should be noted that the researchers score tertiary academics much higher than they do both nurses and teachers. Congalton scored university lecturers as 2.28 or an A2 and university professors as 1.62 or an A1 which is virtually the same as doctors (Congalton, 1962: 12-15; Congalton, 1969: 146-157). Similarly, Daniel's survey ranked university lecturers as a 2.5, which is better than high school teachers (3.5) and directors of nursing (2.8), but not as prestigious as general practitioners (1.8) (Daniel, 1983: 112-116). These results reflect the supposition that there is some correlation, at least in some Western countries, between the length and complexity of an occupation's education and its associated prestige (Treiman, 1977: 104-115).\(^4^3\) In other words the longer the study necessary for preparation for practice in an occupation, the more likely that the public will perceive that occupation as prestigious. Prestige and status are seen as being generally associated with long years of university education. Higher education and high prestige are also associated with higher income. It is not surprising that nursing has associated the attainment of higher status and increased pay with the placement of nurse education in the tertiary sector and promotes a 4 year undergraduate degree and postgraduate study in nursing.

It has been argued that the lower status afforded to bedside nurses compared to nurses in education and administration is largely due to the bedside nurses' lack of tertiary credentials (Chute and Oeschsle, 1986: 163). In the past doctors have been supportive of an increase in nursing prestige, but of course not to a level anywhere nearly equivalent to their own (Editorial, Medical Journal of Australia, 1970: 209-210). The widespread belief that equates tertiary education with higher status is illustrated by the fact that: "Medical students

\(^4^3\) However it is interesting to note that Australian nursing journals report numerous letters of outrage from nurses when papers and magazines publish tables of occupational statistics which continue to list registered nurses as para professionals (Parkes, 1994: 24-25). These objections are based on the fact that the Australian Standard Classification of Occupations (ASCO) was developed in the early 1980s when nursing was still hospital and certificate based, and it is felt by some nurses that its rankings fail to take into account the changed circumstances of tertiary based nurse education.
often acknowledge that the nurse has a claim to higher status than their own on the basis of experience, while they may also believe their own education should accord them the higher status" (Webster, 1988: 132). When she was the Director of the Office of the Status of Women, Dr Anne Summers, stated that "it is becoming clearer what strategies can be adopted to improve the status of nurses ... the transfer of nurse education from hospital based training to tertiary training in Colleges of Advanced Education has been a most important step" (Summers, 1985: 37).

This expressed desire for an increase in status for nurses appears not to be a primary concern of the rank and file of the nursing population, but rather that of the nursing leadership (Fream, 1984: 23-24; Hase, 1983: 39-40; Dachelet, 1978: 22-23; White, 1984a: 559). Vidovich, the Australian Nurses Federation assistant federal secretary, acknowledges this lack of concern about status by most nurses when referring to the difficulties in arousing and uniting the nursing masses: "Why do they start nursing in the first place, you're going to ask. Ask them. You will find that their fundamental values are not about status or money or prestige" (Vidovich, 1990: 13).

Some Australian bedside nurses have expressed concern about the seeking of increased status, especially through tertiary qualifications because tertiary qualifications "were being sought for professional status, advancement or better salary ... The degree was more important than the knowledge and personal enrichment it should have signified" (Creighton and Lopez, 1982: 138). A second concern expressed was that increased status for bedside nurses would be detrimental to patient care as it would impede communication between the nurse and the patient, i.e., talking, listening and asking by both the nurse and the patient (Winkler, 1988: 4). There is a perception among nurses that doctors and patients do not communicate well because the patient is overwhelmed by the vastly superior status of the doctor and is unwilling to ask questions. Conversely, because the patient does not see the nurse as superior in prestige, the patient is more relaxed with the nurse and is more willing to both ask and answer questions that can be useful in determining patient care.

It is suggested that "different types of knowledge attract different levels of social kudos" (Chandler, 1991: 83). Knowledge of nursing theories, the nursing process and nursing
research would appear more theoretical and abstract to the general public and other health care workers than the existing watered down knowledge of medicine and surgery taught to nurses in the hospital setting (Gruending, 1985: 553-558). The more theoretical, the more difficult for others to understand, the longer the period of study, then the more status afforded the sole possessors of such knowledge. Nursing leaders argued that, just like medicine, increased tertiary education and increased professionalisation of nursing will bring with them an increased status. Plus, it has been argued that male nurses would be more likely to emphasise the professional status of nursing than would female nurses, and one way to attract more males into nursing was to place nurse education in the tertiary sector (Rosen and Jones, 1972: 493-494).

This seeking by nurses (the subordinated) to emulate some of the perceived attributes of their subordinators (the medical profession) is consistent with the behaviour and aspirations of an oppressed group towards that other group with which they are most closely associated (the oppressors) (Crawford, 1988: 2.11). Nursing has many of the characteristics of an oppressed group including disunity, lack of confidence, low opinion of self and an irresistible attraction towards the deemed oppressor and his way of life. Nursing's aspirations for the higher education and increased status of medicine are consistent with this analysis of nursing's relationship with medicine.

From a feminist perspective, nursing's bid for increased status is a futile endeavour, as it ignores the sexual division of labour in the health care industry (Beaumont, 1987: 48-51). Game and Pringle assert of nursing that "the symbolism of the family; doctor/father, nurse/mother, patient/child is more evident in the definition of jobs and authority here than in any other industry" (Game and Pringle, 1983: 94). There is a distinct gender separation of professional and semi professional occupations in health care. As long as nursing remains predominantly female and its numbers remain so much larger than that of medicine, then it is fallacious to assume that an increased status will come to nursing with the move into higher education.

Gender is not only linked to status but also to pay. Despite supposed 'gender neutrality' in pay structures (equal pay for equal work) the overseas experience is that nurses fail to be paid equivalent wages to male dominated occupations supposedly requiring a similar
education, knowledge base, skills and decision making qualities (Editorial, 1991: 17). The criteria to determine pay equality fail to capture a large number of important 'feminine' aspects of nursing responsibility, in favour of traditional 'masculine' traits - care versus cure. Women's work is made invisible and not recognised as a valuable contribution to patient care, and this is apparent in the failure to increase nursing's status and pay to comparable levels of other similar but masculine occupations (Dusevic, 1994: 24). While nurses might claim that: "If you want a char woman, hire one. A nurse is a specialist", society still sees nursing as women's work and fails to award it increased status and a commensurate pay (Leser, 1985: 23).

While they fail to attain the same status and pay as equivalent male occupations, the overseas experience is that Bachelor of Science (Nursing) graduates get paid more, have greater responsibilities and better skills than less educated nurses (Young, 1991: 105; Brider, 1991: 28-36). Pay differences among nurses have been linked to educational standards. In New South Wales in 1991, 1st year registered nurses earned a basic salary of $469.70 per week ("Public hospital nurses' (state) award", 1992: 37). There are yearly increments for certificate and diploma holders, supposedly reflecting increased nursing skills and responsibilities coming from experience, till in the 8th year the pay has risen to $653.50. However, in their 2nd year in the workforce UG1 holders jump to a level above the 8th year rate, on $680.30 (instead of the normal 2nd year rate of $484.40) which is equivalent to the pay of a clinical nurse specialist, who is normally the second most senior nurse on a hospital ward. Such a pay jump is meant to reflect the greater knowledge base and understanding of nursing practices of the baccalaureate educated nurse. In New South Wales there is now a definite financial reward for the junior nurse with higher education qualifications.

7.6. A Two Tier System of Nursing

Under the old hospital based system of nurse training there were two tiers of trained nurses. There were the three year trained registered nurses and the one year trained

44 I have used the overseas experience as countries such as Canada and the U.S.A. have had a much longer association of tertiary graduate nurses in the work setting than is the case in New South Wales.

45 An additional factor in this failure could be that nursing as yet has failed to clearly demonstrate its unique activities and to clearly establish the boundaries of its sole responsibilities.

46 There are also a number of unpleasant drawbacks to the above which will be discussed in Chapter 8, The Consequences of the Transfer.
enrolled nurses. Assisting in the delivery of patient care were two groups of students - student nurses and trainee enrolled nurses.47

The recent changes to nurse education have led to the emergence of the 'professional' registered nurse who is educated in a tertiary institution (a university) and a 'technical' enrolled nurse trained in the T.A.F.E. system. Such changes achieved in Australia in the late 1980s are consistent with the pivotal 1965 American Nurses Association position paper on the educational preparation levels of various types of nurses (Bullough and Bullough, 1984: 58; \textit{RANF Policy Statement}, 1989; Johnson, 1966: 30-33). Much has been written about this "level of entry" debate (Marquis \textit{et al.} 1993: 135). For several decades the written desire of the (American) nursing leadership has been to achieve two distinctly separate categories of trained nurses. Registered nurses are to be baccalaureate educated in universities and are meant to display professional behaviour in an innovative and progressive role (\textit{Nursing in Australia}, 1988: 3). Enrolled nurses are to possess some lesser qualification, perhaps equivalent to an associate diploma, and are meant to display technical behaviour, following the instructions set by the registered nurses, and possessing competence at performing nursing tasks (‘Policy on enrolled nurses’, 1996: 19).

There is conflict between this expressed view and the theoretical components of nursing practice. On the one hand, nursing theory promotes the concept of total patient care and holistic care of the patient. All nursing actions required by the patient should be performed by the same nurse on the one shift, with no activity being too basic. On the other hand, many position papers picture the registered nurse in a leadership role directing the actions of the enrolled nurse in performing the basic nursing tasks, with the registered nurse only being involved in the more complex nursing procedures requiring a degree of assessment, judgement and evaluation (‘Policy on nurse education’, 1996: 28; Clay, 1987: 71). While the theoretical approach requires an all registered nurse ward (only achieved in specialist nursing units such as

\footnote{There were also a small number of nurse auxiliaries, especially in nursing homes, with no formal training at all. In recent years nurse auxiliary numbers have increased because they are cheaper to employ. They perform basic nursing care of patients which is almost taking on the connotation of non nursing duties in that it is wasteful of the trained nurse's valuable but limited time. A problem is arising in that university students of nursing often work as part-time nursing auxiliaries, but there is often an expectation of them by the ward staff to work above their job description in a role similar to that of the old student nurse.}
Intensive Care Units), the leadership approach acknowledges the economic reality of mixed nursing wards. There is a conflict between the philosophy of total patient care and a vision of the future with a nursing elite of registered nurses supervising the masses who perform basic patient care on the wards (McEvoy, 1992: 40-41).

A further conflict arises from the limited role of the enrolled nurse which impedes the delivery of total patient care by the registered nurse. Because enrolled nurses are limited in the nursing actions that they can perform, they are unable to practise total patient care (Gleeson, 1985: 42-43). By the time the registered nurse has performed the additional, more complex procedures on the enrolled nurse’s patients, there is insufficient time for total patient care on his/her own patients. The result is the enrolled nurse doing all the basic nursing care on the ward while the registered nurse does the more complex nursing care.

However, there is concern that the present 12 month T.A.F.E. based enrolled nurse course might be upgraded to an 18 month or even 2 year course. This would promote an expanded role for the enrolled nurse who would then have the technical ability to perform some of the registered nurse’s activities such as medications and complex dressings ("Enrolled nurse review", 1991: 13-15). While only the registered nurse would have been educated to assess, plan and evaluate the nursing actions, such an expanded role for the enrolled nurse would encroach on the intervention domain of the registered nurse. Hospital administrations concerned with costs and the delivery of physical care might find it difficult to see the unique role of the professional registered nurse and prefer to employ more enrolled nurses at the expense of the registered nurses.

In the late 1980s the New South Wales Department of Health established the categories of nursing excellence of Clinical Nurse Specialist and Nurse Consultant (‘Clinical career structure proposals’, 1985: 8-9; “Briefing notes on nursing classifications”, 1986: 22-28). While initially many of the limited numbers of these positions went to registered nurses with certificate qualifications, increasingly it must be seen that possession of suitable postgraduate qualifications from a university is the desired path to achieving this recognition and remuneration. Increasingly in Australia more postgraduate courses are being offered at the Master of Nursing and PhD level. Encouraging more nurses to complete postgraduate degrees,
while consistent with the federal government’s policy of an emphasis on higher qualifications, has the additional advantages for nursing professionalism of emphasising postgraduate research to support the development of nursing science.

A clear distinction between the two tiers of educated/trained nurses is being fostered by the nursing leadership so that the public’s image of the professional nurse cannot be confused with that of the technical nurse. Such behaviour is also consistent with the desire to establish and protect the boundaries of the work of the registered nurse, though in this case it is to protect against the encroachment of the enrolled nurse.

7.7. Empowering Nursing

Much has been written in the nursing literature about why nurses are powerless, the need to empower nurses and strategies for empowering nurses (Alm, 1991: 503; Skeleton, 1994: 415-423). The nursing literature selects definitions of power which relate to the ability to get things done, or the ability to get one's own way with only occasional references to the ability to achieve increased status and increased pay (Kalisch and Kalisch, 1982b: 1-29; Moloney, 1986: 270-271). Weber's definition of power as "the chance for a man [person] or a number of men [persons] to realise their own will in a social action even against the resistance of others who are participating in the action" reflects nursing's desire to control its own actions over the opposition of the medical profession and the health care bureaucracy (Weber, 1968: 926). Alice Michaels, Dean of the Faculty of Health Science at the University of Central Queensland, in speaking of nursing as a profession coming of age, acknowledges that "so much of health care is about power", and that an important component of tertiary based education for nurses is about improving the interaction between nurses, doctors and patients (Milburn, 1993a: 19). Generally, nurses refer to power as a single all encompassing concept and choose not to consider different types of power such as expert, referent, positional and informational power (Hamilton and Kiefer, 1986: 86-89). Empowering is presented as the set of processes and strategies for giving nurses the level of power that they need and deserve.

Historically, nursing was a powerless occupation. Nurses have been described as "being ignorant of, afraid of, and isolated from power" (Chandler, 1991: 20). Nursing and
nurse education have been controlled and directed by forces outside of nursing. Nursing's development has been critically influenced by a lack of power over its own destiny, and the difficulties of nursing and its lack of professionalism are said to result from the dominant power position of the doctors (Keddy et al. 1986: 745-753). The nurse-doctor arguments in recent years over the changing role of nursing and the changes in nurse education may be understood as a power struggle over the control of nursing (Clifford, 1985: 103). It has been argued that early in the history of modern nursing, just as nurses were beginning to form nursing organisations, the medical profession was able to argue successfully that nursing was not and could not become a profession and was not fit to self-regulate and determine its own standards and actions (Ashley, 1973: 639).

Doctors deliberately deprofessionalised nursing in order to keep nurses powerless because "medical men view themselves as a ruling class" (Ashley, 1973: 640). Specifically, the medical profession was able to maintain its power over nursing by its control of nurse education, through "the power bequeathed to those who educate" (Keddy et al. 1986: 747). Nursing students were taught only that information required to maintain a supportive role to medicine and this inferior knowledge base kept them non-professional and powerless. Socialisation during the hospital based nurse training reinforced the subordinate role of nurses with rewards for nurses who fulfilled their role as loyal servants. The 'nurse-doctor game' maintained this relationship between the trained nurses and the doctors.

The public image of the nurse has been that of the doctor's handmaiden - an essentially powerless position (McKay, 1993: 35-37). As a predominantly female occupation controlled by a male profession, nursing's lack of power may be seen as a consequence of its femaleness and its association with stereotypically female traits such as caring, which are perceived as lacking power and authority (Dykema, 1985: 443-446; Wuest, 1994: 360).

In recent years, especially in the U.S.A., nursing's relation to power, or more correctly its lack of a significant increase in power, has been closely examined. In surveys in the U.S.A. asking about the power of nursing, nurses rate their own perceived power as high, while the general public perceives nursing as having little power (Kramer and Schmalenberg, 1991: 52-53). Similarly, nurses' own image of the nurse as a knowledgeable professional is
significantly greater than that held by hospitals. A 1980 study of nurses in America found that nurses rated low for the trait of 'responsibility' which requires the nurse to use his/her power and authority to make decisions (Silver, 1986: 47).

It has been claimed that nurses do not display power because the hospital bureaucracy and health care system subordinates them by telling them what to do through hospital protocols, through the control of information and the supervision of bedside nurses by middle level nurse managers (Stow, 1996: 1; Chandler, 1991: 20-23; Johnston, 1971: 31-39). These practices impede the empowerment of nurses. This implies the possibility that nurses could better utilise their potential power through accepting responsibility for their actions in the community setting where there is more opportunity for nursing independence. If the medically dominated hospital is the heart of the western system of health care, then the movement of nurses into the community health care setting could remove them from the restrictions imposed on them by the domination of doctors (Waddington, 1973: 211-224; Sadler, 1978: 188).

Alternatively, nursing's current lack of power has been blamed on the medical profession's and other health occupations' failure to recognise the extent and professionalism of nurse education (Jenkins, 1982: 200). Nursing could be empowered if only others would acknowledge that nurses are ready for it. This represents an interesting phenomenon, where nurses claim to be professionals, but the lack of corresponding empowerment is the fault of others, lies outside the effective control of nursing, and is not a failure of the professionalisation process which nurses portray as the mechanism for gaining power.

Acknowledging that nursing lacks power, the obvious question is: why should nursing seek and be granted more power? Discussions on nursing empowerment seldom touch on the self-interested benefits of increased power, such as increased status and increased remuneration. Rather, nurses speak in terms of the potential benefits to the health care system and patients as the result of increased power to nurses which manifests itself as increased authority and decision making ability (Raatikainen, 1994: 424-432). The existing health care system is portrayed as impersonal, dehumanised, uncaring and rigid. Nurses are powerless to change the current health care system precisely because they lack the power and authority to
implement alternate nursing strategies which are better for the patients because they involve holistic care.

It has been claimed that, since little of the registered nurse’s time is spent on actual patient care, empowering the nurse not only improves the quality of patient care but also makes economic sense (Brider, 1992: 29). Granting registered nurses more authority and allowing autonomous behaviour would enable the full potential of nursing to emerge and would increase the nurse’s time with patients and decrease hospital costs, improving hospital efficiency. It has been argued that in the U.S.A. recognition of and reimbursement for advanced nursing practice by independent nurse practitioners would lead to massive savings in federal health expenditure (Pearson, 1993: 23; Mittelstadt, 1993: 43).48

Commentators have suggested many different ways to empower nurses. One way, only occasionally acknowledged in the nursing literature as a viable option, is political activism or the use of political power (Gray, 1994: 522-523; Moloney, 1986: 273; Goldwater and Zusy, 1990). The large numbers of working nurses and ex-nurses could make them an influential political force if they were to present a united front on specific issues related to nursing. Unfortunately, the heterogeneity of nurses and their acceptance of the status quo makes this an uncommon occurrence (Cheek, 1995: 322-323). The last time this occurred to any extent in New South Wales was in the late 1970s and early 1980s, when widespread rallies and limited strikes over working conditions drew much media attention because of their very rarity, and, as has been discussed, seemingly embarrassed the state government into initiating changes.

Professionalisation is presented by nursing leaders as the preferred method of empowering nurses, and the key element in the public’s acknowledgment of professionalism in nursing is education, especially university based learning. The N.S.W. Nurses’ Association argues that “The nursing profession is accountable to society ...” as a consequence of tertiary based nurse education empowering registered nurses to make informed decisions about the delivery of nursing care (‘Policy on nurse education’, 1996: 28). Freidson refers to the

48 A contrary view to the benefits to health care through increased power to nurses via the professionalisation process is expressed by both Oakley and Illich who suggest that professionalism in health care may actually be damaging to health (Oakley, 1984: 32, Illich et al. 1977).
'institutionalisation of formal knowledge' as being essential to professional power (Freidson, 1986: 209-232). The professions, especially medicine, retain and utilise their power through the control and use of their unique, specialised knowledge base (Turner, 1987). Power is acquired through the recognition by others of the expertise and the monopoly of knowledge in the provision of services (Moloney, 1986: 269).

Hence, nursing acquisition of a body of nursing knowledge coupled with expanding nursing diagnostic skills could, conceivably, give nurses increased power over patients because nurses could have more informed input into directing patient activities. At the same time, medical power over nurses could be diminished because doctors would no longer have such a monopoly over diagnosis and determination of interventions.

The nursing literature makes much of the empowering nature of university based educative learning versus the previous use of technical learning (Lutz et al. 1991: 40-42; Gibson, 1991: 354-361). The acquisition of a unique nursing knowledge (as distinct from medical knowledge) and a university education emphasising the use of the nursing process (reinforced by rhetoric on its imburement with scientific method) applied to the nursing care of patients is seen as establishing nursing as a distinct, professional entity, independent of and interdependent with medicine, but no longer dependent to it. In order to obtain the authority for independent nursing practice (the legitimation of power) it is necessary to alter the public’s and the government’s image of nursing from that of the doctor’s handmaiden to that of a tertiary educated professional with a complex, specialised, unique knowledge of patient care (Wiesel, 1984: 7). This struggle for control of knowledge is seen as a common feature of “lower occupations” seeking to increase their professionalisation, and is based on the assumption, correct or not, that power, rank and status comes with knowledge (Legge, 1979: 42-45).

The nursing literature presents power over rights, standards and rewards as being gained essentially through knowledge. The more expert and the more professional that nursing appears, then the more power and authority that it will gain (Styles, 1987: 229; Ashley, 1973: 639). As part of changing this perception of the nurse to that of an expert professional, a bachelor of nursing degree as the minimum level of entry qualification into professional practice is seen as the key to power (Mason et al. 1991: 73). American studies of nurses in graduate
nursing programmes demonstrated how they utilise power strategies both over other nurses and doctors to get their own way (Damrosch et al. 1987: 284-290; Kipnis, 1980: 440-452; Kilkus, 1993: 1324-1330). The argument is made that tertiary based nurse education, particularly at the postgraduate level, has empowered these nurses. One of the primary functions of nurse academics is seen to be to empower students of nursing through knowledge, technique and example into making independent nursing judgements (Carlson-Catalano, 1992: 139-143).

Yet, for all the emphasis nursing puts on knowledge as the essential prerequisite for altering nursing behaviour towards professional nursing care, there is some concern that, in practice, in the delivery of patient care, most tertiary educated nurses, both in Australia and overseas, fail to do all that they could, based on their improved knowledge and skills (Reid, 1994: 5-11; Gorman and Clark, 1986: 129). The knowledge base is there for the delivery of independent patient care, but the willingness for autonomous behaviour is absent. The practice does not seem to match the expectations.

7.8. Nurse Teacher to Nurse Academic

In the period leading up to the government decision to transfer basic nurse education to the tertiary sector, the nursing literature and various nursing conferences and workshops argued strongly for the need to professionalise nursing. The nursing leadership needed to convince the bedside nurses that change leading to professionalism was to their advantage. Enthusiasm and a united front for change would be advantageous to the nurses in their discussions with the other parties interested in nurse education. For many years nurses were bombarded by arguments for the essential need to professionalise for the good of nursing.

Interestingly, the catchphrase was to "professionalise nursing", i.e., an occupation, rather than to "professionalise nurses". The occupation of nursing is made up of many subgroups of nurses, not all of whom would necessarily benefit from the professionalisation process. The most obvious non-advantaged group would be the enrolled nurses, who by being presented as 'technical nurses' were displayed as the converse of the 'professional nurses'. The campaign for professionalisation specifically excluded this group of nurses.
The majority of registered nurses work at the bedside, principally in the general wards of acute care public hospitals. The advantages to them of professionalisation were vague, unspecified and to be acquired at some indeterminate time in the future. Rather than promise specific, tangible and measurable benefits to be accrued by these registered nurses as a consequence of the professionalisation process, the appeal was presented in terms of benefits to the occupation of nursing in such things as increased status, authority, accountability, flexibility and decision making ability.

Specific promises were not made to any group of nurses. For the majority of nurses it is problematic whether professionalisation can be achieved and if it could, whether it might result in any significant tangible benefits to them. Rather, it is more likely that an aspiration towards the professionalisation of nursing would result in benefits for smaller specific groups of nurses. The American idea of the independent nurse practitioner which vaguely corresponds to the Australian categories of nurse consultant and independent nurse midwife has already been discussed. One group likely to benefit from the drive towards professionalisation is nurses working in the community, which include the preceding categories, and who have a certain degree of isolation from the medical profession and hence the scope for emerging independence. Similarly, nurses working in highly specialised areas within hospitals such as intensive care units where there has traditionally been an expanded nursing role might also benefit from the opportunities offered by professionalisation, though in reality the expanded role has more to do with the medical delegation of responsibility than freedom for independent nursing judgement. This is a common misconception in the nursing literature which equates an expanded role for nurses with professional autonomy. It seems likely that specific subgroups of nurses, recognising the potential benefits to them of professionalisation, would have been amongst the strongest advocates for the move towards nursing professionalisation.

In particular, nurse educators based in hospital schools of nursing in New South Wales would have recognised the likely benefits to themselves of the professionalisation of nursing involving the transfer of basic nurse education to the tertiary sector. Their support for such a move could easily have been as much, if not more, influenced by the potential benefits to themselves as by the potential benefits for nurse education and patient care. Nurse educators in
promoting these supposed improvements in the education of student nurses to be gained by the movement from the hospital to the tertiary education sector would themselves be major beneficiaries of such a move.

Nurse educators working in hospital schools of nursing were partially insulated from the normal hospital hierarchy. Unlike the ward nursing staff they did not have any direct responsibility to the medical staff and were outside the normal chain of command. Freidson perceived such a lateral work movement as an escape mechanism from medical domination (Freidson, 1970a: 66). If this was so, then tertiary based nurse education would involve a further geographic separation; a severance of hospital employment; and, if involved in clinical supervision of university students of nursing, the nurse academics would be in the position of 'invited guests' into the health care environs.

Many studies have shown that nurse educators had a slightly higher status than bedside registered nurses (Chaska, 1978: 102; Chute and Oeschsle, 1986: 163). Because they taught student nurses in hospital schools of nursing they were known as, and perceived by the public as, firstly nurse teachers, and, with a subsequent name change, as nurse educators. Moving to the tertiary education sector (initially in C.A.E.s but with amalgamation into the universities) involved a further name change to lecturers in nursing or nurse academics. Because of this association with tertiary education institutions public perceptions of their occupational ranking should move upwards. Such a movement into the tertiary education sector involved better working hours, working conditions, remuneration and opportunities for advancement to senior lecturer and above which did not exist in the hospital based nurse education system. The severance of the strong medical influence on the nursing curriculum would enable nurse academics greater freedom in the direction and teaching of nursing topics.

Most of the nurse educators who became the initial cohorts of nurse academics were themselves hospital trained with only limited qualifications gained outside the health care system (Speedy, 1987a: 39). For those nurse educators not already strongly committed towards the ideal of professionalisation of nursing, working in the tertiary education environment should help to resocialise and reinforce their commitment to professionalisation. It was argued
that the example of other tertiary academics would help to cultivate their own professional behaviour which would then act as a role model for students of nursing (Speedy, 1990: 15-17).

While hospital based nurse educators were not singled out in the nursing literature as a group which would benefit from the move towards nursing professionalisation through tertiary based nurse education, it would have been easy for them to recognise their likely rewards from such a move. This recognition could not but influence their support for the educational arguments for a transfer of nurse education to the tertiary sector.

7.9. Conclusion

Nursing leaders had a number of objectives in promoting a transfer of basic nurse education to the tertiary sector which had little to do with improving the ability of registered nurses to deliver a better quality of patient care in a changing health care environment. Rather the educational arguments for change, while possessing a degree of validity, had more to do with justifying to non nurses the nursing desire for changes to the preparation of neophyte nurses.

The non educational rationales for change were as equally important, if not more so, to nurses than the expounded educational justifications. These non educational arguments were not part of the official nursing representations for change because they would not be persuasive to non nurses. However, many hospital trained registered nurses were indifferent to calls for changes to the way nurses were prepared. While educational arguments were unlikely to be perceived as being relevant to them, arguments related to professionalisation issues might interest them. It was these professionalisation arguments that nurses, or, at least, the nursing leadership, discussed among themselves. They hoped that tertiary based nurse education would instil in nursing students a number of professional attitudes and behaviours. Possession of tertiary credentials would form the basis of claims for increased salaries and status. Acquisition of an enlarging and unique nursing knowledge base would enable nursing to protect and expand its occupational boundaries and help to establish an independent role for nurses. It would empower nurses in their quest to escape medical domination.
Again, it is largely irrelevant whether or not these covert arguments were superficial, inaccurate or inconsistent. Rather, what is important is that they form part of the explanation of the nursing desire for change and help to explain why nursing education has developed the way it has in recent years. The following chapter demonstrates that few of these objectives have been achieved.
Chapter 8

The Consequences of the Transfer

In this thesis I have examined the inconsistencies of, difficulties in achieving and the consequences of the events, actions, proposals and claims leading up to the transfer of basic nurse education to the tertiary sector in New South Wales. The purpose of this chapter is to examine whether the supposed benefits presented in both the overt and covert arguments for the transfer have been achieved. Additionally, there are some consequences which had not really been acknowledged as amongst the probable outcomes of this transfer. From all this, it should be possible to determine who are the winners and who are the losers from these events amongst both nurses and non nurses, and to what extent nursing and nurse education have changed in N.S.W. as a result of this move.

This chapter will show that most of the educational and professional claims of the nursing leadership have not been achieved. There are so many inconsistencies and difficulties of interpretation with their assertions and arguments that it becomes apparent that there were major problems with the nursing belief that tertiary based nurse education would miraculously lead to educational benefits which would automatically result in nursing professionalisation.

8.1. A Liberal, Multi-Disciplinary Nurse Education

Despite its claimed benefits, the intermingling of nursing students with both students and academics from other non nursing disciplines has never fully occurred. Rather than taking subjects such as sociology, psychology, bioscience, introductory ethics, research and computer literacy in common with other tertiary students, nursing students throughout N.S.W. quickly found themselves enrolled in subjects specifically designed for nurses with their own lecture content, tutorial content and forms of assessment (Illawarra Regional Council of Nurse Education, 1983: 50-57; University of Wollongong, 1991: 44-48; UTS Nursing Handbook, 1991: 10-12; Newcastle Nursing Handbook, 1992: 24-26; UWS Calendar, 1992: 360-361).
There are a number of reasons for this development. Often nursing students were taking only one semester of a subject such as sociology. The existing introductory sociology subject (e.g., SOC103 Sociology 1A at the University of Wollongong) is of limited use to nursing students because it consists of an introduction to sociological theory and assumes that students will go on to do other more specialised sociology subjects (Wollongong Calendar, 1993: 210). Nursing students do not have the freedom to do this, and would not be exposed to the sociology applicable to their learning and eventual work situation (e.g., SOC338 Health Sociology) (Wollongong Calendar, 1993: 213). Instead, a compromise was reached where nursing students undertake a custom-made subject (e.g., SOC111 Sociological Dimensions of Nursing) which "introduces students to the major concepts and theories in the discipline of sociology and emphasises the relevance and usefulness of sociology as applied to nursing" (Wollongong Calendar, 1993: 210). However, concern has been expressed that such attempts to make short social science subjects relevant to nursing and interesting to nursing students occur at the expense of academic rigour (Clough, 1981: 196-199; McMillan and Dwyer, 1989: 95-96).

Reduced time on campus due to clinical practicum blocks strongly influences individualised subject development (The NSW Institute of Technology, 1984: 30; University of Wollongong, 1986: 26-27; University of Wollongong, 1991: 16; Catholic College of Education, Sydney, 1984: 33). This makes it difficult to fit in with the timetabling of other students. In addition, the nursing undergraduate syllabus includes compulsory subjects. In the example of sociology it is assumed that students enrolling in introductory sociology are interested in it, whereas nursing students enrol in it because it is compulsory, irrespective of whether they are interested or not, or see the relevance of the subject.

The likelihood of a lack of interest by nursing students is particularly true of the social sciences. Since most nursing students come into nursing straight from school with little experience of life and health care settings, they lack the practical experiences to relate to the theory and find it difficult to perceive the relevance of these subjects to nursing (Short and

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49 This is where the idea of a "pre-nursing" year covering only the non nursing support subjects would be beneficial as the students would have no clinical commitments and would be on the campus for the full 14 weeks and perhaps could slot into existing subjects.
Sharman, 1989a: 365). While there is no published evidence to prove this contention, it is arguable that the low tertiary entrance scores of the initial cohorts of nursing entrants with their high tertiary failure rate, suggests the possibility that nursing students might not have been able to compete academically with non nursing students when taking subjects in common and hence it was deemed desirable to separate the two groups (Connolly, 1990: 5; Aubert, 1993b: 5; Marquis et al. 1993: 138).

Nursing students have had limited exposure to non nursing academics. For many possible support strand subjects it has been argued that nursing students had special needs which necessitated that these subjects be taught as nursing subjects (Johnstone, 1994: 109). Some departments have specifically advertised for and employed lecturers and tutors with a nursing background to teach these support strands to nursing students (Short and Sharman, 1989a: 363-364). Because nurse academics are only now beginning to complete their higher degrees, which are often in non nursing disciplines, it is argued that appropriate nurse academics are qualified to teach outside the traditional nursing subjects in such areas as sociology and psychology (Bagnall, 1994: 44).

The original course documentation envisioned nursing students taking one or two liberal studies electives in their undergraduate diploma (Catholic College of Education, 1984: 36). With revisions to the nursing curricula and the upgrade to a full bachelor’s degree, liberal studies electives were eliminated in favour of more compulsory nursing subjects. Four years worth of nursing subjects in a three year degree does not permit the freedom of non nursing electives. Virtually all nursing syllabi in Australia now consist entirely of compulsory subjects without even elective choices from within nursing. Again, nursing students have been denied the full potential of tertiary education.

Part of the educational rationale for the transfer was that an increased emphasis on the support strands for nursing such as sociology, psychology and ethics would produce better graduate nurses who were more aware of the psychosocial components of patient care. These subjects could be better taught quantitatively and qualitatively in the tertiary educational setting with both increased hours and qualified academics. Unfortunately these subjects have usually been reduced to single semester subjects and can give only the most basic overviews of the
complexities of these disciplines, especially as relevant to the health care system. There is no provision for nursing students to do justice to these subjects by exploring them further at a higher and more specialised level of study within the undergraduate degree. The potential to explore and discuss these aspects of the psychosocial component of patient care has never been fully realised with the move to the tertiary education sector.

Similarly, three or four semesters of bioscience only permits the most basic overviews of human anatomy and physiology. There is insufficient time for even one in-depth examination of a particular aspect of human biological science. Nursing students cannot do specialised subjects for a semester on, say, cardiorespiratory physiology, but instead must be content with no more than several weeks of related anatomy and physiology as part of a brief examination of the whole human body.

8.2. Integration of Theory and Practice

It was claimed that tertiary based nurse education would permit a closer integration of theory and clinical practice. The results from the tertiary experience in N.S.W. have been mixed. Tertiary nursing syllabi envisioned day release once a week during most of the semester (Catholic College of Education, 1984: 28-30; Mitchell College of Advanced Education, 1984: 140). Nursing students having been taught about and having practised in the controlled clinical laboratory setting a particular group of conditions, for example, disturbances of fluids and electrolytes, would then be expected to go to the wards under the supervision of their nurse academics and spend at least part of their clinical time observing and caring for patients experiencing these problems.

But it is impossible to consistently find sufficient patients over enough days of the week in all the different hospitals visited to enable all the nursing students to encounter patients with such conditions at the recommended times. Instead, these nursing students would often find themselves caring for patients for whom they had little knowledge base about their

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50 For nurses working in medical or surgical nursing, many patients they encounter will be suffering from some form of pathophysiology involving the lungs, heart and blood vessels. A detailed understanding of these body systems would be highly desirable in order to make informed decisions about nursing interventions.
pathophysiological conditions or their specific nursing treatments. There was simply no way that this integration of theory and practice could be met consistently.

At least partly because of this difficulty of close integration, day release for clinical practicum has been dropped from most tertiary nursing syllabi in Australia in favour of clinical blocks of several weeks duration (Reid, 1994: 5). In the case of medical and surgical nursing (or the current title of "acute care" nursing), which runs over at least two semesters of study, nursing students in the first semester's practicum are going to encounter patients who are suffering from complaints which the students will not be taught about until the second semester. Because available health care settings for clinical are limited, while nursing student numbers are large, it is undesirable to pass up clinical teaching opportunities with patients just because the students have not acquired all the necessary theory at that time. The claim for a closer integration of theory and clinical has not been met and this failure has been noted in the recent Reid Report (Reid, 1994: 5).

8.3. A "Comprehensive" Educated Graduate Nurse

Most nurses in the old hospital training system did their first certificate as a general training certificate. This meant that they were medical and surgical nursing qualified with some limited but quite variable exposure to operating rooms, accident and emergency, community, intensive care, paediatrics, maternity and mental health nursing. Additional certificates and registers existed for those wishing to work in these more specialised nursing areas. Tertiary based nurse education was meant to present a more comprehensive syllabus and that it has certainly done. Medical and surgical nursing has been considerably downgraded in the tertiary nursing syllabi across the state with much more time and uniformity of experience given to both theory and clinical experience in other nursing areas (‘Policy on nurse education’, 1996: 28). Students are given a reasonable length of exposure to many different forms of nursing. By giving students this wide range of nursing experience in different health care settings and

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51 Acute care has come to take on several different meanings. Traditionally, acute care meant tertiary health care to be found in high technology, high dependency wards such as the intensive care unit and coronary care unit. The new nursing terminology, wishing to disassociate itself from the medical connotation inherent in the term medical/surgical nursing, adopted the term acute care (or adult health care) to refer to this type of general nursing, resulting in some confusion.
different general hospitals, tertiary based nurse education is an improvement on the old general hospital training where student nurses were usually exposed to only one set of protocols in their training hospital and learnt one "correct" way of doing things.

The problem with these different clinical nursing areas is that nursing students spend little clinical time in any one area of nursing and never become truly clinically proficient in any one nursing area during their undergraduate education (Reid, 1994: 4-6). So many different subjects are needed to be taught so that the students can experience so many different clinical areas that even the time for nursing theory and the fundamental knowledge base becomes compromised. There is time for only very basic knowledge to be given in any one nursing area.

In Australia the basic nursing qualification is a 3 year bachelor degree, though nurses have argued for a 4 year degree consistent with both overseas bachelor of nursing degrees and with most other applied or occupational degrees. Having failed to achieve that, it has been claimed that Australian nurse academics have crammed 4 years of subjects into 3 years of study, to the detriment of their courses and their students (Marquis et al. 1993: 137; McDonald, 1994: 6). Consequently, university based nursing students have a very heavy academic work load. It is quite possible for full time nursing students to be undertaking 5 or 6 subjects in a semester (Charles Sturt University - Mitchell, 1989: 37; Wollongong Calendar, 1993: 688-690). Combined with the likelihood that many nursing students need to work part time to support their studies, this can create considerable stress on the students and could compromise their tertiary education.

8.4. Clinical Practice

While hospital based nurse education emphasised a biomedical model of illness, tertiary based nurse education is meant to promote a biopsychosocial concept of total patient care involving holistic nursing care leading to wellness. Problems occur however with regards to students' clinical experiences and the lack of correlation between theory and practice. Very few nursing environments, especially hospital wards, embrace total patient care in any form (Clay, 1987: 71; McEvoy, 1992: 40-41). If anything, team nursing, and especially task
allocation, are coming back into vogue with such divisions of labour as the "medication sister" for the day and the "dressings sister" while the enrolled nurses provide the basic nursing care. Not only are nursing students placed in clinical situations where the trained nursing staff neither practise nor believe in the concept of total patient care but the students themselves seldom get to practise total patient care. Their observations and own clinical experiences are contrary to what is being taught in the universities.

Nurse academics are being increasingly separated from the clinical setting. As a consequence of this distancing of nurse academics from actual patient care, it has been suggested that "nurses who are theorists and educationalists, and nurses who are engaged in nursing practice tend to use different vocabularies, to have different perceptions of patients and of nursing, and to value different kinds of nursing knowledge" (Miller, 1985: 417). Clinical supervision is being taken over by hospital based supervisors who are released by their employers, the hospitals, to work for the universities during the appropriate clinical placements (Reid, 1994: 19-20; ‘Policy on nurse education’, 1996: 28). Not only have these hospital supervisors been enculturated against the idea of total patient care, it is likely that they do not understand it and do not have the same theory background as the nursing students they are meant to supervise. They are also unlikely to generate opportunities on the wards for their nursing students to practise total patient care. There is a large gap developing between the theory taught regarding total patient care and the clinical opportunities for undergraduate students to practise it - a "theory-practice gap" (Wuest, 1994: 362). Despite the fact that some American studies suggest that it does work when implemented with enthusiasm and understanding, it is not surprising that the students come to see total patient care as an impractical theory with no place in their eventual real working world (Bowman and Carter, 1990: 39-41).

The assumption has been made that as new graduates entering the workforce, university educated registered nurses would be agents of change able to demonstrate the worth of total patient care and encouraging the conversion of existing nursing practice over to this format (Spicker and Gadow, 1980: 20). However, they themselves may not been convinced during their education of the potential benefits of total patient care. When they enter the
workforce they encounter a rigid system of workplace practices which, if for no other reason but that of economics, are resistant to change. The reduced value of the health dollar has meant a relative reduction in ward nursing numbers which, combined with the different work obligations of mixed registered nurse and enrolled nurse wards, means that hospital nurses only have time to deliver physiological patient care with no time and perhaps no incentive to meet the patients' psychosocial needs.

Because of their limited clinical time and the fact that they were supernumerary during their practicum with no ultimate responsibility for patient care, the Reid Report noted that the new nursing graduates often have poor time management skills (Reid, 1994: 4). They find it difficult to meet the minimum biological needs of their allocated patients, let alone find time to sit down with their patients to assess their psychosocial deficits. Finally, the new graduate is usually employed on an initial 12 month contract, subject to renewal, usually in an acute care hospital (Reid, 1994: 21; McDonald, 1994: 6). In this context, those graduates who fit into the current hospital system and do not challenge the existing nursing practices are the ones most likely to succeed and be reemployed. For the above reasons, the concepts of total patient care and holistic nursing practice have remained largely theoretical ideals in N.S.W. and are not practised in the hospital setting.52 Since holism is central to the concept of independent professional nursing practice, the failure of tertiary based nurse education to alter existing nursing practice to incorporate holism prevents the professionalisation of hospital based registered nurses.

8.5. Technology and the Graduate Nurse

University based nurse education is meant to give nursing graduates the educational ability to learn how to understand and to utilise new and constantly emerging health care technology. Rather than having been taught knowledge which may rapidly become outdated, university educated registered nurses are meant to have been taught how to learn for themselves, to know how to gather and use information and to be willing to do so. Tertiary

52 There exists a potentially much more optimistic outlook for their incorporation into nursing practice in situations away from the bureaucratic, hierarchical hospital setting. It is much easier to imagine the use of total patient care in community nursing and in specialist nursing areas such as independent midwifery, where there is far more scope for nursing innovation and experimentation.
based education is meant to produce graduates who are lifelong learners and who are committed to continuing adaptive learning.

Doubts have been raised however as to whether undergraduate education across most disciplines, and not just nursing, actually fosters this lifelong learning process or, instead, has the effect of hindering its adoption (Milburn, 1993b: 7; Juddery, 1995: 15). Most undergraduate students come directly from a didactic high school system where their senior years are directed towards knowledge recall for the Higher School Certificate (Brigham, 1993: 53). They are spoonfed specific information for a series of knowledge recall examinations and as a consequence enter university with few or no "learning" skills.

One criticism levelled at many current undergraduate courses is that "a lot of undergraduate degrees are obsessed with technical content and have the potential to lose sight of the generic outcomes of higher education" (Milburn, 1993b: 7). This is particularly true of the current nursing degree. All the subjects in the current comprehensive undergraduate nursing syllabus are compulsory. There are also far too many subjects crammed into the three year degree. Taken together, this means that virtually all the teaching time is dedicated to learning specific facts about the many different areas of nursing. There is no time to allow nursing students to experiment with the promoted ideals of tertiary based learning. Their commitment to the ability and desire to learn for themselves in a changing work environment is unlikely to have been instilled during their tertiary education.

The university educational system is meant to give its nursing graduates a thorough grounding in the natural and social sciences (Morales-Mann and Logan, 1990: 142-147). However, the limited exposure that nursing students have to the various sciences does not give them an adequate understanding of their true usefulness in determining what is wrong with the patient and the appropriate means of determining the best individualised patient care interventions.

Similarly, tertiary based nurse education was meant to foster low technology assessment skills in nursing students (Ryan and McKenna, 1994: 116). For example, in high technology areas the ability to perform cardiorespiratory assessment to detect physical changes in the patient before altering nursing treatment or alternatively informing the doctor of the
changed patient status would demonstrate the increasing competency of graduate nurses. In the community setting and in the absence of the technological diagnostic infrastructure these assessment skills would give the nurse independence.

It seems likely however that these assessment skills have not been taught to nursing students in a thorough and consistent manner. Many nursing academics lack competency in these skills because of the lack of constant reinforcement in a work environment with real patients. These skills cannot be fully taught in the artificial laboratory setting because of the need to practise what are often very subtle and difficult to find changes in physiologically compromised patients. Nursing students are unlikely to be encouraged to practise these skills on clinical because both the ward staff and hospital based supervisors lack the ability to perform these procedures. The result is that the nursing students are not being given the necessary grounding in what are deemed the basic and essential assessment skills to work in a variety of health care settings.

8.6. Graduate Clinical Competency

Tertiary based nurse education is meant to produce innovative graduates with improved patient assessment capabilities and the ability to think critically, who are willing and capable of making and implementing independent decisions about patient care and nursing practice, and who will be agents of change (Birx, 1993: 22-26; Brigham, 1993: 50-52). There have been no studies completed in Australia on the effects of teaching critical thinking in nurse education. However, there have been some American studies of this issue and it is likely that the American experience would be replicated here. These American studies have produced mixed results on the effects of the role and care delivered by graduate nurses after they have been exposed to critical thinking during their education (Hickman, 1993: 36-47). Some reports show no adoption of critical thinking as applied to clinical decision making while other studies suggest that there is some limited adoption of innovative behaviour. It is suggested that in America, the consequences of a "questioning" nurse education upon graduate registered nurses has been of little positive note because "these baccalaureate nurses fled the hospital scene ... they did not have the independence that they’d hoped for" (Kelly, 1991: 53).
Comparison of American university baccalaureate nursing students with college diploma nursing students, as measured by their success on state registration examinations, shows that baccalaureate students do no better than the diploma students (Raymond, 1988: 6-9; Whitley and Chadwick, 1986: 94-101). However, American nurses have to sit state registration examinations, which are still biomedical and knowledge recall based, and this must influence the direction and content of the university nursing curricula and especially reduce the emphasis and time available for critical thinking skills development. In Australia completion of an undergraduate university nursing course is sufficient for state registration and this should allow more freedom in nursing curricula innovation.

In Australia there have been few published reports about the clinical performance of university nursing graduates even though they are now entering the workforce in large numbers (Parkes, 1984b: 177-182; McArthur et al. 1981). Using research tools such as the Scale of Nursing Performance, these studies suggest that there is no obvious superiority of tertiary educated nurses in the clinical areas (at least on the general hospital wards) compared to hospital trained registered nurses (Battersby and Hemmings, 1991: 30-34; McDonald, 1994: 5). Initially, they are claimed to be slightly better at interpersonal skills and slightly worse at clinical skills than comparable hospital trained nurses. The Reid Report highlights employers' concerns over graduate clinical skills (Reid, 1994: 4). No clearcut evidence has emerged to support the contention that university based nurse education will produce graduates who can utilise critical thinking skills to improve nursing care.

There are a number of complex physical skills which are increasingly difficult to find on clinical release for university nursing students to practice. An example is catheterisation of the patient - a very complex aseptic technique which utilises many nursing skills. It is unlikely that university nursing students will ever be asked to attempt this procedure during their clinical experiences and it is now seldom taught even in the laboratory setting. Yet, many graduates will eventually find themselves doing this procedure in the workplace. In the old hospital training system catheterisation by student nurses was a common occurrence, to the extent that third year student nurses could find themselves teaching junior resident medical officers how to perform their first few catheterisations. There is no guarantee that all nursing
students will get the opportunity to practise a number of these necessary and elementary nursing procedures and they run the risk of entering the workforce with some major clinical deficits.

There is little evidence to support the assumption that the removal of student nurses from the wards would enable their replacement by all trained nursing staff, who presumably would deliver a better "quality" of nursing care. A recent Australian study suggests that an all registered nurse ward is more expensive to run when adjusted for patient dependency in comparison to a mixed registered and enrolled nurse ward (Pratt et al. 1993: 27-39). The norm on Australian hospital wards would seem to be an increased number of enrolled nurses delivering basic nursing care. Whether the limited basic care given by enrolled nurses combined with an increased emphasis on task allocation, with the registered nurses taking responsibility for more complex nursing procedures, is an improvement over the old system of a mixture of trained and training nurses is unclear.

Very few of the educational rationales advanced for the movement of basic nurse education out of the hospitals and into the tertiary sector have been realised. It is not proven that university educated registered nurses are "better" nurses than hospital trained registered nurses. Rather, they are different nurses with different experiences and a different knowledge base. It is very difficult to compare the two groups. It could be that there are no overall differences between the two groups, that the benefits and disadvantages of each educational system cancel out, or it could be that nurse education is still in transition in Australia and any real advantages to tertiary based nurse education are still to emerge.

8.7. Employment Opportunities for Graduates

Nursing leaders argued that the chronic shortage of registered nurses in Australia could be overcome by tertiary based nurse education because tertiary graduates would be more committed to nursing as a career and postgraduate qualifications would open up career paths and promote job satisfaction. It was also argued that a tertiary education would be more likely to attract males. However, the move of basic nurse education into tertiary institutions has seen only a slight increase in the number of males entering nursing (Neill, 1987: 52-61; Neill and Barclay, 1989: 4-11; "BSN schools...", 1992: 84 and 88; Reid, 1994: 2).
New graduates are finding it difficult to get jobs because there is currently an oversupply of registered nurses (Arnold, 1993: 18-20; Featherstone, 1993: 93; Williams, 1992b: 2s). This is partly due to the recession because registered nurses are presumably less likely to quit the health care system when the availability of other jobs is reduced, while it is likely that female registered nurses with children would be prompted to return to the nursing workforce due to family financial difficulties (Aubert, 1993a: 11). Yet, as late as 1990, the N.S.W. government initiated a media campaign "in an effort to overcome staff shortages" by attracting registered nurses back into the public hospital system through refresher courses ("NSW calls out for nurses", 1990: 2).

The N.S.W. Nurses' Association noted that new graduates are no longer assured a job once past their initial 3 or 12 month contract with a state public hospital (Staunton, 1993: 14; Staunton, 1994b: 23). Because graduates holding a bachelor's degree experience a significant salary rise once they have been working for 1 year, it is possible that hospitals prefer to employ more experienced certificate registered nurses who would be cheaper to employ. It is also possible that there are fewer registered nurse positions available, as many hospitals might be tempted to employ cheaper enrolled nurses in preference to more expensive bachelor degree qualified registered nurses. Jan Stow, Director Of Nursing Services at Westmead Hospital, Sydney, acknowledges this cost saving measure, stating that "Registered nurses are being replaced by untrained staff ... " (Stow, 1996: 2). Studies into the projected future demands for health care workers in Australia suggest that there is a developing oversupply of registered nurses except in certain specialist areas such as Intensive Care Units and in certain remote geographical locations, which suggests the need to consider reductions in undergraduate intakes into nursing (National Nurse Labour Market Study, 1991: 21-23; Reid, 1994: 14). It may be that the present oversupply of registered nurses is only a temporary phenomenon and that it "will not last much longer ... history shows an under supply as the norm" (Aubert, 1993a: 11).

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53 It is the public hospitals which are the main health care facilities willing to employ the new nursing graduates while they develop their clinical skills over their initial 12 months of employment and there is an oversupply of registered nurses on the general hospital wards (McDonald, 1994: 6).

54 Such surveys assume that there will be minimal changes in the near future to the existing nursing role and, for example, give little consideration towards nursing's goal of a vastly expanded community health nursing service which would require many more nursing positions, especially in the independent nurse practitioner role.
8.8. Entrants into Nursing

It has been argued that the initially low entry scores of entrants into nursing has made it difficult to structure academically challenging courses (Marquis et al. 1993: 138). Only in recent years have university entry scores for nursing begun to rise. Even today the university entry requirements for nursing remain the lowest of all bachelor courses ("Foundation studies program", 1993: 6). Perhaps Australian nurses should not have been so surprised but instead should have studied the American tertiary nursing experience which noted that "among the large number of educationally disadvantaged students being recruited (into nursing) are some who are the least prepared we have ever had" (William, 1976: 76).

Given such ill-prepared recruits it is difficult to achieve the stated aims of tertiary nurse education in fostering such ideas as critical thinking. The early cohorts of nursing entrants had a high attrition rate, especially in the bioscience subjects, leading to considerable wastage of educational resources (Thorp, 1990: 15; Ross, 1991: 18; Lumby, 1991: 18). In the early years the quality of tertiary nursing entrants was not nearly as high as was anticipated and needed, and Australian tertiary nursing courses suffered as a consequence. America, with a user pays tertiary education sector, has had an under supply of university nursing entrants and graduate nurses in the workforce. Australia, with a government funded tertiary education sector, has had too many (possibly low quality) nursing entrants and an oversupply of new nursing graduates.

8.9. Costs of Nurse Education.

Another factor in the move to tertiary education was the increasing cost of hospital based basic nurse training. Nurse education in colleges of advanced education was presented as a cost effective alternative to this hospital training. Since 1993 all nursing students, like other university students, have had to make Higher Education Contribution Scheme (H.E.C.S.) payments towards defraying at least part of the cost of their education. Increased productivity bargaining with (nurse) academics, leading to greater student to staff ratios, should also help to decrease the costs of basic nurse education.
Opposed to these factors are the high attrition rates among undergraduate nursing students which increase the overall costs of each new nursing graduate. There is also concern about the high costs of clinical supervision of nursing students, with calls by some nursing academics for increased funding for nursing students (Aubert, 1993a: 11; Submission from the Australian Council of Deans of Nursing, 1993: i). While the costs of nurse education have been moved from the health to the education sector and from the state to the federal government it is difficult to quantify how much, if any, cost savings have been made from this transfer. Rather, I will argue later that the real cost savings have been made on the hospital wards through the use of cheaper enrolled nurses.

8.10. Problems with Nursing Professionalisation

The major nursing reason for the transfer of nurse education to the tertiary sector was the goal of the professionalisation of nursing. Undergraduate nursing students are meant to be socialised towards a number of tertiary and professional attitudes. However, contrary to the above expectation and consistent with the notion of a "theory-practice gap", it seems more likely that the clinical setting is seen by the nursing students as the principal learning place for "real" nursing, involving hands-on care of live patients (Bowman and Carter, 1990: 39-41; Coudret et al. 1994: 342-349). The university setting is seen by them as artificial and not related to the practicalities of actually working in nursing. They are unlikely to have been socialised during their tertiary education towards professional attitudes.

Nurse academics present as poor role models because most trained in the old hospital system and taught in hospital schools of nursing and have difficulty in adopting tertiary professional behaviour. Apart from any other factor, there is still a tendency to spoonfeed undergraduate nursing students as much knowledge or "facts" as possible with little of the individual, self-directed learning that is meant to characterise tertiary education (McDonald, 1994: 5-10). It is also possible that, in order to prevent an increasing undergraduate attrition rate, both the teaching and assessment of nursing students is geared towards the least capable students. Such possibilities are evident in the concerns expressed over the developing mediocrity of tertiary education. It is claimed that rather than the traditional university concern with quality and an enriching, intellectual education the mass movement of students into
university based education has produced quantity and a concern with narrow, technical

Overseas studies suggest that tertiary nursing graduates largely fail to internalise the
desired professional attitudes of an inquiring mind, initiative, independence, questioning
behaviour and a desire for lifelong, continuing education (Hupcey, 1990: 196-201; McCain,
1985: 180-186). "Reality shock" is recognised as a formidable problem for tertiary nursing
graduates when they first enter the workplace (Ahmadi et al. 1987: 107-121; Talotta, 1990:

There is such a chasm between the ideals taught in the university setting and the
working realities of the hospital wards that the Reid Report comments that the new nursing
graduate has difficulty in adapting to the existing nursing practices (Reid, 1994: 5). A
university education with supernumerary clinical experience cannot prepare nursing students for
the patient workload, time management issues, manipulative practical skills involving both
speed and accuracy, and the simple physical needs of the patient. New graduates perhaps feel
inadequate and, if they are going to adjust and survive, they most probably end up adopting the
existing, old fashioned nursing protocols. The concerns of the hospital trained nursing staff
about tertiary nurse education are reinforced by the perceived inadequacies of these new tertiary
nursing graduates (Butts and Witmer, 1992: 46-48).

The development and teaching of a unique and relevant body of nursing knowledge
is still in its infancy. Nursing terms do not as yet exist for many commonly encountered
nursing situations and it is necessary to resort to the idea of "collaborative problems", which are
really medical problems or diagnoses. It is difficult to convince others of the uniqueness of
nursing knowledge when it is often necessary to persist with what are obviously many of the
medically directed elements of nursing care that were taught in hospital based nurse training.

Many of the existing nursing diagnoses reflect their American origins with a more
appropriate application in the community settings (with independent nurse practitioners) and in
high dependency units (with nurse specialists), and are not so useful on the general hospital
wards where nursing students spend much of their clinical time and where new nursing
graduates usually spend their initial employment (Carpenito, 1993: xxv-xxxix). The registered
nurses on the wards fail to see the relevance of nursing diagnoses and convey this idea to both students and new graduates ("Comfort state", 1989: 36).

The nursing process provides a useful mechanism for assessing patient needs, setting goals, determining nursing interventions and evaluating the success of these actions. However, there are too many nursing theories which are meant to provide the framework for utilisation of the nursing process in providing holistic care. Student nurses can become confused about the usefulness of different theories in different nursing settings (Knight, 1990: 447; Wuest, 1994: 362). They probably never spend long enough in any one clinical setting to become competent and confident about a particular theory and they are unlikely to receive support from the ward staff in using nursing theory.

If the majority of nurses cannot see the relevance of nursing knowledge and nursing theory, and cannot see the advantages of a university education, then it is difficult to convince others, notably the general public and doctors, that nursing as an entity incorporates the important professional traits of a unique knowledge base, a long period of university education and development of a professional culture. The medical profession can continue to claim that (most) nurses, lacking a unique knowledge base in nursing, cannot be granted increased autonomy and need to be kept under medical control (Submission to Inquiry on Professional Issues in Nursing, 1987: 7; Wertheimer, 1990: 11).

Nursing ethics are a significant component of undergraduate and conversion nursing courses. Most nursing students would be able to recognise the ethical dilemmas that arise in health care and should be able to see that the patient has many rights that can easily be ignored or subsumed in modern health care. While they might be able to recognise that wrongs exist and that there is a role for the nurse as a patient advocate, the problem is that nurses lack the authority, autonomy and support to exercise a direct patient advocacy role (Meissner, 1981: 24-25).

It would be a very brave nurse on a hospital ward who would directly challenge the existing protocol or a doctor's orders because the nurse felt that the patient was being done an injustice. In particular, there are legal restrictions on nursing interventions for many ethical concerns, especially those which might be seen by the courts as impinging on the sacrosanctity
of the doctor-patient relationship (Johnstone, 1994: 251-267). If any action was to be taken by the nurse, it would be done indirectly, by a quiet word to the patient about alternate options to his/her care. The British sociologist Ann Oakley, when she was a cancer patient, gives a graphic example of this indirect patient advocacy by a nurse who fails to bring her concerns to the attention of the attending doctor but instead elects to use an informal route to supply knowledge about her treatment options (Oakley, 1987: 13-14). While such indirect action maintains good working relationships between nurses and doctors, it fails to acknowledge the claimed expanded ethical role of nursing. Once again nursing theory argues and teaches one way while the practice by most nurses involves a different reality.

Some observers have suggested that the desire for nursing’s involvement with universities has had as much to do with promoting nursing research as it has had with teaching nursing, because increased nursing research reflects the ideology of professionalism common among the nursing elite (Dingwall, 1974: 52-54; Wuest, 1994: 361). In comparison with the American impact on Australian nursing, the increase in nursing research in this country has not produced much to directly influence nursing practice or nurse education. Increasing nursing research is needed to elevate the nursing profile within Australian universities in order to make nursing a more acceptable discipline to other university departments. American studies suggest that nurse academics expend considerable time and energy proving the value of nursing as a tertiary discipline to other academics (Speedy, 1990: 2).

For most tertiary nursing graduates the trait approach to professionalisation has failed to meet its promises. The vast majority of nurses have not been professionalised in any measurable way. This is both a partial failure and an opportunity for the advocates of professionalisation. While there has been no clearcut professionalisation of nursing, and because such evaluations are subjective, it may still be argued that nursing has advanced along the professional scale towards complete professionalisation. What is needed is both more time and more activities, such as an emphasis on postgraduate degrees in nursing, as is advocated in the Reid Report, to bring about further professionalisation of nursing (Reid, 1994: 10).

55 Similarly, in Australia there is the situation where Mr Baldwin, the Federal Minister for Education, claimed that nurse academics do not require higher degrees (which obviously involve a large research component) to teach nursing adequately (Susskind, 1991: 11; Reid, 1994: 25).
8.11. Nursing Boundaries

Only rarely has the nursing literature acknowledged the need to protect and expand nursing's boundaries, and declared that tertiary based nurse education is the appropriate forum (Staunton, 1987b: 2). Rather, this is implicit in the discussions of the emerging and expanding role of the registered nurse. Physical separation from the hospital and advocacy of nursing theories, the nursing process, nursing diagnoses and nursing research have all been directed to redefining nursing as distinct from other health disciplines.

The registered nurse is having difficulty, principally due to financial cutbacks which make them too expensive to employ, in maintaining the existing boundaries of the registered nurse in the ward environment (Tattam, 1995: 35). Rather than protecting the existing role, the emphasis in nurse education is on expanding the role of the registered nurse. In specialist units in acute care hospitals registered nurses are being educationally prepared to take on more roles without the supervision of doctors. Nurse education presents this as a collaborative role with the registered nurse as an equal member of the health care team. In reality the registered nurse is taking on more (discarded) medical tasks and the doctor still leads the team (Begany, 1994: 32-33).

It is in the community that the registered nurse is being prepared for a more independent role. In America doctors are increasingly unwilling to work as general practitioners so that there is an emerging demand for independent nurse practitioners who, amongst other activities, could "handle 60% to 80% of the tasks that primary care physicians perform" ("Nurse practitioners", 1993: 69). While they might be adopting a mini-doctor role, they are depicted as working in an independent role.

In Australia the underlying causes are not the same, but result in similar opportunities for non directed nursing activities in a variety of community health care settings as nurse consultants, independent midwives and community health educators. While the boundaries and roles of the general hospital ward registered nurses (which means most registered nurses) are still ill defined and probably shrinking, an elite of nurse specialists has the potential for an expanded role if they can establish that they have the required knowledge
and expertise. It is being suggested by nurse academics that such recognition comes through postgraduate credentialling, especially at a Master's level or higher (McBeth et al. 1993: 45-47).

8.12. Financial and Status Benefits

It seems likely that recognition of nursing expertise and career path advancement with pay increases to clinical nurse specialist, nurse unit manager or nurse consultant will be strongly influenced by the possession of postgraduate nursing credentials. What might happen in Australia, especially in community nursing, is that registered nurses in order to work independently will require postgraduate qualifications. On the strength of this independence and possession of higher degrees, they can argue for classification at the nurse consultant level. Similarly, attainment of a Master of Nursing (Midwifery) degree would be the important first step in becoming an independent midwife, whose patients would be able to claim Medibank reimbursement. In America, where enterprise bargaining is more the norm, some highly credentialled and experienced registered nurse specialists (equivalent to the Australian nurse consultant) have negotiated salary packages with hospitals in excess of US$100,000 per year ("Pay levels ...", 1993: 71).

It is doubtful that tertiary qualifications have led to any noticeable increase in the status of these registered nurses working at the bedside (Adamson and Kenny, 1993: 12). They do not appear to be significantly different to the hospital trained registered nurses and this is unlikely to have elevated their status in the eyes of other nurses, health care workers or the general public. What might emerge over time is that smaller numbers of independently acting registered nurses, recognised as nurse consultants and with Master or Doctorate degrees in nursing, might find themselves with increased status. The large number of registered nurses working at the bedside, principally in acute care public hospitals, under medical and bureaucratic control, and with only a basic bachelor degree will have difficulty in raising their status.

Tertiary based nurse education was meant to produce a more professional image. Unfortunately, for most nurses the autonomy and authority aspects of a professional image are not manifest in the ward environment (Begany, 1994: 29). Because the majority of nurses are
not and cannot be professionalised, the dream of collegiality between nurses and doctors in hospitals cannot be realised, except perhaps in a very few, highly specialised ward areas such as oncology and cardiac surgery (Hodes and Crombrugghe, 1990: 75). To others these nurses remain subordinate to the medically dominated health care system. Status and image are linked together and it is only in the independent role in the community or in the collegial role in high technology units that the registered nurse might be seen in a new light as a professional health care provider with the knowledge, skills and willingness to deliver nursing determined health care.

Despite all the hyperbole about the empowering effects for nurses of tertiary based nurse education, this has not occurred. The way to empower nurses is depicted as professionalisation and the key to professionalisation is seen as control of a unique, specialised knowledge base. At the undergraduate level nurse education has failed to establish its knowledge base and to professionalise nurses. It is more likely that at the postgraduate level, by giving the registered nurses the ability and credentials to work independently, that empowerment may occur.

For nursing as an occupation and for the newly graduated registered nurse, tertiary based nurse education has failed to live up to its many promises, particularly with respect to professionalisation. Only a few nurse writers have acknowledged the fact that in most occupations there are generalists and a small number of specialists or professionals who are the major beneficiaries of change (White, 1984b: 506). One group of nurses likely to benefit from this educational move are specialist clinical registered nurses who can perhaps use their postgraduate qualifications to reap the benefits of an expanded and independent role. However, by far the biggest beneficiaries in the move to tertiary education institutions are nurse academics.

8.13. Nurse Academics

In moving to the tertiary education sector, initially under C.A.E. conditions and subsequently under university conditions, nurse academics experienced significant pay increases. For example, while a senior nurse educator received $903 per week, a senior lecturer
(in nursing) received $1084 per week (Academic Salary Rates, 1991; "Public hospital nurses' (state) award - 17/9/1991", 1992: 37). The Union of Australian College Academics has acknowledged that nurse academics are undervalued because their practical experience is undervalued and has sought "to ensure that nurse academics are treated on a par with their colleagues in other disciplines" with implications for the criteria and rates of advancement within nurse education (Robinson, 1990: 34). The top nurse academics at professorial level not only get paid much more than the heads of the old hospital schools of nursing, but also earn more than the directors of nursing of the largest hospitals. Professors of nursing are the highest paid nurses in the state.

The conditions of employment of nurse academics are much better than under the old hospital system (Australian Universities Academic Staff (Conditions of Employment) Award, 1988). Flexibility of working hours, public holidays off, proper offices and teaching areas, support facilities, dedicated support staff, the freedom to work at home and a reduction in clinical supervision are all important benefits that more than offset any drawbacks from the transfer.

While nurse teachers had a higher rated status than bedside nurses, there was still a strong association with nursing which reduced their occupational ranking. With the transfer to the tertiary education sector, especially after amalgamation into universities, they became university academics first, and only by distant association, nurses second. Among occupational rankings 'nurse' is seen as managerial with less status than 'doctor', while the occupation of 'university lecturer' is ranked as professional along with 'doctor' (Bond and Bond, 1986: 62).

In the eyes of the public, lecturers in nursing are associated with universities and as a consequence should be given relatively higher social status, while nurse educators were seen as nurses associated with hospitals and were given a lower social status. However, among other university academics, nurse academics are still seen as newcomers to tertiary education with a somewhat dubious academic discipline and who still need to prove their worth by conducting research, publishing, completing higher degrees, producing suitable graduates and promoting postgraduate courses (Sheehan, 1986: 36-41; Illing, 1994b: 2).
Nurse academics have done much to protect and expand their occupational boundaries. In the hospital nurse training system lecture content was prescribed, whereas now lecturers decide their own lecture content to meet their own subject objectives. By eliminating doctors as guest lecturers and establishing a purely nursing perspective in courses taught by nurse academics they have reclaimed nurse education. The development of new subjects on nursing theorists, nursing ethics, nursing research and the proliferation of postgraduate nursing courses have expanded the scope of nurse education and created new opportunities for new specialisation, research, publication and an increase in the number of nurse academics.

Nurse academics are actively establishing their own unique knowledge base. They research, publish and teach nursing concepts and terms specific to nursing while discarding biomedical concepts and terms. To doctors and non nurse academics their knowledge and way of thinking is becoming increasingly specialised and esoteric - it is becoming more indeterminate. This unique knowledge base gives nurse academics power because others do not fully understand what they are doing and outsiders cannot perform the activities of nurse academics. However, many non nursing academics have expressed doubts about the scientific validity and usefulness of this new nursing knowledge which brings into question the standing and social authority of nurse academics within the university setting (Lia-Hoagberg, 1985: 155-159; Lippman and Ponton, 1989: 24-27). Nurse academics still lack cognitive authority.

As academics on a university campus with higher degrees, specialised knowledge, research experience and separation from hospital bureaucratic control, nurse academics are now able to represent themselves as equals to doctors. They can act independently of the medical profession or collaborate with the doctors should they wish, but they no longer need to be dependent upon and subordinate to doctors. Their position is now one of total separation from medicine.

It is nurse academics who have been professionalised from the move to tertiary institutions. Applying the four commonly cited attributes of the trait approach to professionalisation favoured by nurses, it could be perceived that nurse academics have acquired the unique knowledge base and years of university education in order to gain the associated autonomy and authority for independent actions. They also have the code of ethics
and professional culture that other academics possess, and hence they meet their own criteria of a profession.56

More importantly, nurse academics have professionalised by separating themselves from the female dominated semi profession of nursing and merging with the male dominated profession of university lecturing. They have also become members of a much smaller elite. Rather than being lost amongst the multitudes of nurses, they have become part of a significantly smaller group of university academics and this scarcity of numbers is a major component of professional status. Social exchange theory sees increasing status resulting from a scarce commodity (Aaronson, 1989: 274-279). It is harder to move a large group from non professional to professional status, than it is a smaller group, since fewer social resources are involved. Nurses as a group are far too numerous ever to become true professionals but nurse academics have been able to become members of the far fewer university academics who have already been granted professional status by the public.

8.14. Consequences of an All Trained Nurse Workforce

There is one major (largely) unanticipated result of the transfer of basic nurse education to tertiary institutions. The removal of trainees from the wards and the significant increase in the salaries of nursing graduates has possibly led to the temptation to decrease the number of registered nurses on the general wards of hospitals and increase the number of enrolled nurses, especially if they can have an expanded role (Gleeson, 1985: 42-43; Stow, 1996: 1; ‘Policy on enrolled nurses’, 1996: 19). Senator Walsh, a Federal government Cabinet minister, has charged that the Federal government’s decision to make nursing a degree course has added significantly to rising unit labour costs in hospitals and that action needs to be taken (Cribb, 1990: 6).

While job opportunities might very well increase for experienced, specialised registered nurses, particularly those with higher degrees, there is likely to be a decreasing demand for new nursing graduates, especially after their initial 12 month contract expires and they become much more expensive to employ (Elkan et al. 1994: 413-420). The Australian

56 The word professor has the same origin as profession (The Concise Oxford Dictionary, 1990: 952). Teaching in a university, university based education and professionalism are all closely interrelated.
Nurses Association notes that a university education and pay rises based on possession of an undergraduate qualification have reduced the short term employment prospects for new registered nurses and resulted in a movement within the areas in which large numbers of nurses work, with fewer positions available on the general wards and more in specialist areas (Vidovich, 1994: 3). Nurse education \textit{per se} will have had little to do with much of this change and some of these changes are contrary to nurse education views on total patient care. Rather, change will continue to be economically driven. The Reid Report suggests that if there are fewer jobs for new graduates and an increased demand for higher degrees in nursing, it could mean fewer entrants into undergraduate university nursing and more postgraduate nursing courses and students (Reid, 1994: v and 14).

8.15. Conclusion

There have been many problems with the proposed implementation of innovative nurse education strategies in the tertiary education sector. Exposure to a multidisciplinary learning environment, development of a psychosocial knowledge base, fostering of critical thinking skills, liberal studies opportunities and the close integration of theory and clinical practice were important components of specific nurse education strategies which were argued could only be developed in the tertiary education sector. For a number of reasons these strategies were found to be non-viable, or, at least, could not be utilised as fully as was argued.

There is little evidence to show that the transfer of basic nurse education to the tertiary sector in N.S.W. has achieved many of its educational and professional aims. In particular, there has been surprisingly little research published into the supposed educational benefits to new graduates of tertiary based learning. This lack of nursing interest is puzzling. It does raise the possibility that either nurses are not particularly interested in these supposed educational benefits or that they are concerned that upon close examination such benefits will not be found and, hence, a major group of arguments for the transfer of nurse education to the tertiary sector are reduced in importance or found to be wrong.

Professionally, while there have been some benefits from the transfer for some groups of nurses, there have also been many drawbacks from the move. For the majority of
registered nurses there is no real evidence to suggest that their status, conditions of employment or autonomy have significantly altered. Factors largely outside the control of nurses may have given some community based clinical nurse specialists and clinical consultants some degree of increased autonomy, which might be considered a component of professionalisation. Similarly, nurse academics have accrued some of the trappings of a profession, not so much as a consequence of their own actions, but more because of their transfer into a professionalised environment.

Thus, it can be argued that nursing's rations of and expectations of this transfer of nurse education to the tertiary sector were unrealistic. The reasons for this failure will be examined in the next chapter.
Chapter 9

Analysis of the Transfer

This thesis has presented a number of theoretical perspectives on professions and the professionalisation process. The trait approach to professions was examined because it was concurrent with the earliest serious nursing discussions about professionalisation and, in a modified form incorporating the idea of nursing autonomy, has continued to remain the foundation of attempts to professionalise by Australian nursing organisations. A short history of the professionalisation of medicine demonstrated that its dominant position within health care delivery did not develop as a consequence of the supposed trait requirements of a profession.

From the early 1970s a number of sociologists of professions have developed different approaches to the professionalisation process. Of all these perspectives, several are of most relevance to the discussion of attempts to professionalise nursing. Freidson's work is important because his discussions on the importance of professional autonomy, domination and monopolisation of an area of work are among the earliest and most influential explanations of professional development. The works of a number of other commentators including Johnson, Collins, Jamous and Peloille explored the role of academic credentials, rituals, mystique, jargon and indeterminacy as justifications by occupations for their professional monopolisation and privileges and serve as part of the explanation of status differences between professionals and their clients. Feminist critiques of professions highlight the patriarchal nature of the existing professions, and present this as the fundamental obstacle to the professionalisation of female dominated semi professions.

Chapter 3, A History of Nurse Education in New South Wales summarised the development of modern nursing, especially the role, influence and consequences to nursing of Florence Nightingale. This chapter began the examination of how nursing found its current position in the hierarchy of health care delivery and demonstrated how the work and educational demands placed on nurses have changed over time.
Chapter 4, Professionalisation and the Sociology of Nursing examined specific sociological issues within nursing which help to explain why nursing would want to professionalise as part of the process of seeking collegiality with doctors and desiring the same status and rewards accorded the medical profession. Nurse-doctor relationships, issues of gender, including female nurses' subservience and the potential role of male nurses, and perceived problems with the socialisation resulting from hospital based nurse training explain why nurses might think (incorrectly) that socialisation of nursing students in the tertiary education sector would be an important component in altering the culture, attitudes and behaviour of nurses towards a supposedly professional ideal.

Chapter 5, The New Nursing Technology: A Professionalisation Strategy discussed how changes to the technology of nurse education in the tertiary sector can be best perceived as part of a professionalisation strategy. The old hospital based nurse training curricula, with their biomedical emphasis, represented an inferior version of medical education which placed nursing in a dependent position to medicine. In the tertiary education setting, away from medical influence over nurse education, nursing is free to promote a biopsychosocial, holistic perspective to nursing care, incorporating nursing diagnoses, nursing theories and the nursing process, and utilising nursing researched and generated knowledge. This new nurse education supposedly gives primary nurses and independent nurse practitioners the ability to independently implement their own nursing care, largely irrespective of medical considerations. It represents the pursuit of the goal of nursing autonomy, though reality falls short of this ideal.

As part of the quest for changes to what, how and where nursing students were taught, nursing presented a number of educational arguments for change. These considerations are presented in Chapter 6, The Overt Arguments for the Tertiary Transfer of Nurse Education. The majority of interested parties were in agreement that the existing hospital based nurse training was inadequate in its preparation of registered nurses for the changing health care environment. There were some perceived educational benefits to be gained from a transfer of basic nurse education out of hospitals and into the tertiary education sector. However, rather than a gradual and carefully evaluated upgrading of nurse training, the abrupt and radical
transfer of nurse education into the tertiary education sector had ultimately more to do with state political and economic considerations than with any carefully reasoned educational arguments.

Chapter 7, *Nursing’s Covert Reasons for the Tertiary Transfer* showed that nursing also had more than just educational reasons for wanting the transfer of nurse training out of hospitals. While educational arguments were the official justifications for seeking change, issues relating to promoting professional socialisation, pursuit of credentialism, protecting and expanding nursing’s work boundaries and seeking professional status and remuneration were equally, if not more, important concerns. Of particular importance were the potential benefits to be gained by nurse academics who obviously had a vested interest in this self-promotion.

Chapter 8, *The Consequences of the Transfer* argued that the educational goals used to justify the transfer of nurse education into the tertiary sector in N.S.W. have not been achieved. There is little supporting evidence that it has produced a 'better' registered nurse while there is evidence that there are some problems with these changes to nurse education. More importantly, I have argued that such a move has done little to professionalise nursing in this country. Neither the overt or covert aims of nurses for such a transfer have been achieved.

This chapter analyses the failure of the current professionalisation strategies deployed by Australian nurses. In particular, I wish to single out for detailed discussion four major issues concerned with technological change in nurse education as a professionalisation strategy. First, there is the mistaken assumption by nurses that technological determinism has resulted in medical domination of health care and the subsequent belief that the same mechanism can result in nursing professionalisation. Second, changes in the terminology or jargon of nursing may be seen as an unsuccessful attempt to increase the indeterminacy or mystique of nursing. Next, there is the failure of Australian nurses to learn from the problems encountered by American nurses with their earlier and continuing professionalising strategies in nurse education, which Eliot Freidson commented upon as early as 1970. Nurses in Australia and overseas have also failed to appropriately address the issue of autonomy among professions. Finally, there are the patriarchal constraints on professionalising a female occupation such as nursing, especially when it falls within the dominant domain of a masculinist medicine.
9.1. Technological Determinism

Much of the change in nurse education in N.S.W. has been driven by the idea of technological determinism. It is likely that few members of the nursing leadership are aware of the meaning of this term and its simplistic and erroneous explanatory nature. Rather, they have utilised the concept in their arguments for change in nurse education without conscious awareness of the technical term to describe their reasoning.

Technological determinism is most commonly used retrospectively to explain why a piece of technology has become widely utilised and has had an important impact on the wider society. In the context of health care it is often used to explain how medicine, with its technological dependence, has come to dominate health care delivery (Shryock, 1969). The emergence and expansion of medical technology, consisting of medical knowledge, interventions and equipment, has so influenced the modern health care system that: "technology may be beginning to characterise the overall design of services offered within the hospital" (Brewer, 1983: 2).

Technological determinism implies much more than just the use of artefacts (the material component of technology). Of necessity, it implies specific social relationships as a consequence of the development and use of these artefacts (the social component of technology) (Daly and Willis, 1987: 3-4; Palmer and Short, 1994: 174; Willis, 1994: 19). However, the technological determinist argument inappropriately sees the social component as the inevitable derivative of the material component of technology (MacKenzie and Wajcman, 1985: 5; Willis, 1994: 19-20).

Technological determinism normally has an assumption of passivity on the part of those affected by the changing social relationships seen to result from the adoption of some material aspect of technology. Importantly, it removes the responsibility for the social relationships and consequences from those involved. Doctors are thereby presented as the passive recipients of their elevated social position because of the impact of their medical technology. The adoption of medical technology as the preferred health care technology also implies an inevitable medical domination over nurses, other health care providers and patients because they all rely upon the medically determined technology. Technology is thus presented
as the independent variable which affects everything else (Elliott and Elliott, 1976: 5; MacKenzie and Wajcman, 1985: 4; Daly and Willis, 1987: 4; Volti, 1992: 233-235). There is a technological imperative which "asserts that technology is a single entity, monolithic and incapable of being differentiated", and assumes a "'cargo cult' view of technology" (Jones, 1982: 216).

Within the health care system an emphasis on technological determinism and technological rationality may be seen as part of the medical ideology which serves to legitimate medical domination (Willis, 1989: 4 and 35). It also implies an ideology of expertise with the claim that only doctors have the expert knowledge to judge the value of their own actions, the utilisation of medical equipment and the actions of others (Freidson, 1970b: 141-144; Johnson, 1972: 41-47; Daly and Willis, 1987: 5; Palmer and Short, 1994: 161-181). The medical domination of health care is presented as the inescapable result of improvements in medical technology, with there being no deliberate medical input into establishing and maintaining medicine's privileged position.

However, as has been demonstrated, such an explanation is ahistorical because medicine's domination of health care occurred before the expansion of medical knowledge (Willis, 1989: 201; Johnson, 1972: 25; Larson, 1990: 24-25; Freidson, 1994: 19-20). Technological determinism is far too simplistic an explanation of the relationship of technology with society. Rather, an 'interactionist approach' supplies a much more realistic analysis of the complex interplay of class, gender, politics, economics, ethics and technology involved in the adoption or rejection of various technologies and their relationships with society (Elliott and Elliott, 1976: 12-13; MacKenzie and Wajcman, 1985: 8-25; Willis, 1989: 202; Epstein, 1970: 965-982; Baumgart, 1985: 20-22; Daly and Willis, 1988: 115; Murphy, 1990: 71).

9.2. Technological Determinism and Nurse Education

The occupation with which nurses have the most contact, most aspire towards and have a classical love-hate relationship is that of medicine. When nurses look at doctors they see professionals with status, remuneration, authority, independence and power - all attributes that the nursing leadership would like to attain for themselves and suppose that all nurses would
also desire (Lynbaugh, 1980: 266-270; Salvage, 1988a: 517-518; Mason et al. 1991: 72-77).

Nurses have tried to determine the mechanisms by which doctors have obtained and retained this dominant relationship over nurses, other health care providers and patients so that they might adopt similar strategies in order to elevate their own position to a level equivalent to that enjoyed by doctors.

Nurses have looked at what purports to be the history of the emergence of medical influence on health care, seen as a consequence of technological determinism involving changes to medical technology, and have generally accepted the view of a passive role for medicine in changing social relationships. The nursing leadership has for several decades been trying to actively influence changes to the social relationships of nurses by creating a distinctive nursing technology (Murray and Chambers, 1990: 1099-1105). Just like the supposed case with medicine, it is assumed that this new nursing technology, of itself, will improve the social position of nursing - that it will inevitably professionalise nursing in the eyes of other members of society.

It is easy to note only the obvious and superficial differences between medicine and nursing, and conclude that it is these very differences that directly cause the unequal relationship between doctors and nurses. It is supposed that if nursing can eliminate these differences or substitute equivalent factors, then nursing will rise to the same professional position as medicine. This simplistic view is the main nursing motivation behind the drive for tertiary based nurse education as the principal means of attaining professionalisation.

Since the emergence of modern medicine in the second half of the nineteenth century, doctors have conducted widespread research into the causes of disease and effective mechanisms of intervention. This research has, through complex mechanisms, ultimately resulted in a professionally and socially validated body of knowledge known as medical knowledge (Kipnis, 1990: 87-92). Much of this original research has been done by medical doctors. Even when the actual research is done by non-medical researchers, say in the areas of human physiology, biochemistry and pharmacology, it is the medical profession which controls, integrates and utilises this information (Freidson, 1973: 28-29). In so doing it claims
this knowledge as its own, maintaining an effective monopoly of this knowledge (Moloney, 1986: 269; Brown, 1986: 33-51; Abbott, 1988: 9).

An example of an item of medical knowledge would be the medical diagnosis of subacute bacterial endocarditis (S.B.E.). This succinct medical term conveys a significant amount of information about the pathophysiology of the physical illness and is a major determinant of the likely patient interventions. A piece of knowledge in the form of a few words as a medical diagnosis holds within it reams of important information for those who understand its meaning and implications. It is a classical illustration of jargon - highly complex, technical language which means much to those in that particular occupation, or closely related fields, but is largely meaningless, very mysterious and impressive to outsiders (Spicer, 1971: 799; Brown, 1986: 40). Much of medical language is comprehensible to most doctors as a result of their medical education and constant usage, and has varying degrees of understanding and significance to other occupations such as nursing and physiotherapy which were educated about, constantly encounter and are obliged to use this language in their work environment. Traditionally, nurses have been obligated to learn and to use medical terminology, reinforcing their dependence on the profession of medicine.57 To the general public, and more specifically the patients, most medical language or jargon is meaningless or they have a vague understanding of it, but they certainly lack a full appreciation of all the possible information implied in just a simple naming of an illness.58

57 Student nurses in the old hospital training system and now university based nursing students when on clinical release blocks are initially confounded by health care terminology, for example, medical diagnoses used in nursing change of shift oral handover reports. Increasing familiarity through constant exposure to these terms and an expanding nursing education enable them to, at least partly if not completely, comprehend their meaning and anticipate the likely medical and nursing interventions. It is likely that university nursing students, who have limited teaching and clinical time, in what are a number of largely medically determined health care areas, for example, in medical and surgical nursing, probably do not come to understand this medical terminology to the same extent as the hospital student nurses did during their training. It is only when they graduate and work constantly in one area that they become more knowledgable about these terms.

58 Patients when labelled with a medical diagnosis usually have no idea of the meaning and implications of this piece of terminology. Over time they learn a little about, but by no means all, the implications of their diagnosis. Only in a few instances, such as a permanent diagnosis of insulin dependent diabetes mellitus, do some patients, but by no means all, become reasonably knowledgable about their condition. Even then, as new medical information and ideas emerge, the patient’s knowledge can become outdated. As a consequence of this normal lack of patient comprehension of their medical diagnoses, nurse education has recognised and taught the role of the registered nurse as a patient educator, often translating complex medical terms into more comprehensible language appropriate to the understanding of the individual patient. This translation role by registered nurses of medical jargon into common, everyday language is an important recognised patient education function of nurses (Oakley, 1987: 14-15, Kozier et al. 1991: 278-284). In recognition of the importance of this
From their professional understanding of a piece of medical knowledge, doctors plan and implement an appropriate set of actions - medical interventions - or determine and set guidelines for the actions of other health care workers under their direction (doctor’s orders or protocols for nurses or physiotherapists or other health care workers) (Chandler, 1991: 20-23).

For example, a medical diagnosis of acute appendicitis is ultimately going to lead to surgery, an appendectomy. A surgeon’s understanding of the diagnosis, educational preparation and familiarity with surgical technique enables him/her to cut open the patient and eliminate the problem. No one but a surgeon has the knowledge, training, experience and legal right to perform what is a simple, routine and commonplace operation. Even though an operating room registered nurse may have seen and assisted with literally hundreds of appendectomies, the nurse does not have the technical competency or legal right, nor probably the knowledge of both gross and fine abdominal anatomy, to operate with any degree of expertise.

The twentieth century has seen increasingly more use of medical equipment.59 For various reasons medical diagnosis increasingly relies on medical equipment.60 Advanced diagnostic equipment aids in refining some diagnoses, helps to eliminate some possible alternate diagnoses, in some cases speeds up diagnosis making possible more rapid confirmation of the provisional diagnosis, is readily available and is highly promoted, and there are often legal incentives to overuse expensive diagnostic equipment to minimise the risk of being successfully sued for medical negligence in failing to detect some rare and unlikely problem or failing to detect at an early stage a deterioration in the patient’s condition.

An example of this would be a CAT scanner, a computerised axial tomograph, which uses a computer to analyse in cross-sections a series of X-ray slices of, say, the brain, in

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59 While commonly referred to as medical technology, I find that this is too general a term in this usage because it really refers to just the hardware. So I have used the term medical equipment instead.

60 While medicine makes use of high technology for its diagnoses, the new nursing tries to distance itself from medicine by emphasising the use of low technology in formulating nursing diagnoses, based on use of the senses and simple equipment such as the stethoscope. Additionally, the doctors control the modern diagnostic technology in that only doctors can request or order most tests. Hence, nursing diagnostic independence necessitates the rejection of much of the existing complex array of diagnostic equipment already employed by doctors.
order to detect a number of gross anatomical changes such as tumours, blood vessel blockages or haemorrhages, especially those associated with the medical diagnosis of a CVA, a cerebral-vascular accident, known to the general public as a stroke. The scanner is very expensive to install, maintain and to operate. It most commonly only confirms about patients what is already known or strongly suspected. Yet, doctors routinely order cerebral CAT scans.

Doctors effectively control this piece of technology. They may not have designed and upgraded it, or know the details of how it works, or even be able to operate it. They leave that to the designers and technicians. Their control comes from the fact that only doctors are legally permitted to order CAT scans and it is a doctor who interprets the results as they appear on polaroid. Either the supervising medical specialist can interpret the results himself, or the medically trained radiologist consultant reports back to the ordering doctor. Gross cerebral abnormalities are not necessarily that difficult to detect. With experience, technicians and registered nurses can often read the polaroids and determine the correct medical diagnosis. However, only doctors are legally able to make diagnoses based upon the test results, a fact justified by their specialised educational preparation allowing recognition of subtle abnormalities.

Similarly, in the high technology, high dependency, tertiary health care units of acute care hospitals it is the doctors who control the invasive, interventionist equipment used to treat the patients. Even when it is the registered nurses who routinely use this equipment, they are only permitted to do this because they are doing so under medical orders or hospital protocols based on the normal medical requirements, and certainly not under their own nursing initiative. It is the doctors who control the high technology equipment used in patient intervention (Reiser, 1978: 163-165).

Nursing has looked at the preceding processes and decided that the doctors control the health care technology to their own benefit. The doctors conducted and/or used research to develop and control a unique body of medical knowledge which is highly technical and difficult to understand without considerable specific educational preparation. Possession and control

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Registered nurses with their limited education have a partial working understanding of this medical knowledge, but it is seldom as complete as that possessed by the doctors who had a longer educational preparation - whose education was specifically directed towards this end and who constantly utilise this information. So, for example,
of this knowledge results in a plan for treating the patients - a plan which largely determines the actions of the whole health care team, most notably that of the nursing staff involved in implementing the medical orders. The patients remain the property and responsibility of the doctors and other health care team members in caring for the patients are caring for the doctors' patients. The doctors 'own' the patient, so that while the patient might be referred to by members of the health care team as "Dr Smith's patient", the patient is never referred to as "Nurse Jones' patient". Changes to nurse education seek to alter this exclusive medical 'possession' of the patient. Doctors also control access to and permissible use of the diagnostic equipment and the interpretation and use of the results to direct health care interventions. The more expensive and more dramatically interventionist equipment is either solely used by the doctors or its use by others is under strict medical control.62

Their control of medical research, knowledge, diagnosis, interventions and the appropriate equipment gives doctors the dominant role in the health care team. Restrictions on nursing access to these keep nurses subservient to the doctors' needs. The implication seems to be that if nursing can develop its own unique technology encompassing all the above, then nursing will be removed from this subservient role and the doctors will have no option but to reevaluate their working relationship with nurses and accept them as equal members of the health care team.

Many of the aspects of the emergent university based nurse education relate to this technological determinist assumption. Extensive nursing research conducted by nurses, primarily by nurse academics, enables the development of new, discrete nursing knowledge, the testing and expansion of nursing theories and the validation of nursing interventions. The emergence of a distinct nursing knowledge in the form of nursing diagnoses is seen as having a number of benefits for nursing. Nursing diagnoses serve notice of the separation of nursing from medicine and medical diagnoses (Taylor-Loughran, 1990: 71). Legally, nurses are not

while an experienced nurse midwife might know more about labour than the average general practitioner who has little to do with this condition, the midwife is unlikely to be as knowledgeable as the obstetrician who is constantly working in this field.

62 I have given numerous examples, such as ECG recording and cannulation, of medical diagnostic and interventionist equipment and procedures which have been discarded by the doctors in favour of newer, more challenging equipment, and which have been gladly adopted by registered nurses.
permitted to make medical diagnoses, but they can make nursing diagnoses which in many
instances, relate to the same patient problems (Stevens, 1984: 108). Thus, the development of
nursing diagnoses can be seen as an attempt by nurses to circumvent the legally enforceable
exclusive right of doctors to diagnose illness. Medical control of diagnosis has given doctors
control over the actions of other health care workers by making these other workers dependent
upon treatment regimes initiated and controlled by doctors. Nursing diagnoses are an attempt to
challenge this control over nurses.

For a patient with respiratory problems suffering from the medical diagnosis of
Chronic Obstructive Pulmonary Disease, the registered nurse can (nursing) diagnose the
patient's problems as altered breathing pattern and/or impaired gas exchange, with possible
activity intolerance. For the independent nurse practitioner, nursing diagnoses can serve as not
only the bases for nursing interventions but also for reimbursement for nursing services from
the government and possibly from private health care funds (Mittelstadt, 1993: 47-49). Because
nursing care should be considerably cheaper than the comparable medical care there could be
considerable economic incentives to support this type of independent nursing care (Campbell-

For a medical diagnosis of a patient's problem, the doctor's orders and/or existing
hospital protocols largely determine the nursing interventions. Any variation from the standard
nursing care could require medical clarification first. However, the ability to correctly use
nursing diagnoses gives the registered nurse flexibility in individualising patient care by
choosing the most appropriate nursing interventions. Nursing diagnoses give registered nurses
greater freedom for independent action. There are a number of psychosocial nursing diagnoses
in areas such as altered role function which many nurses feel that (most) doctors ignore in the
ongoing assessment of their patients (Holden, 1990: 223-224; Campbell, 1990: 1359). This
expands the role of the nurse, encompassing more than the mere pathophysiological problems
of the patient.63 Nursing diagnoses also formally acknowledge the nurse’s traditional role and
actions in treating the major patient concerns such as "knowledge deficit" about his/her

63 Studies suggest that registered nurses evaluate patients as having more psychosocial "worries" than the
patients believe that they actually have, while underrating and undertreating their physiological concerns such as
pain (Oakley, 1987: 15).
(medical) diagnoses. Meeting the patient's needs relating to knowledge deficit demonstrates the nurse's role as a patient advocate, by empowering the patient through information (Meissner, 1981: 24-25). In so doing the nurse gives the patient an increased ability to be involved in the decision making regarding his/her treatment options.

This nursing knowledge, as illustrated by the example of nursing diagnoses, gives nurses control over their subsequent actions. Individualised nursing actions become acceptable with variation in treatment for different patients becoming a nursing concern. Rote implementation of nursing care is not claimed to be professional (Hicks, 1981: 714). Assessing and implementing varied care to meet individual patient needs demonstrates a far greater degree of understanding by nurses and reflects a professional education preparation (Nursing in Australia, 1988: 3). Periodic revaluation of the success, or otherwise, of the patient's progress towards meeting the evaluation criteria for "the desired patient outcome" for the various individualised nursing diagnoses, gives the registered nurse control over determining whether the nursing interventions have led to an improvement in the patient's condition. Just as the doctor determines the success or not of the medical interventions, so now the registered nurse can be seen to be scientifically determining the success or not of the nursing interventions.64

Nurses do not have access to the diagnostic equipment that doctors do because only doctors can order tests. While nurses can utilise the information from test results to help formulate and confirm various physiological nursing diagnoses and to evaluate the success of nursing interventions the registered nurse cannot always guarantee that these test results will be available when needed. Hence, the nurse must rely on low technological diagnostic equipment which is outside the control of the medical profession and which does not require a doctor's authorisation. Nursing assessment leading to nursing diagnoses emphasises talking to the patient to elicit information on patient symptoms and the detection of the signs of problems through the use of sight, hearing and feel involving inspection, auscultation and palpation of various body systems (Jarvis, 1992: 3-13). Nursing assessment equipment is simple, involving such items as a stethoscope, peak flow meter and ward urinalysis. Once use of such equipment and activities was the exclusive domain of doctors but they have subsequently been discarded

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64 This idea will be expanded upon in the following section on nursing indeterminacy.
or deemphasised in favour of high technology diagnostic equipment and have been picked up by nurses.

A deliberate association of nursing with low technology equipment also serves to demarcate nurses from doctors who are associated with high technology equipment. High technology assessment is presented as impersonal and uncaring and distanced from the patient, while low technology assessment, involving as it does significant communication (talking) with the patient, presents as personal and caring, and permits a nursing involvement in psychosocial patient concerns and not just physical problems (Nicholl, 1986: 117-122). This is holistic care of the patient and is seen as being significantly different to biologically based medical care (Staunton, 1987a: 3). Similarly, the equipment used in nursing interventions tends to be low technology, involving such items as catheters and sterile dressings - all items which do not require medical input. More high technology equipment such as respirators, which require a medical involvement, do not fit into (independent) nursing diagnoses but rather fall within the domain of dependent/interdependent collaborative problems.

Many patient problems require some type of drug therapy and in virtually all instances medications currently require a doctor's order (except for some common drugs such as paracetamol for minor pain relief). There is agitation for certain classes of nurses such as independent nurse practitioners and independent midwives in certain situations to be legally permitted to prescribe most forms of drugs ("Guidelines for the handling of medications ...", 1995: 34). This would permit the transfer of many collaborative problems - because they require medical involvement in ordering drugs - into independent nursing diagnoses without any medical involvement.

Nursing research leads to a validated, discreet, unique body of nursing knowledge which is best exemplified as nursing diagnoses (Vincent, 1984: 22-37). Using this nursing knowledge registered nurses can formulate and implement their own plan of care. Nursing assessment, diagnosis and interventions involve nursing controlled low technology equipment. This knowledge, ways of doing things and equipment form the basis of the new nursing technology. Together they supposedly give nurses freedom, autonomy of action and a certain
degree of legal authority. Along with nursing research, a unique body of knowledge and years of university study they are significant components of the trait approach to professionalisation.

Nurses want to be professionals because medicine is seen as professional. All this nursing technology is meant to determine that nursing takes a pathway towards professionalisation. It represents a deliberate attempt to forge a technology which will lead to a particular desired outcome - the professionalisation of nursing. The fact that the whole premise is wrong because it ignores a number of more important factors is simply irrelevant. Technological determinism as an explanation of medical professionalisation is a fallacious, but commonly and easily accepted, argument which forms the basis of an erroneous approach to attempts to professionalise nursing. Medicine did not become a profession as a consequence of the development of medical technology in the form of important and useful knowledge, equipment and skills. Rather, medicine professionalised through a complex interplay of numerous factors, especially in the politico-legal area. The technological determinist explanation of medical professionalisation attempts to justify, in a far too simplistic manner, the privileged position of medicine in society.

Despite this what is important is that this form of technological determinism has strongly influenced the pathway that nurse education has taken in Australia and overseas. This new nursing technology is problematic because it also depends upon a low technology, holistic emphasis which is in tension with the 'scientific' claims and aims of nurse education and research in the university setting. Additionally, it is inconsistent with the work situation of most nurses in hospitals due to the facts that it is unwieldy, time consuming, incompatible with divisions of labour within nursing, inconsistent with the high technology emphasis of hospitals and difficult to implement due to legal constraints on nursing practice.

9.3. Nursing Indeterminacy

Again, without actually being aware that there is a term to explain the reasoning behind their actions, it can be argued that changes to nurse education represent an attempt, conscious or unconscious, by the nursing leadership to increase the indeterminacy/technicality (I/T) ratio of nursing, so as to increase the social status of nursing. Medicine has a high I/T
ratio because medicine's knowledge base and its ability to utilise this complex knowledge effectively, to exercise judgement in the application and interpretation of this knowledge in specific cases, has traditionally been seen as being beyond the capabilities of the rest of the members of society. The 'mystique' of medicine gives doctors considerable social distance from non doctors, and is seen as an explanation of and a justification for medical power and privilege (Daniel, 1990: 37-38). Professions have a high I/T ratio because the client lacks the esoteric knowledge of the expert professional (Johnson, 1972: 41-47; Turner, 1987: 135; Daniel, 1990: 37-38). This esoteric knowledge is grounded in a scientific discipline, and because of the nature of this legitimated knowledge, only the profession is qualified to regulate its own activities, be autonomous and display independent judgement (Wilson, 1983: 51; Freidson, 1986: xiii).

Conversely, nursing has a low I/T ratio because nursing knowledge and care has traditionally been seen as 'inherently feminine' with the 'common sense' application of widely known facts, while nursing knowledge is seen as a vastly simplified form of medical knowledge (Goode, 1960: 903; Baumgart, 1985: 21; Johnstone, 1994: 125-131). The expanded role of the registered nurse has resulted from doctors delegating the technical and routine tasks to the nurses, while retaining the more complex and indeterminate procedures for themselves (McCoppin and Gardner, 1994: 47). There are widely held beliefs that just about anyone with only a little training can do what nurses do, that there is little specialised judgement in nursing practice and that nurses are dependent on the orders of the doctors (Stevens, 1984: 241; McKay, 1993: 35-37). Hence, nurses have little social distance from their patients and little power or prestige (Keddy et al. 1986: 745-753).

There are two nursing views on this lack of social distance. On a positive note, it is seen as an aid to nurse-patient communication. While doctor-patient communication is depicted as poor because of inappropriate use of medical jargon and with the awe of the patient towards the doctor affecting the ability of the patient to ask the doctor questions, the nurse has no such problem with the patient. In fact, nurses have been taught to question the patient, clarify, reinforce and reexplain medical information in a form that the patient can understand (Carpenito, 1993: 166). The nursing diagnosis of "knowledge deficit" illustrates this nursing
role function. Nursing has chosen to utilise this lack of social distance from patients to create an expanding role as a supplier of health care information and as a patient advocate (Taylor, 1994: 123-129).

The negative connotation for nursing of this lack of social distance is that nurses are seen as little more knowledgeable than their patients and therefore as inferior to the professional doctors. Changes to nurse education seek to make nursing knowledge and care mysterious to both patients and doctors, and to clearly demarcate this nursing knowledge and care from medical knowledge and care. Nursing diagnoses and the nursing process lead to a unique nursing terminology which is opaque to outsiders. Since "a nursing diagnosis is a clinical judgement" there is an implication of nursing expertise which outsiders cannot possess (MacRae, 1988: 12). Nursing assessment coupled with nursing diagnoses lead to legally acceptable independent nursing interventions which can be claimed to have scientific rationales. As a consequence, it is hoped to make what it is that nurses do more indeterminate, increasing the social distance between nurse and patient, raising nursing's social standing and leading to increased privileges for nurses.

This has not occurred however for the majority of nurses. Most nurses do not understand the new nursing technology and do not utilise it in their work (Tartaglia, 1985: 34; Barnum, 1987: 27). What these nurses do at the bedside remains understandable to the patients. The nursing philosophy of holism encourages patient involvement in his/her own care (Staunton, 1987a: 3; Turner, 1987: 8-9; Donnelly, 1993: 1-7). Of necessity this requires a high degree of patient understanding of nursing and other health care interventions. It is in conflict with the idea of developing an indeterminate mystique to nursing actions. Similarly, the nursing diagnosis of 'knowledge deficit', requiring the reduction by the nurse of complex medical terms into everyday language which is understandable to the patient, serves to reduce the mystique of nursing. While nursing has deliberately chosen to create for itself the role of patient educator, this is a technical role, lacking in indeterminacy.

Some independent nurse practitioners are taking on more advanced and 'mysterious' activities which might raise their status in the eyes of society. This has more to do with them taking on a 'mini-doctor role', rather than a purely 'nursing' role (Briggs, 1990: 31).
An argument could be made that nurse academics may have increased their status as a consequence of an increased I/T ratio. Non nurse academics would be increasingly incapable of teaching, or presumably understanding, what nurse academics do because the nurse academics have created a specific nurse education technology which the non-initiated cannot understand or utilise. Nurse academics have successfully created their own specialised knowledge base which only they can understand and use. It could be argued that what nurse academics do has become more indeterminate to other nurses, doctors, other academics and the general public. As such, the social distance or status of nurse academics should have increased. A strong counterargument to this is the fact that many non nurses question the need for and validity of nursing knowledge, reducing the indeterminacy of what nurse academics teach and challenging the status of both nursing and nurse academics in universities (Lia-Hoagberg, 1985: 155-159; Sheehan, 1986: 36-41; Lippman and Ponton, 1989: 24-27 Speedy, 1990: 2; Illing, 1994b: 2).

Changes within tertiary based nurse education include an increasing emphasis on a specific nursing language, including nursing diagnoses. Implementation of nursing care is taught as requiring an extensive biopsychosocial knowledge base, a nursing theoretical perspective and utilisation of the nursing process. Together they should lead to a nursing language and skills which are increasingly indeterminate, and this should have the consequence of increasing the status of nursing with both the public and other health care workers. However, this has not happened because many nurses do not understand or believe in this new approach to nursing care and because much of this care is still perceived as little different to that traditionally delivered by females in the home setting. The ‘professional’ nursing emphasis in education on ‘care’ does not serve to separate it from non-paid nursing care and, as such, is counterproductive to increasing the indeterminacy of nursing. Doctors still perceive that there is nothing fundamentally different about nursing knowledge, which is seen to remain as an inferior version of medical knowledge. While the rhetoric of nurse education suggests an emergent nursing indeterminacy, the reality in the clinical setting is quite different.
9.4. Freidson's Analysis of Paramedical Occupations

Eliot Freidson did some of the earliest and most important work in the early 1970s on the motivations for and strategies of professionalising occupations (Freidson, 1970a; Freidson, 1970b). He examined the situation with respect to a number of paramedical occupations such as nursing. In particular, he was commenting on the situation among American nurses in the 1960s and 1970s (Freidson, 1970b: 47-70). At that time American nurses were more concerned with and were further along in their attempts at professionalisation than was the case with Australian nurses (Abdellah, 1972: 223-235). Thus, it is worthwhile discussing whether his observations and analysis at that time and place are relevant to the situation with Australian nurses and nurse education in the 1980s and 1990s. In other words, did Australian nurses at all heed his warnings about the futility of attempting to achieve full professional status for their occupation? While acknowledging that Freidson's work applied to a different time and culture to that of Australia in the 1990s, nevertheless his comments still provide a valuable insight into the problems of nursing professionalisation.

Freidson commented on the difficulty of retaining females as nurses committed to a lifelong career (Freidson, 1970b: 54-55). He argued that too often females undertook nursing as a short term occupation, to be abandoned upon marriage and family commitments. This created a transient and uncommitted workforce which was perceived as needing little formal training - a situation which was hardly compatible with professionalism (Freidson, 1994: 122-123; Cheek, 1995: 322-323). In the U.S.A. nurses attempted to contend with this problem by developing, through changes to nurse education, a 'professional' commitment to work, which would have the additional benefit of altering the way nurses perceived themselves from that of dependent to independent practitioners of health care delivery (Freidson, 1970a: 55; Freidson, 1970b: 21). However, the net effect was to make nurses more sensitive to their subservient position to medicine. Pushing a professional orientation during their educational preparation did not prepare nurses for their subsequent subordination in hospitals (Freidson, 1970b: 21).

Indeed, Freidson claimed that nurses were unlikely ever to attain full professional status because of the already existing strength of the established medical profession (Freidson, 1994: 116). As long as nurses cannot give orders to and evaluate the work of doctors, the two
groups cannot be considered equals (Freidson, 1970a: 77). Historically, medicine has retained
a monopoly over the creation, dissemination and application of exclusive knowledge related to
health care which has given it power over nurses and other health care providers (Freidson,
1973: 28-29). This exclusive medical knowledge is "formalised into theories and other
abstractions" which are "expressed in terms unfamiliar to and impenetrable by the many and
discussed by techniques of discourse that are opaque to outsiders" (Freidson, 1986: 3).

Like other professionalising occupations, nursing has adopted the same institutions
as the existing professions such as medicine. Nursing has attempted to create or find abstract
theories to describe what it does, it has established formal, standard curricula of educational
preparation in universities, it has written codes of ethics and it has sought support for licensing
or registration in order to exercise control over who does what within nursing (Freidson,
1970a: 77). However, in seeking to change its status, nursing is seen as abandoning its own
distinctive tasks - abandoning 'nursing' for a supervisory and a delegated medical task role
embracing the trappings of medical professionalism, nursing still lacks the essential of full
autonomy over its work (Freidson, 1984: 14). What limited autonomy small groups of
specialist nurses have is second hand autonomy, derived from a delegation of discarded
responsibility from the doctors (Freidson, 1970a: 77; Eaton and Webb, 1979: 69-84; Ovretveit,
1985: 76-79; Bond and Bond, 1986: 179). Within the confines of the hospital setting nursing
will always be under the control of medicine (Freidson, 1970a: 57; Freidson, 1986: 165). The
greatest opportunities to develop a functional autonomy occur among occupations which
operate outside the walls of institutions, while, traditionally, the vast majority of nurses work
within the bureaucratic hospital setting (Freidson, 1970a: 57).

In a later re-examination of nursing, Freidson states that nursing has become firmly
credentialed, displaying a preoccupation with tertiary qualifications at the expense of practical
experience (Freidson, 1986: 165). Freidson now writes of nursing as a profession, though the
term seems to be used more out of politeness and common usage, especially among nurses,
rather than any implication that nursing has an equivalent status to that of medicine. Indeed,
Freidson goes on to state that nursing is unlike other 'professions' because it is conducted in a
very elaborate, highly technical division of labour in the hospital setting, which places great constraints on individual discretion (Freidson, 1986: 165).  

This implies that as long as nurses are in close proximity to doctors, as is inevitable in the hospital setting, then nurses cannot practise autonomously. The fact that patients are admitted to hospitals under medical diagnoses and under the direct care of the doctors implies that the doctors must dictate the care delivered to their patients by other health care workers including nurses. However, it could also be inferred that outside the medically dominated hospital setting in the community with patients who might no longer be under medical care and by utilising nursing diagnoses some nurses acting as independent nurse practitioners might be able to act autonomously (Parkes and Spilsted, 1993: 21; “Nurse practitioner”, 1993: 69; Stow, 1996: 3). Certainly, many of the changes to nurse education seem to be directed towards the creation of an autonomous role for nurse practitioners working in the community setting. At the same time these changes to nurse education have created many problems, such as a lack of clinical preparation and reality shock, for nurses working in the traditional hospital setting (Talotta, 1990: 111-115; Bowman and Carter, 1990: 39-41; Wilson and Startup, 1991: 1478-1486; Wuest, 1994: 362).

Australian nurses in the 1980s and 1990s did not learn from the difficulties encountered by American nurses in the 1960s and 1970s in their attempts at professionalisation. Freidson's earlier comments are applicable today to Australian nurses and nurse education. The principal mechanism embraced by Australian nurses in their drive towards professionalism is tertiary based nurse education (Wiesel, 1984: 7; Bagnall, 1994: 44; ‘Policy on nurse education’, 1996: 28-29). In this setting a unique and esoteric knowledge base and a scientific rationale for nursing actions have been created and promulgated by nurse academics. It consists of such things as holistic care, nursing assessment, nursing diagnoses, the nursing process and a low technology emphasis. This approach is based upon the earlier and continuing work of American nurse academics towards a 'professional' nurse education. Despite the fact that the American experience has been unable to produce any unambiguous evidence that such changes

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65 This is consistent with the idea of a low indeterminacy/technicality ratio for semi professions. Much of what nurses do remains readily understandable and repeatable by outsiders.
to nurse education produce a more 'professional' nurse, who has the ability to function in an autonomous role, (Whitley and Chadwick, 1986: 94-101; Raymond, 1988: 6-9; Kelly, 1991: 53; Hickman, 1993: 36-47), Australian nurse academics have uncritically adopted the same approach.

The often repeated argument is that insufficient time has passed for nursing to fully professionalise (Reid, 1994: 10). The unique knowledge base of nursing is still in the early stages of being produced and verified (Perry, 1985: 35-36; Jennings, 1986: 506; Rapley and Robertson, 1990: 233; “Nursing research”, 1994: 6). Over time nursing has become more professional, but is not yet fully professionalised. Given yet more time nursing will succeed in its goal of achieving equality with, but separation from, medicine. Nurse academics speak of the health care team with the possibility existing that, as appropriate, nurses could act as the team leader directing the actions of others including doctors (Sarkis and Skoner, 1987: 63; Forbes and Fitzsimons, 1993: 2). The fact that doctors categorically reject this notion is seen as the doctors' fault and not a fault of unrealistic expectations in nurse education (Staunton, 1987c: 2-3). Nurse education refers to a spectrum of nursing roles encompassing dependent, interdependent and independent relationships with doctors (Kozier et al. 1995: 138). While nurse education emphasises an independent role, most bedside nurses enter a dependent and occasionally interdependent role (Hodes and Crombrugghe, 1990: 75; Jones, 1994: 1-11). Again, the problem is seen as the resistance to change by the bureaucracy and the doctors, coupled with insufficient time having passed for the full development of the new nursing.

Autonomy, inappropriately, is seen as an inevitable consequence of a unique knowledge base, abstract theory and educational preparation (Slater, 1978: 40-43; Kritek, 1985: 356-359; Schorr, 1991: 38-40). It is seen as just one more attribute of a profession. The nursing leadership has continued to ignore the comments of such writers as Freidson and Willis on how autonomy was attained and is retained by medicine through a complex political process (Freidson, 1970b; Willis, 1989). Perhaps the nursing leadership continues to ignore this problem because it does not suit their own self-interested purposes. As I have argued, changes to nurse education have professionalised nurse academics by making them university academics, without much corresponding effect on the majority of nurses.
Despite the fact that the majority of Australian nurses work in hospitals, especially public hospitals, the changing emphasis in nurse education seems to be aimed at altering and expanding the role of the registered nurse in the community. Nursing assessment, nursing diagnoses and the nursing process, coupled with an absence of doctors, could enable community based nurses to exercise independent judgement. Separated from the hospital setting and free from medical domination, these nurses, just as Freidson implies, might very well be able to attain, through an altered nurse education, especially at the postgraduate level, some degree of professional status. Their autonomy cannot be considered as complete as that of doctors because the scope of the work permitted these community based nurses is carefully limited by legal regulations (Freidson, 1984: 14; Sherwood, 1991: 52). However, as Freidson has argued, the majority of nurses cannot professionalise as long as they are dominated by the presence of the medical profession in the occupational place of work. Hence, it is fallacious to consider that changes to nurse education of themselves can ever professionalise these nurses.

9.5. Professionalisation and Patriarchy

In Western society the traditional professions of medicine, law and university teaching have always been male dominated and are currently controlled by white, middle class males (Ehrenreich and Ehrenreich, 1973: 50). New professions such as architecture and engineering are also male dominated. These professions all have high status, privileges and financial rewards. In countries such as Russia, where most doctors are female, medicine has a much lower status (Roberts, 1980: 35). While increasing numbers of females have entered the traditional professions such as medicine they tend to be low ranking generalists, while the specialists and influential leaders remain males.

Most commentators on the sociology of professions would now agree that the privileged position of the professions arose through a complex political process involving patronage by the Church, aristocracy and State, which were also male dominated (Bullough, 1966). The elevated position of the professions was attained in the late nineteenth century in Anglo-American society. Many of the practitioners of medicine and law were university educated and had close relationships with the leaders of society (Ehrenreich and English,
If nothing else they were gentlemen. They were able to use this patronage to achieve legislation which restricted the activities of alternative providers of health services and this gave them a dominant position in their domains (Pensabene, 1980: 113). They were also able to restrict their own numbers making themselves a scarce and valuable commodity supposedly deserving of high remuneration and special privileges, including self-regulation (Aaronson, 1989: 274-279). A rewriting of the popular history of their professionalisation processes and the creation of attributes or functionalism served to justify their privileges and dominance (Freidson, 1970a: 83).

Many of the semi professions which service the full professions and aspire towards their own professional status are female dominated. They are more numerous in their practitioners, who also tend to come from lower socioeconomic backgrounds than members of the established professions (Muff, 1982: 224). Thus, elements of both class and gender are intertwined in the different positions of the professions and the semi professions (Willis, 1989: 202). While they have been acknowledged, issues of class difference as a root cause of nursing's problems have been of little concern to nurses. Gender issues as a cause of nursing's difficulties have dominated nursing's concerns (Gray and Pratt, 1995).

Nursing has become inescapably linked with femaleness (Hartnett et al., 1979: 57-67). Modern nursing was deliberately created by Florence Nightingale and her followers as a respectable female occupation. To ensure medical support, or patronage, for this new nursing it was necessary to subordinate nurses to the needs of the doctors. Nurses became the handmaidens of the doctors (Hodges, 1988: 50; McKay, 1993: 35-37). Over time the nursing leadership has come to see this relationship as an unwanted legacy of Nightingale's actions (Smith, 1982: 178). Hospital based nurse education and nursing practice traditionally occurred in a medically dominated patriarchal setting which reinforced the subordination of the female nurses to the male doctors (Batey, 1969: 4).

The patriarchal nature of health care is well documented by sociologists (Game and Pringle, 1983; Turner, 1986: 369; Bond and Bond, 1986: 301). Nurses have also come to recognise the patriarchal nature of nursing subordination. The nursing literature depicts male medical domination as a principal cause of nursing's dependency, lack of initiative,
powerlessness and low status (Beaumont, 1987: 48-51). Attempts to alter this male medical domination are used as a justification for changes to nurse education, hopefully leading to changes in nursing practice, which are presented as better for both the patients and the nurses.

Nurses have gotten it half correct. They correctly perceive that many of the problems with nursing are, to varying degrees, a consequence of the patriarchal domination of health care. However, in attempting to professionalise nursing in order to overcome these nursing concerns, they have ignored the patriarchal nature of professions and the contradictions inherent in trying to professionalise a female dominated occupation.

Professionalisation through changes to nurse education seeks to alter the nurse-doctor relationship from one of nursing subordination to one of nurse-doctor collegiality (Cohen, 1981). University based nurse education reduces the hospital socialisation of nursing students and substitutes tertiary socialisation in the absence of doctors (Weller, 1988: 179-184). The new nursing education seeks to create and impart a uniquely nursing knowledge, theories and terminology in order to make nursing different to, but equal with, medicine. However, nursing's emphasis on holism and low technology retains an association with femaleness as opposed to the dominant masculine reductionist, high technology medicine. Nursing's leaders seek to recruit more males into nursing in order to reduce the 'femaleness' of nursing (Speedy, 1990: 71). Unfortunately, nurses have fallen into the trap of accepting the ahistorical account of medical professionalisation and the possession of certain attributes as leading to professional status. Nurses ignore at their peril the considered argument that there "cannot be a female profession".

Professions arose at a particular time and place which no longer exists. Their practitioners used their gentlemanly associations to acquire a privileged and dominant position. Within any hierarchical organisation, such as health care, there can only be one profession, which, in this case, is medicine (Freidson, 1994: 116). Nurses are and will be for the foreseeable future part of a medical team. Thus, nursing cannot professionalise. Nurse academics successfully professionalised by moving across to an already established and still male dominated profession of university academics (Aaronson, 1989: 274-279). Independent nurse practitioners might be able to achieve some degree of professionalisation because in the
community setting they are often physically separated from the control of medicine (Freidson, 1970a: 69). Changes to nurse education can be seen as a strategy to professionalise nursing, but it is arguable that this goal is impossible to achieve because nurses are mostly female, far too numerous and mostly continue to work within a medically dominated health care system.

9.6. Conclusion

This thesis has presented a number of arguments about technological change in nurse education in N.S.W. as a consequence of its transfer to the tertiary education sector. It has shown that changes to nurse education in N.S.W. have been driven by a simplistic and fallacious nursing perspective towards the process of medical professionalisation. Changes to the technology of nurse education represent an attempt to recreate a similar kind of technological determinism said to have caused the professionalisation of medicine. In fact, the emergence of the established professions was the consequence of social and not technical considerations, involving complex interrelationships of politics and patriarchy. Once established the monopolistic practices of a profession such as medicine prevents the successful professionalisation of competing occupations such as nursing.

Educational rationales for the relocation of nurse education from hospitals to the tertiary sector were the overt arguments utilised by the nursing leadership in various official submissions and reports to the state government. They were based on the premise that tertiary nurse graduates would be superior nurses who would be more adaptable and flexible in a changing health care environment. These nurses would be capable of delivering a better and more cost effective nursing care because they would be educated to provide individualised and holistic total patient care which would meet the spectrum of biopsychosocial patient problems encountered in a variety of health care settings.

An examination of the nursing literature of the time and an analysis of the consequences of the tertiary transfer demonstrates that the more important covert reason for the promotion of this move was that it was viewed by nurses as a means of increasing nursing's occupational control over its work - it was a professionalisation strategy. Removal of nursing students from the control of both the medical profession and the hospital bureaucracies during
The critical years of their education would enable these entrants into nursing to be moulded by nurse academics towards so-called professional attitudes and behaviours. These nursing graduates would have obtained the specialised knowledge base, the code of ethics, the professional culture and the ability and willingness to make independent nursing decisions which were deemed essential in order to clearly demonstrate to non nurses that a new generation of professional nurses had emerged.

Despite the many seemingly valid educational arguments for the transfer, the decision to relocate nurse education was a device of political expediency by the state government. However, the nursing leadership claimed the transfer to the tertiary education sector as a nursing initiated victory and has continued to promote its own particular aims for nurse education.

Unfortunately the nursing leadership in Australia, following the American lead, assumed a simplistic professionalisation model incorporating a trait approach to professionalism which is inconsistent with more sophisticated theories of professions put forward by such writers as Freidson, Foucault, Johnson, Collins, Turner and Willis. Nurses have implicitly assumed that nursing would be professionalised if, like medicine, it had its own, unique knowledge base and code of ethics, acquired over years of tertiary study. Development of a professional culture, authority and autonomy would automatically follow from this. This would lead to occupational/professional independence, job satisfaction, financial rewards and increased status for registered nurses. These assumptions are problematic as sociologists of professions argue that medicine's professional status, in fact, resulted from a history of state enforced exclusion, limitation and subordination of its competitors, along with rhetorical claims of scientific legitimacy which were used to justify to the state and general public the need for special privileges and rewards for medicine. The professionalisation of medicine was primarily a political process with explicit class and gender dimensions which continues to necessitate male medical domination and female nurse subordination.

The simplistic technological determinist viewpoint equates the development of medicine's professional status with its progressively more effective scientific knowledge base and improved technology. This viewpoint is complicated by the idea of medical indeterminacy
which explains the social separation of doctors from patients, the general public and other health care providers. However, the new nursing technology promoted in tertiary based nurse education is inconsistent with both technological determinism and indeterminacy because it has a low technology and holistic emphasis. These incompatibilities undermine nursing's own approach to professionalisation through changes to the technology of nurse education.

The results of a university based education for nurses have been few and mixed. In spite of having taken on some of the traits or trappings of a profession, nurses continue to lack the essential autonomy and occupational control over their work which most authorities regard as the major defining features of professions. Nurses have failed to acknowledge that professionalisation is a political process. Because of medical domination of the health care system nursing will never be able to professionalise. As a consequence much of what is taught in tertiary based nurse education cannot be fully utilised by nurses in the work situation. Nevertheless, the present focus of nurse education in N.S.W. is likely to continue because it suits the ideology and aspirations of nurse academics and other important groups of nurses. It is unclear what will be the long term consequences to nursing in this state of the present emphasis in nurse education.
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