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Going into nursing: women describe their experience

Barbara Anne Bowler
University of Wollongong

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BARBARA ANNE BOWLER

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ABSTRACT

This thesis, based in the qualitative paradigm, investigates the reasons why twenty five women went into nursing and the impact that the experience of nursing had on them personally. The epistemological and philosophical foundations of the research are based within feminism.

Data were collected through five focus group interviews with two groups of participants. Group A had trained as nurses in hospital based training schools and had been practicing as nurses from between ten to thirty five years. Group B had graduated as registered nurses from tertiary educational institutions and had been practicing from between six months to seven years. The data were analysed using content analysis.

The findings from this research demonstrate a psychosocial and intellectual process through which both groups of participants passed. This process of learning how to be a nurse had positive and negative consequences for the participants and is described in their own words in this research. The desire to give succour to the sick and needy was common to all of the participants. Conflict however arose for some when this desire was compromised by the system in which they worked as nurses and also by the way society values (or fails to value) work that has traditionally been done by women. Group B participants described a dissonance between the values espoused in their education and the reality of working within the health care system. In seeking to understand the experiences reported by the participants, social attitudes to nursing and to women's work are discussed and the connections between them explored.

Due to the nature of this research and the small numbers of participants generalising the results to a population is not possible. Rather this research provides a starting point for understanding why women choose nursing as a career and how the experience of nursing impacts on them personally.
CHAPTER ONE - PROLEGOMENON

Understanding the experiences of women who undertake nursing as a career and how this career decision impacts on them personally has not been well addressed in the literature. The accumulation of myths and stereotypes regarding the role of the nurse have been handed down through history as beliefs about women and women's work and its value in society. Ideas about how a nurse should conduct herself and what it is that constitutes a 'good nurse' are constantly being promulgated through books and through the media and reflect traditional views of women and their place in the world. These strongly held societal views have personal consequences for women who undertake nursing as a career and this area is the subject of this research. The research found that the participants in this study underwent in their nursing training and practice, a profound psycho-social and intellectual process which has had effects on their lives as women and the way in which they view themselves.

In this introduction the reasons for researching this topic, a brief description of the two participant groups and the use of the literature are described. The philosophical and epistemological foundations of the research will be highlighted. A brief discussion of the use of the first person in academic writing along with discussion of the incorporation of the epistemological and philosophical approaches with focus group interview method will be described. At the end of this chapter there is an outline of the chapters to follow.

Reasons For Undertaking This Research Topic

The aim of this research was to examine the reasons why twenty five women chose to go into nursing and the impact they believe this has had upon them as individuals. The research was based within a feminist paradigm and utilised a qualitative method - focus groups.
The research investigates the complex area of gender and work. It shows how societal attitudes and beliefs coupled with the personal experiences of the women as nurses or trainee nurses had a profound impact on them as individuals and the way they view themselves. The focus groups gave these women the opportunity to speak for themselves in some depth and this thesis describes the experiences, ideas and feelings that they reported in relation to nursing, as well as examining the social and historical context.

I am a nurse. I spend my working life in the company of other nurses._ Working closely with other women and hearing what they say about themselves and their lives aroused my curiosity regarding women's reasons for going into nursing and the effects of this choice upon them. In turning to the literature I found that while a lot had been written by academics in sociology and psychology and by writers of popular fiction there was little written by nurses themselves about the experience of nursing. I wondered whether this gap in the literature and the ways in which nurses talked about themselves and, in particular their lack of confidence in putting forward a point of view and reticence in standing out from their peer group were connected in any way. The idea of elucidating some women's experiences of nursing began to take shape. Research into individual women's experiences of nursing could elicit information that has not been well documented or understood in the past and provide a different view to that gained in quantitative studies. A conscious gender decision would allow a focus on the participants experience as women and as nurses.

Understanding the participants personal experience of going into nursing and how this impacted on them personally has relevance in a number of areas. Firstly, there is the possibility of new ways of understanding the participants experiences in light of the approach taken in this thesis, that is its foundation in feminist ideology. Secondly, identifying those aspects of participants experiences that they found personally
empowering or disempowering could provide information about why women remain in nursing and why they leave nursing. Through listening to the participants the impact of and value attached to certain experiences and how women communicate these experiences may be better understood. Thirdly, supporting women who are nurses to speak out regarding their experiences may encourage more nurses to write and to research in this area and begin to build a body of literature. Fourthly, through the encounter of sharing their experiences and understanding them women who work as nurses may be emboldened to speak out socially and politically for themselves and for those that they care for.

The Participants

Data were collected from two groups of participants. Group A was comprised of fifteen women who had been registered nurses for between ten and thirty five years and who trained in hospital based schools of nursing. Eight of the women were currently working as Clinical Nurse Specialists (C.N.S.) in hospitals and the community and seven were working in a variety of high level positions in the private health care sector, education and industrial relations.

Group B was comprised of ten women who had graduated from tertiary educational institutions with a Diploma in Nursing. This group were in current practice as registered nurses in the public health sector and had been in practice from six months to seven years. One participant was employed as a C.N.S. For some of this group, employment had been elusive since graduation. All the participants worked in a major metropolitan city in New South Wales and all were working full time, apart from one participant in Group B who was on call with a nursing agency.

The findings of this type of research are not able or intended to be generalisable to a population. The methodology, including both the the number and the selection of
participants precludes this. The findings are nevertheless valuable in suggesting areas for further research such as how changes in nursing and nursing education are impacting on both individuals and the profession. The essential goal of this research is not to test a hypothesis or to measure or predict anything. The aim is rather, to elicit and understand in-depth the experiences of particular women in relation to nursing as a career, to relate these to social and cultural conditions and to create a fuller picture of the diversity and richness of these women's lives.

**Use of the First Person**

In contrast to traditional approaches to the research process this thesis is written in the first person where appropriate. Use of the first person occurs where I have described how my use of self was integral in the data collection process and where I offer possible explanations or opinions related to occurrences which arose during data gathering. Using the first person reflects my role as the medium through which the research happened. Use of the first person occurs frequently in qualitative work (Swanson-Kauffman 1986, Webb 1992). Webb (1992:747) argues that to write in the traditional, anonymous third person often required in academic writing 'is deceptive when applied to qualitative research because it obliterates the social elements of the research process' and that:

use of the first person is essential to counteract the notion that researchers do not influence, exercise choices and make decisions about the directions of their research and the conclusions they draw (Webb 1992:751).

An emphasis on backing up statements with evidence has meant in Webb's view, that researchers have tended to believe that offering a personal opinion is not permitted. While she supports the use of evidence, Webb also believes that researchers should have greater confidence in giving their opinion in the first person.
Philosophical and Epistemological Foundations

This research was designed within a feminist paradigm in which it is necessary to acknowledge a gender decision in research and the connections between ourselves as researchers and the people and issues we are studying. Feminism may in part, be defined as “a political movement for social change” (Harding 1986:24), and in particular for the same rights for women “that society accords men, particularly in the spheres of economics and politics” (Vance et al 1985:281). A feminist philosophy according to Speedy (1986/7:21) arises from the awareness “that women are oppressed and that their position in society results from patriarchal dominance”. While there are different theoretical and political stances within feminism, all promote equal opportunity for women, whether through changing structures such as the law or through challenging and redefining our understanding of the world and ourselves as women and men.

Duffy (cited in Parker and McFarlane 1991:65) states that;

Professional and public awareness, sensitisation, and advocacy for changes in the social, health and political policies that affect women are the essence of feminist research.

Whilst focus groups (the methodology used in this research), are not per se based in a feminist paradigm, they are as a method of data collection, consistent with the principle of empowerment in feminist based research. Duffy (1991) has identified criteria through which this principle of empowerment can be translated. These include the researcher being a women who approaches the task in an open and honest way and demonstrates equality and respect in her interactions with participants. The study should have the power to help the participants and the researcher, as well as be focused on women and eliciting their actual experiences. This research meets and demonstrates these criteria.
This research also aims to incorporate and maintain the relationship and integrity between feminist research and epistemology, as described by Campbell and Bunting (1991), Duffy (1991) and DeVault (1990). DeVault (1990:110) describes how articulating and naming experiences and writing about people's lives constructs and controls meaning and interpretation. Naming is political and has often resulted in the subordination of women through the ways in which information is interpreted and understood. In the feminist paradigm, the researcher is expected to be able to articulate her own experiences related to the area under study, and have insight into how this influences her understanding, as well as to appreciate the political and social context in which her own and other women's experience takes place. In this thesis, appendix three looks at my own experiences, whilst the political and social contexts are analysed and referred to throughout the analysis and discussion of the findings.

My ability to work well with people interpersonally and assist them to explore an issue was valuable in this research. The method demands that the researcher use herself in the research process and I extended this approach to include what DeVault (1990:112) calls listening and talking from a "woman's standpoint". Carrying out research within a philosophical framework that actively values women was important to me both personally and in terms of my academic pursuits. By seeking new ways (or adapting old methods) of obtaining knowledge, I believe that we may be led to new and different ways of understanding people and their experiences.

Use of Literature
A wide range of literature was consulted for this study. This included both historical and current texts in the areas of nursing, sociology, social psychology, psychology, women's studies and history. However, while these areas are relevant to the study of women's career choice, particularly the choice of nursing, and the impact that that choice has had on women, there is not a great deal that specifically examines the areas
addressed in this research. The literature which was relevant has been incorporated into the method, analysis and discussion chapters of this report where it is used to support and elucidate the data presented. The decision to use the literature in the body of the thesis was made because the literature that was helpful in understanding the issues that arose from participants accounts, seemed better placed adjacent to the verbatim data. This approach of incorporating the literature with the data, produces a compelling and powerful synthesis of participants experiences along with historical and contemporary approaches to understanding these experiences. The literature presented in this way, will not be further discussed here.

In this section, I briefly review some of the relevant theoretical concepts and theories relating to gender and sex roles and discuss the available studies dealing with nursing as a career choice and how these relate to my study. Some of these concepts and studies are referred to in later chapters.

Before further discussion, it is important to note the country of origin of the literature involved. Whilst Australian researchers such as Curthoys (1988), Game and Pringle (1983) and Power et al (1985) have made valuable contributions to the literature in the realm of women's work, career choice and nursing, most of the literature has been generated by American scholars. Much of the American literature is useful and has along with the Australian literature been used in this thesis. In relation to nursing as a career choice and as women's work, however, the differences in culture between the countries and in particular the differences in the education and health care delivery systems might be expected to affect the interpretation of data and results and there is a need for caution in extrapolating to this country.
Biological Theories Related to Work

Biological determinist theories explaining the differences in behaviour between men and women date back to the last century (Salzman 1977 and Sayers 1982). Gould (1981) traces the use of statistical tools to perpetuate common cultural beliefs related to these perceived differences. Craniology, criminal anthropology and innate I.Q. were all theoretical constructions developed to explain the inferiority of undesirables, minority groups and women. Proponents believe that 'biology is destiny' and that sex role differences are due to the genetic inheritance of particular patterns of existence and activities as natural propensities in each sex (Leibowitz 1986:43). As Rogers (1988) points out, explaining such divisions as natural and inevitable assists in maintaining sex segregation in the work force and social and political inequality between the sexes. A frequent explanation of the division of labour by sex is that males have the physique for work that requires a greater size and physical strength, while the prolonged rearing period of the human infant has required the females to stay at home. Most or all societies today have some sexual division related to work (Leibowitz, 1986:45).

Jaggar (1983), however, takes the view that many of the physiological differences between females and males are produced by different diet, exercise and work patterns and that procreation and sexuality are as much socially constructed as they are biologically based. Lorber and Farrell (1991:357) believe that;

although the physiological differences have seemed a natural starting place for the social construction of gender, anthropological studies suggest that the division of duties pertaining to food production and childrearing is more central to gender as a socially organising principle than dichotomous procreative biology.

Along a similar line, Connell (1986) maintains that biology is relevant to but does not determine social structures and that social processes deal with but are not determined by biological patterns.
Harding (1986) points out that much of the research in this area is androcentric in that it is highly abstract and attempts to mimic the physical sciences in objectivity through the use of statistical methods. This has hidden its own gendered character and therefore ignored or diminished women. An example of this is Wilson (1978), who claims that men rule the corporate world and women perform the domestic labour because this reflects the origins of human experience and behaviour when the men went together to hunt down wild animals and the women stayed at home with the children. Australian scholar and feminist Curthoys (1988) argues that while it is important to acknowledge sex based biological differences, biology can not be used to justify social inequality. Rather, the universality of biological duality between females and males could be used to understand the past and to guide us towards a future based on social justice rather than on biological differences. The biological approach in relation to the sexual division of labour becomes less and less credible as attitudes to women's work and men's work alter over time and types of work alter in status and prestige.

Social Theories Related to Gender and Work

In a social or political perspective gender can be viewed as the relations between men and women - the way in which gender is socially constructed and played out (Game and Pringle 1983). Occupational sex structuring based on gender and cultural and social stereotypes is clearly demonstrated within the health professions. Feminist writers agree that occupational structuring by gender is rooted predominantly in patriarchal values and beliefs (Garmanyikow 1991, Greenleaf 1980, Hamby 1982 and Game and Pringle 1983). Ashley (1976) provides a powerful analysis of the effects of patriarchal structures on the politics of care and the effects of male dominance in health care. Ashley was influenced by other writers such as Daly (1978) and Rich (1976) who wrote with concern regarding the treatment of women patients in the health care system. Ashley's work focused on nurses and has made a significant contribution towards nurses gaining a deeper understanding of their proscribed roles and social
position. Her work mentions, but does not analyse the historical context in which early nursing leaders often colluded in their oppression.

Power et al (1985) uses Australian Bureau of Census and Statistics figures to demonstrate the institutional discrimination experienced by women in the work force and suggests a number of reasons which are discussed in the body of this thesis. Her approach to understanding the relationship of gender to work is economic and social and combines the use of survey method research with economic and political theory. The issues related to discrimination and segregation are described in broad terms and not at the personal level of their impact on individual women, as in this research.

A vast amount of research has been generated in the area of sex roles and gender over the last century. Unfortunately much of this lacks replication or has become out of date due to the rapid social changes in attitudes and beliefs related to women, women's work, sex roles and stereotypes (Kritek 1988).

Most of the relevant research investigates one of four main areas; sex differences, sex roles, women as a minority group and the politics of caste (Hardy and Conway 1988). Sex difference research focuses on emotional and cognitive personality traits whereas sex role research focuses on roles and their proscribed activities, role conflict and role models. Much of the research carried out in this area has used the survey method which is useful in describing the characteristics of populations and establishing the interrelationships between variables (Polger and Thomas 1991). However most studies cannot be generalised to nurses as sample selections were constricted to groups such as college students, house wives or professional workers (O'Leary 1974).
Nursing as a Career Choice

The following research described in the literature has been useful in understanding the sort of work that has been done in relation to nursing as a career. Game and Pringle (1983), Horsburgh (1989) and Lewin (1977) focus directly on nurses and have been particularly useful in interpreting the results of this research. The other research cited in this section relates to nursing as a career choice among high school children or nursing students at entry into university nursing programs and is useful because it reflects societal values related to women and work.

Lewin (1977) used feminist theory along with qualitative and quantitative research methods to determine whether the emphasis on education and professionalism for nurses conflicted with the sex role construction held by this group. She did not explore the question of why women went into nursing. The sample consisted of 189 female respondents who were first surveyed as students in colleges of nursing and again ten to fifteen years after graduation. Open ended interviews were conducted with seventeen of the 189 respondents and focused on descriptions of the women's lives since nursing school and the issues that concerned them. The survey questionnaire included multiple choice and open ended items and dealt with the respondents work experience, their views on issues affecting nursing, their opinions on the status of women and appropriate sex role behaviour. Items included statements such as "if a married women must work, her first thought should be for the economic well-being of the family and not for her own career and ambitions" (Lewin, 1977:98) and were scored from strongly agree to strongly disagree using a Likert scale. The data were analysed through content analysis and through the use of statistical procedures. Lewin's analysis is still most useful in its powerful demonstration of the attitudes, beliefs and experiences of a particular group of nurses, but it lacks replication and is becoming somewhat out of date. Her study demonstrates how two quite different research methods can be used effectively to make sense of data.
Horsburgh (1989) used a natural field work study to understand new graduate nurses initial adjustment to employment. Data were collected through the use of participant observation, comprehensive field notes, questionnaires, interviewing and diary keeping by the participants. Whilst the number of participants in this study was small (ten) and the participants were all graduates of the same school of nursing, care was taken to establish credibility in the conduct and outcomes of this study. The strategies employed included prolonged engagement, persistent observation, triangulation, peer debriefing, negative case analysis and host verification. Horsburgh’s study addresses with rigour the problems new graduates experience in their initial employment and is the first major study in this area in the Southern Hemisphere (conducted in New Zealand) since the transition of nursing education into tertiary institutions. It has some similarities with this research in that in depth interviews were used, and some of the participants were new registered nurses who experienced ‘reality shock’ in relation to their initial employment. The term reality shock was first used by Kramer (1974) to describe the process undergone by new graduates in her extensive study of role conflict and role deprivation. Reality shock was found to be appropriate in describing both Horsburgh’s work and some of the findings of this research. The small homogeneous sample used by Horsburgh precludes generalising to a larger population.

Kersten et al (1991) utilised an exploratative descriptive study into why 752 undergraduate nursing students from various geographical, educational and cultural backgrounds chose nursing. Demographic statistical data were obtained and through the use of open ended questions, qualitative data were collected by questionnaire. The qualitative data were analysed by content analysis with inter-rater reliability being established among the researchers, although the degree of this reliability was not stated. The authors acknowledge that potentially useful information that this study did not seek, would have included such questions as what life or previous work experiences influenced your choice of nursing and at what age did you decide to do nursing? These
questions are not explored here or elsewhere in the literature and relate to the areas focused upon directly in this research.

In response to concern at falling enrolments in nursing courses, Kohler and Edwards (1990) designed a questionnaire using a Likert scale format to identify the beliefs of high school students about the education, status, earning power and working conditions of registered nurses. A total of 306 students (176 girls and 126 boys) participated. The results showed that the majority of students considered that the education required for nursing was too costly and that they perceived nursing to have a low status as well as to lack job security. The study was carried out in a small middle class urban area and different results may have occurred with a different population. Also the study does not identify how students came to hold these perceptions or explore experiences which may have influenced their attitudes.

Currie (1982), surveyed 1,514 twelfth year students in Western Australia in order to examine the sex factor in occupational choice. Females indicated a range of 74 occupations and males a range of 101 occupations. The most striking finding was that 50 per cent of females chose either teaching, nursing or therapy. Currie suggests that girls choose jobs that are humanistic, based in the so called ‘soft’ sciences and that are complementary in nature such as nursing, social work and therapy and that job choice for girls remains contingent on non job related factors such as marriage and child rearing.

Whilst all the literature included either here or in the body of this thesis has informed this research, it should be noted that little related directly to the areas addressed in the research. The lack of a contemporary in-depth understanding of the lives of women who take up nursing, their beliefs in relation to the decision to undertake nursing and the impact of this decision on them is an apparent gap in the available research
literature. Game and Pringle (1983) are the exception in that they report briefly, in their book Gender at Work (1983), on the reasons why some women undertook nursing and the impact that their experience of training had on them. Some similarities and comparisons with the findings of this research are included in chapters three and four in this thesis. Unfortunately Game and Pringle include only a small amount of data in their report and do not examine in depth the experiences of women who go into nursing.

The research reports cited above address some aspects of women's experience of nursing and of societal attitudes related to nursing as an occupation. This research begins to redress the gap in the literature related to an in-depth understanding of the impact of the experience of nursing on women and their lives.

In the remainder of this report;

Chapter two describes the qualitative methodology used and the experience of putting theory into practice.

Chapter three presents the findings along with supporting literature. It also describes content analysis and its use in analysing the data.

Chapter four is a discussion of the issues which arose out of the data and incorporates relevant literature. The implications for further research and the limitations of this thesis are discussed.

There are three appendices.

Appendix one - the consent form which was signed by each participant prior to data collection.

Appendix two - the guideline questionnaire which was utilised in the focus group interviews. Both appendix one and two are referred to and discussed in the body of the thesis.
Appendix three - in which I describe the impact of early life events on me and later
my experience of nursing and how these events and experiences have shaped the
person I have become. I believe that it was important to ask myself the questions I was
asking the participants. Through the process I realised that I was asking the
participants to share information and experiences which had the power to evoke
memories and feelings which might be painful, or difficult to speak about due to their
intensely personal nature. This reinforced in me a sensitivity in the way I approached
each woman’s story and reflected on the data I was given. Stacey (1988:22) describes
how feminist based researchers are encouraged to;

seek an egalitarian research process characterised by authenticity, reciprocity
and intersubjectivity between the researcher and her ‘subjects’.

Through understanding my own history I was able to more fully embrace these values.
Appendix three is not discussed further in the thesis.

In conclusion, this chapter has introduced the research topic and given a brief outline of
the two groups who comprised the twenty five participants. The relevance and
usefulness of the research has been suggested and its philosophical and epistemological
underpinnings outlined. The reasons for diversions from the traditional ways of
presenting research such as use of the first person and telling my own story (see
appendix three) are discussed briefly. The way in which the literature has been utilised
has been described and the lack of specific literature which describes the experiences of
nurses and the impact of these experiences on them has been commented upon.
CHAPTER TWO - METHOD

This chapter will address the issues related to the theory and practice of using a particular method to collect data. Focus group method as an approach is described in detail in part one of this chapter with reference to relevant literature in the area. The reasons for the selection of the method and its advantages and disadvantages are discussed and the pivotal role of the facilitator in the data collection process is emphasised. In the second part of this chapter the details of my own experience in putting focus group method into practice is described along with a description of each of the five focus groups conducted. The reality of putting theory into practice is discussed as well as the divergence this research took from the ideal described in the literature.

Part One

Data were collected using focus groups. Focus groups have been utilised in research to extend understanding of a wide variety of health issues including tropical disease research (Khan and Manderson 1992), the effectiveness of counselling for nurses working in a hospice (Gray Toff 1980), and identifying benefits that guide consumer choice in selecting health care services (Flexner et al 1977). The decision to use focus groups to collect data was made after I attended a workshop on the utilisation of focus groups in public health education areas and had read relevant literature on the subject.

The use of this method was in harmony with my epistemological framework and philosophical beliefs, which are based in a feminist paradigm. As Gadamer (1975) argues, all research contains value laden understandings which arise out of the cultural context of the researcher. These values are not vices in the research process but necessary ingredients which guide the process towards its outcomes. Acknowledging the values inherent in the culture and in a research methodology contributes to producing research which is useful and meaningful to the participants and ultimately the wider society. Buker (1990) and Harding (1986) have argued convincingly that the
positivist claim to neutrality in research is a fiction that demonstrates the unconscious affirmation of the dominant forces in society.

Focus Groups

Focus groups are a qualitative method of eliciting and gathering the thoughts, feelings, opinions and attitudes of a group of people. Initially, (since the first decade of this century) focus groups were used in market research to test consumer opinion of products or ideas for new products (Basch 1987). Focus groups were little utilised for other types of research until quite recently when public health promotion programs used this method to assess the impact of educational materials on specific groups. The other area in which this method is now being increasingly used is in social science research (Basch 1987).

A focus group can be defined as a formal structured group, with participants who have come together to discuss a specific issue within a time frame. Authors including Merton et al (cited in Basch 1987:422) describe a number of uses for focus groups. These include establishing the likelihood of a relationship between variables in a study, that is the internal validity of the study, gathering information which may contradict previous theories and while speculative at this level of investigation indicate future directions for research, and gathering responses from which tentative interpretations may be made regarding participants' experiences. Authors such as Basch (1987), Kahn and Manderson (1992) and Murphy (1992) agree that focus groups have particular features that are useful in social science research. They comment that they are frequently being used today to gather material in the realm of the psychological and socio-cultural domains where both conscious and semi-conscious information may be required.
Data obtained by this method are not generalisable to a population, rather they generate possible hypotheses for quantitative testing and suggest areas for further investigation within the qualitative paradigm. Focus groups may also be useful in exploring results from quantitative research.

Focus groups are able to provide information about why individuals behave in certain ways and their beliefs about specific subjects. Data gathered by this method do not reflect the strength of positions taken by the participants in relation to the issue, but rather, by probing beneath the surface of socially acceptable responses, provide access to feelings and ideas at a deeper and more personal level. To achieve depth of disclosure the facilitator must establish quickly an atmosphere in which participants feel safe to express themselves. Basch (1987) and Murphy (1992) emphasise the importance of creating a pleasant physical environment in conjunction with a safe psychological environment.

Morgan (1988) suggests that the number of focus groups used to investigate a particular issue is dependent on the variability of the data required but one group is never sufficient. Once the researcher can accurately predict the outcomes of a focus group meeting then no more groups are necessary. In this research five focus groups were conducted.

Murphy (1992) recommends having six to eight participants in a focus group. Less may impede gathering sufficient data, particularly if one or two of the participants are not very forthcoming. Members in a very small group may feel under considerable pressure to perform and this may reduce the quality of the data collected. There is also more possibility of one member dominating a small group. Too large a group may make it more difficult to establish enough trust for participants to be able to express themselves openly and quieter group members may be overlooked or feel intimidated.
by the size of the group. The number of participants in the focus groups in this study varied, with two in the smallest group and eight in the largest. The perceived effect of the size of the groups is discussed in part two of this chapter.

Focus groups are usually audio taped and this procedure was followed in this research. Audio taping frees the researcher from manually taking notes so that attention can be focused wholly on the group. The facilitator should explain the reasons for audio taping to the participants. These include the necessity to recall what is said with accuracy and that taking notes may be intimidating as well as distracting for both participants and researcher. While the audio tape provides the main material for analysis, a record of the researcher’s observations of the interview, whether made during or preferably immediately after the group enhances the quality of the data.

Khan et al (in press cited in Khan and Manderson 1992:64) found that the use of audio rather than video taping provided for the most accurate interpretation of the data and that it was faster and easier. However “the validity of the findings also depends on how the transcripts are analysed” Khan et al (in press cited in Khan and Manderson 1992:64). Validity is often defined as “the extent to which a test measures what it is meant to measure” (Polger and Thomas 1991:333). However, while still relevant, this is not such a satisfactory definition when engaging in qualitative research. Guba and Lincoln (1981) suggest credibility rather than internal validity as the criterion against which the truth value of qualitative research should be measured. This means that the researcher presents a faithful construction of the events that occurred within the research process and that they represent the human experience that the participants undertook. Other researchers and readers should be able to understand the experiences described from reading the report. Participants in the research should be able to recognise their own descriptions or interpretations of them. Hammersley (1992:69) concurs, and further suggests that in conceptualising validity it may be useful to
understand it in terms of "subtle (as opposed to naive) realism." Validity and reliability in the analysis of the data obtained are further discussed in chapter three, part one.

Criteria for selection of participants and the use of homogeneous or heterogenous groups need careful consideration. Calder (1977) suggests that homogeneous groups have a greater likelihood of being able to establish expeditiously some degree of trust in the group and therefore higher levels of interaction. Homogeneity in demographic details, life experience and socio-cultural aspects may facilitate this process. Using heterogeneous groups provides a more diverse information base but group interaction may be compromised if the participants are too disparate. It is important that the researcher select participants and the type of group appropriate to the issue under examination and the aims of the research. In this research, focus groups were run with two different homogeneous groups of participants.

Basch (1987) and Calder (1977) recommend that group members not be known to one another prior to the focus group. These authors suggest that this increases the likelihood of members being able to participate without feeling inhibited by relationships with other members outside the group and that anonymity of the members increases the possibility of in-depth disclosure. Many of the participants in the focus groups in this research did know each other and this divergence from the literature and its perceived outcomes are discussed in part two of this chapter.

Confidentiality and informed consent to participate in the research are also important, although current literature on focus groups does not emphasise these issues. Participants have the right to be assured that information given in the focus group will be confidential and each participant must agree to this condition (see informed consent form, appendix one). The storage of the data and access to it must be carefully planned and the researcher needs to clarify for participants the steps being taken to maintain
confidentiality. Participants must also be given the opportunity to withdraw from the research at any time prior to, during, or after data collection. Obtaining informed consent is an important and necessary part of the process, although sometimes problematical in qualitative research, as explanations given to potential participants may not convey the extent of the personal information they may find themselves divulging. As Robinson and Thorne (1988:66) point out:

of concern is the reality that the nature of qualitative inquiry precludes prior knowledge of precisely what will occur in the context of the research encounter.

As focus groups operate within a time constraint, the facilitator must make decisions whilst the group is in progress regarding areas for further investigation and those areas which may not be so fruitful or pertinent. Kahn and Manderson (1992:57) explain that the facilitator cannot follow up individual issues in great detail. However one of the strengths of the method is that the discussion stimulates the memories and feelings of participants and this may lead to new and rich material. Flexibility, as well as careful thought and planning on the part of the researcher is necessary in order for this method to be useful.

The Role of the Facilitator

The researcher is the tool (Murphy 1992:5).

The facilitator has a key role and is vital to the conduct of focus groups. All the relevant literature emphasises the significance of this role and that outcomes rely heavily on the skill of the facilitator in establishing an atmosphere where participants feel able to express themselves, to disagree with another and to go beneath the usual socially acceptable and expected responses.
Basch (1987) emphasises the importance of preparation prior to the focus group. The researcher should be clear as to the aim of the group and have formulated questions to guide the focus group (see guideline questions, appendix two). Nyswander (cited in Basch 1987:415-416) outlines lack of group cohesiveness, individuals becoming insecure and unproductive, high status participants or more dominant personalities attempting to define goals for the group while less dominant participants withdraw, as the likely consequences of having unclear aims for the research process.

Questions should introduce the topic in a non threatening manner and be general in nature to “warm the participants up” (Murphy 1992:3). The facilitator needs to be flexible and decide as the focus group progresses whether certain questions are irrelevant or have become redundant, or whether questions have not been addressed in sufficient depth and need further exploration. Khan and Manderson (1992) raise the issue of the personal style of the facilitator in relation to the validity of the conclusions drawn from the data and ask such questions as:

How much flexibility should a moderator have to provide, encourage, cajole, push and prompt participants? To what extent does personal style and tone affect participation and the validity and reliability of the responses within the group, or foreclose discussion because of perceived disapproval or resistance? (Khan and Manderson 1992:64).

Clear guidance from the facilitator about what is expected will assist in creating sufficient trust for participants to talk about the issue and not feel judged or ridiculed. The ability to draw out quiet, shy participants and to tactfully and respectfully manage aggressive or dominant participants is important. The facilitator must be constantly monitoring the dynamics of the group, noting non verbal cues and any questions which the group appears to find difficult to answer. Disagreements among members must be managed and everybody given the opportunity to give their point of view on the issue.
Clarifying areas of consensus and of dissension and asking for further information is important.

The facilitator must be able to get the discussion started with some questions that will help participants relax and begin to talk and should place the more difficult or controversial questions later in the focus group. The facilitator also is required to be able to summarise the discussion as it proceeds and to check with the participants that she has understood them correctly. Ensuring that the area under investigation has been thoroughly explored, that the guideline questions have been addressed and that there has been sufficient time for collecting data that may not have been considered pertinent or thought of prior to the focus group are important tasks. Whilst it is possible for the facilitator to review guidelines or manuals on running focus groups, Basch (1987) recommends that expertise is best gained by practice. This practice should include the selection of participants, developing the questionnaire, running the group, and data analysis.

**Disadvantages of Focus Groups**

Focus groups are not useful for testing hypotheses, for drawing inferences about large populations or for statistical testing (Basch 1987). Whilst the cost of running focus groups may not be as high as using individual interviews they can still be costly and as Basch (1987) points out may, depending on the issue being researched, require a highly trained facilitator. The setting needs to be conducive to sharing personal information and this may increase the cost of the focus group. Comfortable seating in a room that is pleasant and private is desirable with access to tea and coffee making facilities. Using a venue which is neutral territory is helpful as work settings or peoples homes may be inhibiting for participants.
Participants need to be verbally able and willing to express their views in a public forum. This may exclude the experience of people with hearing and speech problems, the very young, the very old, and others unwilling or unable to share their views in such a setting.

The data obtained rely heavily upon the ability of the facilitator to create the climate in which participants feel safe to share. If this is inadequate due to lack of interpersonal skills, poor preparation, or lack of training in this method of data collection, the quality of the data obtained will suffer. In a focus group it is not possible to explore one facet of an issue in-depth with an individual participant. It may however, be possible to use individual interviews to follow up on an issue if this is likely to give more depth to the analysis and outcomes.

Bellenger et al (1976) believe that this method may lend itself to supporting preconceptions more easily than other methods. This has implications for the validity of the data and Murphy (1992) recommends that the primary researcher not be involved in the data collection in order to keep their preconceptions from influencing the focus group. This recommendation however, is only tenable where resources allow and it does not acknowledge the feminist paradigm which regards the researcher’s self awareness in relation to the research, including acknowledgment of her beliefs, experiences and prejudices as integral to and important in the data collection.

In a related concern Basch (1987) suggests that there are no standards for judging the veracity of the conclusions reached and questions how standards, if they existed, could be applied to data obtained from focus groups. This concern falls into the realm of interpretation theory and concerns the methodological status of the social sciences and in particular qualitative research. These issues are further discussed in part one of chapter three. One response is that of Madison (1988:Chapter 2), who rejects the
notion that this type of data lends itself to an interpretation or conclusion that is "correct in itself", but nonetheless argues strongly that methodological rigour in interpretation is both possible and necessary. He proposes such criteria as coherence, comprehensiveness, penetration, thoroughness, appropriateness, contextuality and suggestiveness in establishing rigour.

**Advantages of Focus Groups**

Focus groups are a useful method for uncovering the beliefs, experiences and attitudes of groups of people. As well as gathering the information asked for this method also has the potential to uncover as a by product, other important information that may not have been anticipated.

Focus groups can provide a starting place for gathering information about a topic prior to quantitative or more in-depth qualitative investigation. Exploring sensitive issues which have come to light in quantitative research is possible with this method. As the data are permanently recorded they are available for analysis and reanalysis in the light of emerging questions.

Bellinger et al (1976) believe that using this method reduces the emotional pressure on participants as they do not have to respond individually to every question as they may feel bound to in an individual interview. Foch-Lyon and Trost (1981:445) argue that participants may feel more able to reveal attitudes, beliefs and behaviours about sensitive issues in a group situation rather than in an individual interview. This argument is based on the belief that participants will become caught up in the process of the group and feel more able to self disclose among others who have had similar experiences, especially if the facilitator has been able to provide a permissive and understanding milieu. Basch (1987) suggests that group norms which are not present
in individual interviews or in written questionnaires, may inhibit participants from providing misleading information.

Focus groups also lend themselves to flexible and innovative methods of data collection such as conducting groups on site or using telephone link ups (Basch 1987). Conducting a focus group on site (e.g. with adult skiers at a ski lodge) has the advantage of easy access to a homogeneous group and a telephone link up may in some cases reduce costs.

In a focus group, the skill of the facilitator is the primary factor in whether the method provides useful data. A good facilitator can create both physically and emotionally an environment in which participants may feel safe and willing to express themselves in-depth.

This section has discussed the details of using focus groups as a method of data collection and has utilised the literature in support of the approach. The role of the facilitator has been emphasised as being essential to the data gathering process and the methods strengths and deficits have been addressed.

Part Two

Focus Group Method - My Experience

Part two will explore my experiences of each of the five focus groups conducted. The participants, the ways in which they were selected, and the experiences we shared in the process of gathering data will be described. I will also comment on the extent to which my expectations of this method were realised in practice.

I selected two different groups of women for the focus groups. Group A were registered nurses who trained in the hospital system and had been in practice for ten
years or more. Group B were registered nurses who had graduated from university schools of nursing and had been in practice for less than seven years. The question guidelines (appendix two) drawn up prior to holding the focus groups were similar for each, with some additional questions regarding proposed career paths and the decision to choose nursing for Group B. The following figure shows the number of participants in each focus group.

Figure 1

<p>| Number of Participants in Each Focus Group Interview |
|---------------------------------------------|-----------------|</p>
<table>
<thead>
<tr>
<th>Group</th>
<th>Focus Group</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (hospital trained)</td>
<td>One</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Two</td>
<td>7</td>
</tr>
<tr>
<td>B (tertiary trained)</td>
<td>Three</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Four</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Five</td>
<td>3</td>
</tr>
<tr>
<td>Totals</td>
<td></td>
<td>25</td>
</tr>
</tbody>
</table>

I started with recruiting participants in Group A (the more experienced and hospital trained nurses) as I felt that I would be most comfortable with a group of my peers. While Murphy (1992) recommends that the primary researcher and the focus group facilitator are different people, for philosophical and resource reasons this research was generated and carried out by myself.

It was difficult to recruit participants to each of the five focus groups. Possible reasons for this include that I am new to this country and do not have an established professional network here. This meant that I was reliant on the goodwill of others to introduce me to potential participants and I found asking unknown people to make a two hour commitment in their own time a difficult process. I received a number of refusals, but was generally encouraged by the willing and often enthusiastic response
of many of these, as yet, unknown women. It was interesting that potential Group B participants proved to be less reliable in keeping their agreement to participate than those in Group A, who almost without exception kept the commitment.

Deciding the best place to hold the groups was also problematical. As I could not afford to hire a room which would provide both private and neutral territory, two of the focus groups with Group B were held in my home and one at my work place and the two focus groups with Group A were held in participants' homes. While these environments were adequate, and their drawbacks managed, none were ideal and I would recommend for any future research that neutral territory be established.

**Group A - Focus Group One**

This group was convened from one initial contact and then by each participant providing the names of other potential participants. This did not allow for anonymity as the literature suggests and in fact, I found that most participants were keen to be among friends or colleagues and were more willing to participate if they knew some of the others. One of the participants offered to have the focus group at her home, an offer I accepted partly because the only other choice was my home and partly as I appreciated the generosity of her offer and did not want to turn it down.

The focus group was held in the evening after a meal together that was provided by participants and myself. The meal provided an opportunity for me to meet the participants and set up my tape recorder and for participants to relax and chat. I described my background as a nurse and as a student and the research in general terms. After the meal, I gave each participant a copy of the informed consent form (appendix one) and read it through aloud with them. Participants asked whether there would be an opportunity for them to share the outcomes of the research and I explained my intention of posting written feedback to all those who were involved in the research.
The need to tape record the focus group interview so as to get as accurate an account of
the proceedings as possible was explained to the participants. I also explained that by
tape recording, the data could be revisited over and over and perhaps new and useful
insights gained. I described my role in the focus group as the person who would ask
some questions, follow up on issues and ensure that they all got the opportunity to
speak. The participants were asked to try to speak one at a time to make transcribing
easier. A rough sketch was made of where people were sitting, which I found useful in
transcribing the tapes as I could usually identify the speaker by how close or far away
they sounded from the tape recorder. Overall I was satisfied with my explanation of the
focus group to the participants and with how readily they understood the research and
data collection process.

This group of participants were all women who had trained in the hospital system and
by now, been registered nurses for between ten and thirty five years. They all had very
successful careers and were in positions of responsibility in private industry, industrial
relations within the health field, and in nursing education. Of the eight participants one
was currently married with a grown up family, one was divorced and the other six
were unmarried. Their ages ranged from thirty three through to the late fifties. All the
participants were pursuing or had completed studies at university level and expressed
commitment to higher education. They were very articulate and appeared to be
cognisant of the current debates in health care which were discussed before and after
the focus group interview.

They all lived in the inner city region of a major city in New South Wales, worked
Monday to Friday and also sometimes bought work home to complete in the evenings or
at weekends. Due to the positions they held I assumed that they were all earning well
above the average weekly wage for women and were able to enjoy a financially
comfortable lifestyle. My impressions were reinforced by their clothes which were
sophisticated and professional. This image was augmented by their self confidence and assertiveness in expressing themselves.

These participants had a good understanding of the research process and approached the focus group with enthusiasm and curiosity. No one was especially keen to go home after the focus group interview was concluded and we spent an enjoyable hour sitting and talking afterwards. The participants asked to meet again to share the outcomes rather than receiving the information by post and I agreed to do this. A number said that they found the focus group an interesting process and that they had not really thought about their reasons for nursing and their early experiences of nursing for many years. They were willing for me to phone them to clarify any issues and were warmly supportive of me and my work.

**Group A - Focus Group Two**

This group was set up after my being given access to a university class of postgraduate nursing students. The advantage of this access was that people were not put on the spot on the telephone as I felt they perhaps had been with the first focus group. I presented a broad outline of my research to the class and asked them to write their names and telephone numbers on a circulating sheet of paper if they were interested in participating. This worked well in getting about twelve names. Some of these were not able to participate but recommended other friends or colleagues from the course and after many phone calls, I obtained seven participants.

This focus group took place in a south western suburb of a major city in NSW in the home of a participant. I arrived a little early to meet the hostess and set up my equipment and I took flowers and a cake for the hostess. Food for the group was being baked as I arrived and as I chatted with the hostess and her husband she put huge quantities of food on the dining room table. I felt quite awkward as I realised that this
woman had been on an early shift in an intensive care unit all day and on returning home had fed her three children and her husband and then baked for the focus group. The home was a very busy place with three adolescents and their friends, music, television and the phone all vying for attention. There were frequent admonishments from the parents as the children whipped food intended for the focus group off the table. Gradually the seven participants assembled around the dining room table and the children and the hostess's husband disappeared.

This group were all employed within the public health system. They worked as registered nurses in the community or in specialised units within a hospital e.g. intensive care. One participant was a Nursing Unit Manager and all the others were Clinical Nurse Specialists. This group were currently completing a graduate diploma and two were considering commencing or converting to a post graduate degree. They had been nursing between ten and twenty five years and all except one were married with children. Most of them knew each another from their course at university and talked about these classes when they first arrived.

I used the same format to introduce the focus group interview as I had with the previous group. I detected a lot more initial hesitancy in this group in that they were generally less enthusiastic and asked for more personal information. I was asked about my impressions of the university we all attended and of various staff members and some participants seemed a little concerned that I might report to lecturers on what they said. Two of the participants advised me that doing a Masters in Nursing was a waste of time and that they would never consider it for themselves. I found myself being very careful in what I said and reiterated the confidentiality of the focus group interview and the data. Some participants wanted to know what the first focus group had said before beginning but, after further explanation of the process, they accepted my suggestion that it would be better to wait and see what came up in this focus group.
This group was more challenging than the first, and I had to work harder to get the focus group functioning and to help participants feel safe. Providing the requested information about myself as a nurse seemed to be helpful in reassuring participants that I was trustworthy. I did not emphasise my academic pursuits and in retrospect realise that I did this intuitively, from the feeling that this may have felt threatening to them. All of this group, except for one, were very family orientated and frequently made reference to their husbands and children both during the focus group interview and before and after the interview. A number of the participants worked shifts and all except one were involved in direct patient care. Fatigue was an problem for many and this group was keen that we finish on time so they could get to bed.

By the end of the focus group interview the participants were much more relaxed and open and were also keen to meet again with me rather than receive the results of the research by mail. This group also expressed how they felt personally more enlightened and aware at the conclusion of the interview.

The hesitancy and reticence of this group in the initial stages of the focus group was an interesting phenomenon. Participants in this group were quite different from those in the first focus group. They seemed to be subject to more and diverse demands in that they had families, they worked in direct patient care (except one) within the public sector of health care delivery, they were working full time, and they were undertaking part time university study. They lived in a suburb that was predominantly working class and their dress on the evening that I met them was very casual. They would probably be earning less than the first group and have more financial commitments due to their families. Their lives appeared to be very hectic and demanding.

The two focus groups conducted with Group A participants were exciting and the data dense and rich. The difference in the way the two groups approached the focus group
interviews was particularly interesting and was perhaps influenced by the differences demographically between the two groups.

**Group B**

Three focus groups were held with Group B participants. These participants had been in practice for six months to seven years and had all graduated from tertiary institutions with a Diploma in Nursing.

Group B participants were the hardest to locate and assemble. Not only was gaining access to this group more difficult but they were not reliable in attending the focus groups as arranged. There are many possible reasons for this, perhaps mostly related to their being a younger group. The meetings were not held on neutral territory and this may have felt threatening to some potential participants or perhaps it was difficult for them on the phone to directly refuse my request. My being older may have put some of them off, the topic may not have been of real interest to them, a better offer for that time slot came up, or perhaps they had simply lost my phone number. As I did not contact anyone who failed to attend after saying they would, it is only possible to speculate on the reasons for non attendance.

**Group B - Focus Group Three**

The participants for this focus group were contacted after a lecturer in the school of nursing at a university in a large metropolitan city gave me the name of a possible participant. After agreeing to participate this person gave me the names of several other potential participants. Once again I spent many hours on the phone explaining my research to get a group together. Eventually eight people agreed to participate and to meet in my home.
Five of the eight participants arrived as arranged and we had dinner together. One phoned to say she could not come and I was not contacted by the other two who failed to attend. The five participants either knew each other or knew of each other and spent some time before the actual focus group interview catching up with one another. These participants in the third focus group were all graduates from tertiary educational institutions. Four of the five were working in major public hospitals in acute care settings such as intensive care, a burns unit and in surgical wards. The fifth participant had graduated six months previously, had not been able to obtain full time employment and was working about three to four days a fortnight through a nursing agency.

We chatted over a meal and this time provided an opportunity for us to relax and get to know each other. I used the same explanation of the focus group interview process as I had with the two previous focus groups. It appeared that the participants were comfortable with my explanation and they did not ask any questions, but did comment that they had been involved in research at university, both in an academic sense and very often as subjects. It occurred to me that the frequency of having been research subjects in the past might have been another reason for the disappointing response of potential Group B participants.

This group had little difficulty with the focus group process, they were keen to answer questions and were assertive when they had differing views from another participant. They were articulate and well informed in their views about the health care issues which arose in the context of the focus group interview. Once again at the conclusion of the focus group interview, participants expressed their enjoyment of the process and that they felt that they had gained some valuable personal understanding of themselves. This group appeared to work very well. Sharing a meal seemed to assist in the process of building sufficient trust for participants to express their thoughts and feelings and describe their experiences.
Group B - Focus Group Four

The names of potential participants for focus group four were obtained from the participants in focus group three. Those who agreed to take part were invited to have a meal at my home followed by the focus group interview. Of the expected six participants, two arrived, two phoned on the evening to cancel and the other two did not contact me. This posed a difficult and somewhat embarrassing situation. I decided to go ahead with the focus group because the two young women who arrived were keen to participate in the research and I felt it was unfair and disrespectful to them not to proceed as planned. I was also aware that I was anxious to collect more data with Group B participants and was becoming concerned about gathering sufficient participants within the time available for the research.

The two participants were both in full time employment in intensive care units in the public health sector, one in a children's hospital and the other in an adult surgical intensive care unit. One had been in practice for two years, the other for a little over a year. Both expressed relief at having a job and told of the anxiety experienced by many recent graduates looking for work.

As with the participants in focus group three, these two participants were familiar with research processes although they were unfamiliar with this specific method. They accepted my explanations readily and despite the focus group only having two members, the interview lasted nearly two hours with neither participant keen to stop. They were enthusiastic regarding their experience in the group and one commented that those who had not come had missed out on a very worthwhile encounter. There was a genuine feeling of closeness between the three of us by the end of the interview and both participants were eager to meet again to discuss the findings.
Group B - Focus Group Five

This focus group was convened differently to the others as by this time it was necessary to expedite the research process. I asked three registered nurses from the private psychiatric clinic where I work to participate. At the time, I had been working as a psychotherapist at the clinic for one month and the three registered nurses had been working there for between two to five weeks. For two of the graduates this was their first employment since graduation and for the other it was her second job since graduation two years previously.

They were all aged under twenty five years and were unmarried with no dependents. One lived at home with her parents, the other two in flats with friends. The three participants were all smartly dressed in the clinic uniform. Because I worked with them, we had already established a relationship. Part of my role at the clinic is to provide support and guidance for staff and this had occurred with each of them both formally and informally. I believe that they had experienced me as supportive in our day to day work and were aware of my emphasis on maintaining confidentiality, not only for clients, but for all staff members as well. These three participants were keen to help me by participating in the focus group.

The focus group interview took place after they had completed a morning shift at the clinic. As it had been an especially demanding and busy day, I used the first fifteen minutes over coffee for them to debrief and relax. We used a room at the clinic with comfortable armchairs and a power point for the tape recorder. We were interrupted twice during the focus group interview by clinic personnel coming into the room and I realised too late that I should have put a notice on the door.

I used the same explanation of the focus group interview process as I had in the previous groups. I also emphasised that this research was separate to my work at the
clinic and that the clinic was not involved in the research except by the three of them participating. As with the two previous focus group interviews with Group B participants, there was an understanding of the research process, and the participants demonstrated a willingness to share their own personal viewpoints and experiences.

Summary

There were some notable differences and similarities between Group A and Group B participants in their approach to the focus group interview. Group B were clearly more comfortable with the research process, they asked fewer questions about this research but did talk about the research they had been involved in at university and they appeared to be well informed. Group B were also not as curious about my life or my academic career as Group A participants. This may have been related to the differences in our ages and life stage development. Both Group A and Group B were however, similar in their responses to the focus group interview. Once they had relaxed all found it an interesting and personally illuminating experience and a few participants from each group experienced some profound self understanding as a result of their participation. All, (including the participants in Group A, focus group two, once the ice had been broken), were warmly supportive of my endeavour and, I feel, gave the experience their best effort.

In all of the focus group interviews there was a gap between the ideal discussed in the literature and the reality of collecting the data. This divergence from the literature is mainly in two areas;

1. the number of participants in each focus group, and
2. the recommendation for anonymity among the participants.

My experience in the field may well reflect the difference between theory and actual practice, particularly when there are limitations in resources, access to appropriate potential participants, researcher experience and time constraints. It would have been
better, for example, to have been able to conduct the focus groups on neutral territory. Also the method proved to be very time consuming, and it was disappointing when people did not turn up. Yet while I would have preferred a greater number of participants and was concerned that the lack of anonymity between participants diverged from the literature, the data obtained are still very rich. In practice it did not appear as though the relatively small size of some of the focus groups was detrimental to participation or that participants were inhibited by knowing other participants. Rather, they seemed to welcome the opportunity to explore with friends and fellow nurses issues of common concern.

Part two of this chapter has described how the focus group method was utilised in practice and the strengths and limitations of this data collection method have been acknowledged. The complex issues involved in collecting data from participants and the many considerations I had to stay aware of have been described.
CHAPTER THREE - ANALYSIS AND FINDINGS

The analysis is in two parts. The first part will deal with the way the data were analysed. The reasons for choosing content analysis, the ways of establishing validity and reliability, and how the content analysis was carried out for this research will be described. The second part will focus on the findings related to Group A and Group B. These findings will be incorporated with relevant literature and with excerpts of verbatim data from the transcripts to give authenticity and validity to the findings.

Part One

Content Analysis

Content analysis as the method for analysing and understanding the data obtained in this research was chosen after reading on the subject and discussions with researchers and academics. It was appropriate for the type of data that were collected and manageable within the constraints of time.

Content analysis is an old method of analysing data. Often the method is used in conjunction with quantitative methods or involves a reduction of qualitative data to numbers or an enumeration of specific variables (Polit and Hungler, 1978). Content analysis may be defined as;

a research method applied to texts for purposes of identifying specific characteristics or themes (Minichiello et al, 1990:320).

Historically, content analysis was used as a tool for analysing qualitative data whereby the researcher simply counted the words in a document that reflected or represented the area under study. The current approach using this method of analysis can be divided into two parts; semantic content and latent content or feeling tone (Wilson 1987). Semantic content involves counting a particular word or word synonyms in a text or script and is sometimes referred to as manifest content. Latent content analysis is used
when the researcher does not report only what is said but goes beyond this and infers meaning.

Using this method of data analysis raises issues related to validity and reliability. The way data are selected as significant in relation to the area being studied, the possibility of researcher bias and how data are selected for inclusion or exclusion are all important aspects of content analysis. Leininger (1985) suggests that in considering validity and reliability it is helpful to return to the purpose of the research. The aim in qualitative research is not measurement but rather;

- gaining knowledge and understanding of the true nature, essence, meanings, attributes and characteristics of a particular phenomenon under study . . .
- knowing and understanding the phenomenon is the goal (Leininger 1985:68).

Because human experience is varied this can make verification difficult and at times impossible. Factors such as context alter and often cannot be standardised. Rigour in terms of reliability is important however. Comparing individual and group accounts, the degree of stability of the themes over time and across groups and individuals all support the concept of reliability. Wilson (1987) suggests that some of the questions that should be directed at studies using this method include, the reliability of the coding, whether another researcher would come up with the same codes independently, and whether the codes used are specific, clear, inclusive, homogeneous and useful (Wilson, 1987:273).

Hall and Stevens (1991:20) recommend that reliability and validity should not be compartmentalised as in empirical research, but that the two “can be considered continuous and expanded into a more encompassing standard referred to as ‘adequacy’.” Adequacy is supported when the following criteria are demonstrated: reflexivity, credibility, rapport, coherence, complexity, consensus, relevance, honesty
and mutuality, naming and relationality. These are similar to Madison’s criteria for methodological rigour in interpreting texts and qualitative data (Madison 1988:Chapter 2), referred in chapter two of this thesis. Hall and Stevens (1991:27) also point out that criteria for adequacy lie within the realm of post empiricism, the methodology of qualitative research and the politics of feminism. These criteria are each briefly described below.

*Reflexivity* means that the researcher’s own attitudes, beliefs and motivations are examined to see how they fit with the literature, theoretical framework and interpretation of the findings. *Credibility* exists when the participants are able to recognise their experience in the findings and endorse the interpretations made. A further endorsement is other nurses and scholars finding the accounts believable. *Rapport* is when the researcher is able to establish a relationship based on trust with participants and they are able to feel comfortable and be open about their lives. *Coherence* is shown when there is consistency and plausibility in the component parts of the research and in the whole. *Complexity* means that the research has been able to capture the complexity of women’s experience at a personal level and also by locating it in social and political processes. Complexity also includes an historical context.

*Consensus* exists when the researcher has not only described those women’s experiences which are well represented or universal among the participants, but also those which are different or stand alone. Inconsistency among participants does not invalidate the data but rather represents the variety of women’s experience. *Relevance* includes the usefulness of the research in reflecting on or changing women’s lives socially, politically and economically. *Honesty and mutuality* are met when women understand the purpose of the research and are given access to the findings. *Naming* means articulating and thereby giving power to the way women see the world. Incorporated within this is the awareness of the value of egalitarianism between
researcher and participants. *Relationality* is collaborating with others including scholars and participants to uncover new dimensions and ways of understanding. This may take place through talking and critiquing proposals, monitoring the interpretation of data and ensuring that the focus on women’s experienced is maintained.

As data were collected, I transcribed the audio tapes and used these transcriptions, along with the notes that I had made immediately after each focus group interview. The notes included my responses and reactions to the participants and to the focus group interview and were useful when analysing the transcriptions. The process of transcription provided the opportunity for me to critique my performance during focus group interviews and to consider appropriate codes.

I initially used some of the categories suggested by Bogdan and Biklen (cited in Minichiello et al 1990:296) as these provided a useful framework. The categories I selected were; perspectives held by the participants i.e. “how the informants think about their situation”; process codes, i.e. “activity over time and perceived change occurring in a sequence, stages, phases, steps, careers”; event codes, i.e. specific activities; strategies codes, i.e. ways people accomplish things, and relationship and social structure codes, i.e. regular patterns of behaviour and relationships. As I proceeded I was able to develop my own codes and collapse some of these codes.

In order to check my findings I went back to two or three participants in each focus group and explained what I thought the data were saying. This also provided the opportunity to clarify any points that were unclear to me. In all cases this contact by telephone with participants was warmly received and participants were unanimous in verifying my interpretations. This host verification gave me confidence regarding the adequacy (Hall and Stevens 1991) of the process and the findings. The process of
carrying out a content analysis proved helpful in understanding the data, and my initial reasons for using this method were borne out in practice.

Part Two
Findings

Group A
This group of participants were all women who had commenced their nursing careers in hospital schools of nursing and who had been working as registered nurses for between ten and thirty five years. In analysing the data obtained from Group A the following headings are used:

* Why Nursing?
* Going into Nursing: Not so Much a Choice as a (Feminine) Destiny;
* Moulding the Nurse: (i) Loss of individuality/ autonomy
  (ii) Learning to fit in;
* Developing Character, and
* In Retrospect.

Much of the data collected were in the form of stories told by the participants about their lives and experiences of nursing. Story telling as a means of communication will be discussed in chapter four.

Why Nursing?
It became apparent that choosing nursing for this group was a decision closely tied in with society's and the participants' views of women's roles and appropriate place in the world. Participants described the narrow choices available to them and the idea that a job was just a fill in between leaving school and getting married. Although some participants described nursing as entirely their own idea and two participants went nursing against their parents wishes, all had read books and watched television and films in which nursing was depicted as being a women's occupation in which she
could use her talents in caring for and comforting the sick. Participants also expressed the view that the general community viewed nurses positively and that nursing was often seen as a vocation and sometimes as a sort of divine calling. The image of the nurse, at the time Group A participants were beginning their nursing training included such stereotypes as the angel of mercy, the good woman/mother and the doctor’s handmaiden.

From the data it became apparent that a process of moulding the student into a proficient nurse began the moment a novice entered the hospital. This moulding process pervaded every aspect of the young student nurse’s life and was according to participants, a test of personal hardiness, absolute commitment to nursing and suitability for the role of nursing sister to which she was expected to aspire. The success or failure of the moulding process was felt by participants to lie entirely with them. Very high attrition rates and an emphasis of working above and beyond the call of duty were thought to demonstrate that only some are chosen or fit and that leaving nursing whilst training was a personal and moral failure of the individual woman. It was not regarded at the time by participants as any shortcoming within the system.

The impact of the experience of growing up in the 1950s and 60s and of successfully negotiating the moulding process from young woman to nursing sister is well described by the participants and excerpts from the data are included. Care has been taken to protect participants’ identities and the first names used are fictitious. Verbatim data are in italics.

**Going Into Nursing: Not So Much a Choice as a (Feminine) Destiny**

The following excerpts from the data demonstrate how the participants in Group A viewed themselves in relation to the world and how they were influenced by society’s
traditional views of women. In most of these excerpts there is a unifying theme of lack of power and control in the lives of these participants at that time.

For three participants there was a desire to leave home or school and nursing offered a way out. Nurses homes were viewed by parents as being acceptable establishments for their daughters. Game and Pringle (1983) in their study of nurses and their reasons for going into nursing recognise this as giving up one institution (the family) for another (the hospital), but "for many it was the only escape possible" (Game and Pringle 1983:101).

Amy:  
My parents got divorced and in those days it was a bit of a stigma, you know, and I didn't like my so called step mother. I decided to get out of home and I knew Dad would let me go because I could live in [the nurses home], I don't think I really wanted to be a nurse, but I saw it as a way out.

Susan:  
I did not think about nursing until one of my friends went. I thought this is it, this is my ticket out of home and out of [small country town], it was my passport out of an unhappy situation.

Sarah:  
My father died when I was fourteen. I never wanted to be a nurse, I wanted to be an Egyptologist or a marine biologist but my mother said there's no money or jobs in that especially for a girl. and she was trying to keep us both at school. My sister was keen to go to uni, and Mum didn't have much money, so I thought oh well I may as well go nursing, and at least I will be independent and earning my own money and I won't be dependent on Mum.

Megan:  
I always wanted to be a singer, I loved it as a kid and I was quite good but Dad wasn't keen, he said it's not really proper you know, respectable and that. We didn't have the money to put me through a proper training. My brother went to uni and took up all the money, I still feel bitter that
brother] could do what he wanted but I had to bite the bullet. Mum and Dad were pleased when I suggested nursing.

Both Sarah and Megan had aspirations very different from nursing and due to circumstances at the time sacrificed these aspirations. Nursing seemed a good alternative choice as it was more in keeping with parental attitudes of appropriate work for women, and because it meant that they would not be a financial burden to their parent(s). They each went on to describe how their parent(s) were supportive of their going into nursing as they would be looked after in a safe environment—the nurses home.

In the following excerpt a participant describes how she received some very clear messages from her family about how book learning is not useful, or real work, and in any case that girls are not worth educating.

Sandra: I was quite academic at school, I just loved it but in my day and in my sort of family you did not sit round reading books, you worked and hard too. I wanted to stay at school but Dad said, what for. it's just a waste, you will only get married so I went nursing with my friend from school. I think they were pleased that I started to earn my way and that they didn't have to worry about me any more although they were always there for me I knew that.

Another participant described how:

Gail: There was quite a lot of kudos in those days if you chose nursing. It was seen as a calling, a real vocation like being a nun. My parents, especially Dad, were pleased as punch that I became a nurse. He said it will make a lady out of you.
This experience is interesting in that the participant’s father saw nursing as providing her with status which had religious significance and as having the power to teach her about being a lady. This status is in relation to a familiar stereotype of what a good woman should be. The connection between the merciful and charitable nurse and the good woman can be traced back to such women as St Helena (250 - 330 A.D.), and Fabiola who was eulogised by St Jerome in 339 A.D.

... she gathered together all the sick from the highways and streets, and herself nursed the unhappy emaciated victims of hunger and disease ... she fed the sick with her own hands, and revived the dying with small and frequent portions of nourishment ... if I had a hundred tongues and a clarion voice I could not enumerate the number of patients for whom Fabiola provided solace and care (St Jerome, in Dolan et al 1983:47).

Within the limited choices open for women there was a hierarchy in the status attached to occupations, which the participants explained, was expressed by many of their parents. Of the three occupations mentioned most frequently as being suitable, there was a definite pecking order with teaching first, then nursing and thirdly secretarial work. The following excerpts are from participants who chose nursing even though their parents considered it second best.

Chris:  
My parents were not very keen for me to nurse, they hoped I would teach. They saw it as a real step down. My father said, you will only be a pannie annie and you will have to keep your lip buttoned.

Cathy:  
My parents wanted me to do something and said that I could be a teacher or a nurse. I think they were quite keen for me to choose teaching as it is a bit more upmarket, a bit more professional, but I chose nursing and I never regretted it.
Most of the participants in Group A described limited choices when it was time to leave secondary school. Teaching, secretarial work or nursing were their main options. Shop and factory work were not considered options by any of the participants.

Angela: *There wasn’t a lot of choice, you must understand it was nursing or teaching or working in an office, just those three really.*

April: *I honestly don’t know why I went nursing. I haven’t the foggiest idea but there were very few options in those days. Teaching, nursing or air hostessing were about the only options given to you by vocational guidance, not that there was much guidance any way. You were just expected to decide for yourself and that was that, it’s not like that now though.*

Five of the participants in Group A had experienced the death of a parent during childhood and four of this five described life as becoming more difficult for them after this. There is a theme of reparation, or of helping others by using their skills and knowledge, perhaps to make up for not being able to save their parent.

Kay: *My mother died when I was five and half and I thought that by going nursing I could save lives even though no one could save my mother.*

Harriet: *I have never thought about my father’s death as being connected to my going nursing until tonight, but yes, I’m sure there is a connection, wanting to help and save lives when you couldn’t because you were just a kid.*

In contrast to the theme of lack of choice and personal power in these excerpts, some participants expressed the belief that they made a clear, positive choice to be a nurse. About a third had either had early positive experiences of being nursed by a compassionate and caring nurse and wanted to emulate her, or had a family member or friend of the family, who as a nurse served as a source of inspiration.
Lucy: We used to go to the hospital on Sundays when I was growing up, for afternoon tea with my aunt who was the matron. She wore a veil and had lots of badges. Every one stood up for her when she walked into the room and she was highly respected. I remember being very impressed by her.

Cordelia: I was in hospital for six weeks as a child and I was nursed by this wonderful women. I always felt so good when she looked after me and she was very kind and lots of fun. I wanted to be just like her when I grew up, she was a terrific nurse.

These early experiences were influential for these participants in their decision to go nursing. Each aspired to the high ideals that they believed were present in the nurses they knew when they were growing up. Ackerknecht (1976) describes how early recollections can be highly influential in career decisions. These early recollections may be defined as; “a specific scene or event that a person remembers taking place in early childhood years” (Ackerknecht 1976:44), and are important in framing a person’s perceptual framework and therefore their view of themself and of the world.

All participants explained that wanting to help others was a factor in choosing nursing and for some, this appeared to be a very strong need.

Maisie: I really wanted to care for others. It is something that I really felt I could do.

Linda: To look after people who needed you, it seemed to be important and to save lives.

Susan: Women are nurturers, it is the scheme of things. It is an extension of the home and girls moved outside the home to do what they did inside the home.

Gail: We were expected to be totally devoted and dedicated, if you got married you were no longer a nurse.
This theme of caring for others and of protecting and nurturing them was strong in both groups. Caring is often defined as the "essence" of nursing (Morse et al 1990:1). However as Lewin (1977:90) points out, the term nursing and caring have become synonymous with women and even viewed as a biological function. Lewin goes on to describe how strong links between nursing and femaleness have meant that nurses are viewed in terms of a "sort of maternal intimacy" (Lewin 1977:91). These beliefs about gender roles and biological destiny mean that nursing is often understood as a kind of "professionalized femaleness".

Leininger (1981 and 1984) describes caring as an affect, that is, as a feeling of dedication, empathy, concern, interest and protection. Through the experience of caring, the nurse and her patients may move toward greater self actualisation. Many scholars (Blattner 1981, Leininger 1981 and 1984, Mayeroff 1971 and Watson 1985) have attempted to define and describe what the caring that nurses do actually is and Morse et al (1990) call for the concept of caring to be clarified. It is clear from the literature that the act of caring is not straightforward but rather is complex and difficult to conceptualise.

Many participants were influenced by books and the media. Almost all described having had fantasies about working alongside doctors such as Dr. Kildare, or working with a surgeon and being his special nurse.

Lucy: I used to imagine myself in the operating theatre, with the doctor and we would save lives together and fall in love.

Chris: I was in love with Dr. Kildare he was wonderful, I wanted to be his nurse.

Harriet: After you had proved yourself by saving a life the doctor would notice you and eventually he would fall in love with you - very romantic!
These three excerpts perhaps demonstrated a burgeoning adolescent awareness of sexuality. There is the tension of the strong all knowing doctor, heroism in the saving of life, and the woman trying hard to please the man and hungering for his recognition. The image of the nurse as the doctor’s handmaiden is probably the most pervasive of a number of common images of nurses. Writers such as Austin (1977) and Oakley (1984) suggest that this is related to the idealisation of Florence Nightingale's model of a nurse and her assertion that the nurse must be responsible and obedient to the doctor. The image of the obedient and deferential handmaiden is also part of the Victorian attitude toward women and reflects the idea of the nurse as being a good wife/mother.

This image of submissiveness and dependency became coupled with the image of the nurse as sexy or 'naughty' (Bridges, 1990:852), and the object of male erotic interest, in the media in the 1960s and 70s. The focus on the nurse as sex kitten and sexual object has been described by a number of writers and researchers, including Kalisch and Kalisch (1982) and Salvage (1986). Possible explanations for this image of the nurse as both sexual plaything and good submissive woman have been offered by Fagin and Diers (1983), Karpf (1988) and Salvage (1986). Creating an image of the nurse as a readily available sexual object is an attempt to diminish her status and the value of her work. Seeing her also as a submissive woman maintains male authority and provides assurance that the necessary tasks of caring will be carried out.

**Moulding the Nurse**

All the participants described in great detail their experience of being student nurses. Out of all the data collected, the area of examining the personal impact of nursing on individual participants elicited the most intensely emotional responses. The experience of being moulded into a nurse involved the new student giving up her own identity and taking on another. This was described as an all or nothing experience. As one
participant said, "you were either in or out, no half measures." The moulding process could be seen as having two parts; loss of individuality/autonomy and learning to fit in.

**Loss of Individuality/Autonomy**

Participants described how, from their first day as a student nurse, they had to give up their sense of personal power. The hospital controlled when they worked, ate, slept and played. There were strict rules of dress, even in off duty time, and leaving the hospital or nurses home was strictly controlled by home sister with bed checks twice a night and signing in and out. For many participants the initial experience of nursing was a shock and for some, the loss of their individuality or developing sense of who they were, had a major impact.

Kay: *I felt so strange at first, I felt like I lost myself. I certainly lost a lot of my self esteem. I was seventeen, they kept saying, you must fit in you can’t be different. It was like being in the army you know, you quickly realised that life existed only within the hospital.*

Linda: *You were taught not to be different, you had to all be the same. We were interchangeable really, like there was one mould and if you did not fit in to it, well you didn’t make it. They did not encourage you to think or act different to any one else. In fact being different was seen as you having a problem and you did not want to draw attention to yourself so you were very careful not to be [different].

Kay: *I realised pretty quickly that I had to give up any ideas about myself and be what they said was right. You had to all look the same too, no individual touches to uniforms like nurses do these days.*

Another participant was not so startled by this loss

Cordelia: *You were one of many, you were not an individual. It did not worry me much at the time, I think I had expected it to be like that.*
The young nurse's experience of giving up any developing sense of her own individuality and autonomy is described in the literature. Goffman (1959) describes how the total institution in which a person works, plays, eats and sleeps and is always under surveillance and the authority of others has an immense impact on the social identity and self concept of the individual. Similarly, Lewin (1977:102) concludes that the sex role values among nurses may be less related to their prior convictions than they are to the workplace, especially the extent to which it rewards or punishes assertiveness, autonomy and authority. Lewin maintains that nursing work hovers perilously close to the traditional nurturance and submission which have been shown to be related to the oppression of women.

Learning to Fit In

Fitting in for Group A participants was described as essential to their survival as a nurse. They emphasised its importance and gave many examples. Fitting in involved a number of learned behaviours and the comradeship of fellow students in order for the individual student to survive. Self-containment was highly valued, and the importance of always giving the impression of coping to those in authority and to patients by not letting feelings show whilst at work, were some of the first things new students had to learn. Discovering and making sense of the strict hierarchy and learning the appropriate behaviours towards others was also an early learning experience.

The following excerpts describe coping experiences:

April:  
You always had to show that you could manage in front of patients, you put on an air of confidence that you knew what you were doing even though you didn't. You just pretended because that was what was expected, you were constantly tired and stressed.

Linda:  
I remember being terrified being left on night duty on my own. I had to get a patient to show me how to do his dressing. I had never done one
before, I felt very embarrassed. It was sink or swim and we thought nothing of it.

Cathy: You could never say no to more work. You never said I can't do it, it's too much. You never let on that you felt overloaded or that you were at the end of your tether. You stayed on duty until the work was done and that was that. You knew that that was what was expected, everybody did the same so you never really thought about it, just accepted and got on with it.

Lucy: We always went on early duty an hour early otherwise we couldn't get the work all done on time and it looked like you weren't coping.

Containing feelings and appearing to be in control are described in the following excerpts:

Megan: Sometimes I would be so full of feelings I felt like I might explode, but you learnt very quickly to hide them. Like the first time a patient that I knew died, I went in to the sluice and cried and cried but I didn't let on to anyone that I was upset. You were told that it was bad for a nurse to get emotionally attached to patients and I thought that meant being upset when they died.

Sarah: I often had to fight back tears or words as you were not supposed to show any feelings, you had to be cheerful and have a professional approach.

Sandra: Even if an injustice was done to you, you just accepted it, you did not answer back or stand up for yourself or not often. Some girls did and they got the names of being trouble makers, it didn't pay to stand out.

Participants described how the hierarchical structure of the hospital made an immediate impact on them and how important it was to learn quickly where you fitted. This learning, like much of the learning these participants did at the time, occurred through trial and error and copying others.
Sandra: *We were told that the cleaners were beneath us, and every one else we stood for and let go ahead of us. I learnt on my first day on the ward that some cleaning ladies were not beneath me when one of them tore a strip off me for leaving some glasses on a bench.*

Lucy: *I got sent to labour ward and my legs were shaking so much with fear I sat down in the sisters office and she was furious that I would dare to sit in her presence.*

Amy: *We had to stand up with our hands behind our backs and ask the ward sister for permission to go to breakfast or off duty and you had to excuse yourself [to go] on duty which was pretty silly really when you think about it.*

Cathy: *You watched what those ahead of you did and you just did the same, that is how you knew what to do.*

Linda: *They had total control over you, even your privacy, they would come into your room when you weren't there and they would check what underwear you were wearing, you couldn't say anything.*

Game and Pringle (1983) use the imagery of the family in explaining the hierarchy:

... nurses have been disciplined by mother daughter relations, particularly under the old matron system, nurse-nurse relationships are analogous to sibling relations; sisters. Nurses felt some loyalty to their matrons even if they saw them as tyrants ...

and;

... if junior nurses are treated as children, then the patients are clearly babies (Game and Pringle 1983:105-6).

To survive these experiences, the young student nurses formed very deep attachments to fellow students, almost always within their own intake group. The hierarchy was so
strict that student nurses six months ahead were seniors who had to be stood up for and deferred to. The importance of these friendships was stressed by participants again and again and for some it was their main reason for staying in nursing. Many of the participants maintain friendships today that date back to their first year as a student nurse. Friendships formed prior to the participants starting nursing tended to fall away. Mostly, this was explained by the shift work though the participants also described how they felt that these pre-nursing friends did not connect with them any longer. The empathy and support they needed could only be found with those sharing the same intense experiences.

Sarah: I loved living in the nurses home with the other girls, it was great fun, they supported you and you supported them, they were like sisters. It was a big family and we really cared about each other.

Cordelia: You made very deep friendships and that is what got you through. We would spend hours talking about work and being sympathetic when someone had had a terrible day.

Harriet: We did mad things together, my friends were wonderful and they understood when you felt upset and that about the work. It was like having more sisters. It was a real bond that we had and we still have today.

Angela: Your friends were always there for you, you borrowed clothes and even money sometimes and you had fun together. We used to really yell and scream and get drunk. I think it was letting off steam for what we were experiencing at work. We drank like fishes and your friends would put you to bed at four in the morning.

Developing Character

Participants in both Groups A and B described how the process of learning about nursing and how to fulfil the role of a nurse, had a profound impact on their personal
Participants felt that nursing had developed their characters and that this was one of the most positive outcomes of their student nursing experiences. All participants described strengths, abilities and attributes that they believe they gained from the experience of nursing and which they find useful in their lives today.

Cathy: *Nursing teaches you a lot, how to cope under enormous pressure without cracking, to keep going even when you were exhausted. That really helped me when I had my children and I was always tired.*

Kay: *I learnt to trust my own judgement, to be able to do disgusting unpleasant things and keep a professional facade.*

Sarah: *I learnt to talk to people and I gained a lot of self confidence through that.*

Chris: *Nursing in those days was sink or swim, you had to toughen up, distance yourself a bit and learn to control yourself. It was good practice for dealing with life.*

Megan: *Nursing gave me a social life, a terrible sense of humour and I learnt to trust myself.*

Gail: *I am an efficient person, nursing did that for me, I can be doing three things at once and thinking about how I will do the fourth. I learnt to manage things and manage myself and that was very helpful, nursing makes you a better person too. I am compassionate but I can be quite tough too.*

This belief, that nursing had a beneficial effect upon the characters of the participants as young nurses is an interesting one. I asked the participants to identify any other occupations that they considered incorporated a character building aspect. They found this a difficult question but eventually suggested that perhaps entering a religious order or the armed forces may have a similar effect on a person's character.
Nursing has historical ties with both religious orders and the armed forces. The armed forces have an emphasis on discipline and learning to work as a team but also on being self-sufficient and in control of oneself in order to survive. Maintaining a sense of equilibrium and being calm under fire is important, as is learning to obey senior officers. All these requirements and qualities have similarities with nursing.

The suggestion of the relationship with religious orders ties in with notions of compassion for others, of the giving of self and the epitomising of the good and honourable woman, who is obedient and gives without complaint or thought for herself. The woman is admired and revered for the work which she performs with humility and grace. In what might be a description of religious life, Littlewood (1991) describes how:

\[\text{... on becoming a nurse, the woman is separated off and is purified} \]

\[\text{(Littlewood 1991:177).}\]

This purification occurs in part through being ‘contained’ in a nurses home and by being ‘contained’ in a uniform.

Nokes (cited in Van Hooft 1987:33) points out from a sociological perspective that professions such as nursing experience confusion arising from the feeling that to be a nurse one must be dedicated and have a sense of vocation. The criticism of this view argues Nokes, is that the moral goals inherent in the notion of vocation are unattainable.

**In Retrospect**

Participants were mixed in their views as to whether they would encourage their daughters or sons to go nursing. None of the participants would actively discourage their child, but interestingly, none of the participants' children had expressed interest in nursing, although they did have other careers in mind. The daughters of these
participants were considering such options as airline pilot, artist and doctor. Fagin and Maraldo (1988), point out that, although occupations such as nursing, teaching and secretarial work remain predominantly jobs done by women, women are increasingly taking up occupations traditionally seen as men’s work. Jobs with status, power, prestige and earning potential now lie in such areas as business studies and computer science and young girls are being told by their mentors;

be a doctor, not a nurse, be a computer scientist, not a teacher (Fagin and Maraldo, 1988:365).

Fagin and Maraldo (1988) attribute some of this shift away from encouraging young women into nursing and other traditional women’s occupations to the women’s movement for equal opportunity. This movement has always had an uncomfortable relationship with nursing (Vance et al 1985). The ideals of feminism have, in part, focused on breaking down stereotypes associated with women and men, including the work that each gender traditionally does. This attempt to break down stereotypes may be seen as being partially successful, with more women entering non traditional occupations and also with more men entering nursing. A cost however, may be that work with values such as the compassion, care and concern for the sick and needy that are espoused in nursing, may be viewed as detrimental to women’s progress. In a quantitative study, Firby (1990) found that less than two per cent of the sixteen to eighteen year olds studied were considering nursing as a career and that;

they seemed to have replaced nursing with the professions as potential occupational choices (Firby, 1990:732).

Both Fagin and Maraldo (1988) and Firby (1990) cite increased occupational choice for women, the poor image of the nurse and lack of remuneration for experience and ability as being factors in women not choosing nursing.
Of concern to two participants, who would be hesitant to encourage a child who wanted to go nursing, was the perceived increase in violence towards nurses in the workplace and the risk of acquiring such illnesses as hepatitis and H.I.V. infection.

Harriet: *We never thought about our patients being violent when we trained, now it is much different and nurses are often in situations that are potentially dangerous, and I would worry about [my daughter] being exposed to AIDS and things like that. That would cause me to worry if she took up nursing.*

Drug addicted clients were perceived to be potential threats for both violence and infection by two participants and a number of the other participants agreed that this was a good point although they had not really considered it before.

The majority of participants were very ambivalent as to whether they would do it all again. On the positive side, all participants felt that their careers were important to them and believed that they had done and were doing useful and important work. They valued the friendships made while nursing and their current nursing work provides them with income as well as work that is generally very challenging and personally satisfying. Participants described again how their characters had been moulded and shaped through their experience of nursing. Many felt valued in the community for their knowledge and expertise, as neighbours, friends and family consulted them regarding health matters. However, when considering the bottom line of whether, with hindsight they would make the same choices, two thirds thought that they would not and only one third were clear that they would.

Those with no regrets about the choice they made were adamant that nursing was what they wanted to be doing, they felt they did it well and they could not conceive of doing anything else.
Lucy: *I love nursing I always have, I love the challenge and it is very rewarding, I get a lot of job satisfaction and I can’t think of anything I would prefer.*

Linda: *Nursing is terribly hard work but the satisfaction is tremendous.*

Those participants who felt that they might or would not do it all again listed a variety of occupations that they believed they would rather have entered had circumstances been different.

April: *I am happy to be nursing don’t get me wrong but my father was an engineer and I would have loved to have been one too if I could._

_Goodness I have never said that to anyone before!_

Angela: *I am fairly arty and I think I would have done something like interior design or something in that line if I could have but nursing has been great too._

Kay: *I find that a hard question to answer. I suspect I would have preferred teaching over nursing. Although nursing has given me a lot sometimes it is a thankless job and you don’t get much credit for brains or anything._

This ambivalence and co-existence of opposing feelings appeared somewhat difficult for participants to express. Possibly it was hard to acknowledge that after years in nursing, there were other occupations that still held a great deal of appeal. This makes sense in light of the data collected on the process of moulding the nurse and the inculcated attitudes of acceptance of one’s place and unquestioning obedience. A prevalent attitude in society, at the time when these participants trained, was that nursing was a calling and nurses therefore were very often totally devoted to their work. A combination of these powerful beliefs, the particular character building process involved in nursing, an initial lack of occupational choice and later other commitments, would contribute to this ambivalence. While the focus groups did not
explore the reasons, it is interesting to note that many Group A participants no longer work giving direct patient care.

**Group B**

Group B participants were educated in a tertiary setting and had been in practice for a period of six months to seven years. They shared some common themes with Group A participants but there were differences too. In analysing the data obtained from Group B the following headings are used:

* Why Nursing?
* Being Educated;
* Reality Shock, and
* Stepping Off to a New Career.

As with Group A, all names used are fictitious in order to protect the privacy of participants.

**Why Nursing?**

All the participants had a desire to help others and to care for people but this was not the only reason that they went nursing. Unlike Group A, this group did not go nursing to get away from home, possibly due to the fact that these participants all trained in a university system, in which living in a nurses home is not a requirement or an expectation. About half of the participants lived with their parents while at university and the others shared accommodation in flats. All had weekend or holiday jobs to help finance their education. None believed that books or the media had in any way influenced them to choose a nursing course. In fact, they made scathing comments about the way nurses are generally depicted in the media and saw this as detrimental to the image of nursing. One of the participants cited researchers in this area, Kalisch and Kalisch, who have written extensively on the image and portrayal of nursing in the
media, in support of her views. Also unlike Group A, none of these participants had had childhood experiences with nurses that inspired their choice of career.

This group seemed to have made a decision to choose nursing for a number of reasons which, as well as the desire to care for others, included reparation for a death experienced in childhood and economic factors. None of the participants felt that they had insufficient choice of jobs or careers, or that family attitudes had played a big part in their decision.

All the participants expressed altruistic motives for nursing similar to those expressed in the following excerpts.

Melanie: I wanted to do something useful with my life. I wanted to help others. I hope to work overseas with children once I have more experience.

Kate: I think nursing is a job where you can express your compassion for people, I always wanted to be a nurse and to help people.

Perhaps in a similar vein, one participant cited religious reasons;

Julie: I believe that I can serve God through nursing.

Kersten et al (1991:32), in a study carried out in the United States of America with 752 nursing students in baccalaureate and associate degree programs, found that caring and concern for others was the most common reason given by respondents for choosing nursing. The opportunity to nurture others was important and was given as a reason by 62.6 per cent of respondents. Seventy eight per cent of these respondents cited 'caring' as what nursing meant to them.

Nearly half of the participants in this group had experienced the death of a parent or sibling at a young age. As with Group A, it was apparent that many of these
participants felt the need to make an attempt at reparation for this death of a family member.

Simone:  *Watching my brother die at the age of nine was probably a factor. We all felt helpless and I try and help families who have experiences like ours. That is why I hope to work in a hospice when I can get a job at one I like.*

Two participants had held aspirations other than nursing, but were unable to fulfil these due to academic requirements.

Lily:  *I would have preferred medicine but I didn’t have the brains.*

Patricia:  *Nursing was my third choice after physical education and biochemistry.*

Both these participants, however, also expressed their satisfaction with nursing.

Economic considerations were also a factor in going into nursing for some of Group B. Whilst the actual salaries earned by nurses were not mentioned as attractive, belief that nursing work was relatively easy to come by was an important factor. This hope had not been fulfilled for some of the participants who had been or were currently experiencing periods of unemployment.

Anne:  *I am so disappointed, I really never thought that I would be unemployed as a nurse. That is one of the reasons I chose it and I have only got agency work so far. I did not get into a graduate program, hopefully I will next year.*

Celia:  *Everyone said you will never be out of a job, but that is not true, quite a number of my friends have been unemployed. I have been lucky.*

Louise:  *My father was encouraging of me going nursing because there seemed to be less likelihood of my not being able to get work, but I was unemployed when I first graduated and that was a real shock.*
Kersten et al (1991:32) found, in their study, that job security (16.9 per cent of their 752 sample), and financial needs (32.9 per cent), were important motivational factors for respondents choosing nursing.

A number of participants were quite clear that nursing was attractive to them as a career because of what they perceived nursing could give them personally. These merits of nursing are depicted in the following excerpts.

Kate: 
I needed self discipline and I thought that nurses are very disciplined people, so that was one of my reasons for nursing.

Joyce: 
I had no parental guidance at all, my family had a lot of problems and I thought nursing would give me a good job and the security I felt I needed.

Louise: 
My mother died when I was young and my dad has a drinking problem and my sister has a drug habit and my aunty has breast cancer and other problems. I hoped nursing would show me how I could help my family with problems and it would educate me about how to do this and give me more confidence.

Jane: 
I always admired how nurses were so caring and could do so many things. They seemed to be very in control of themselves and I thought that I would like that sort of self discipline and self control.

It is interesting that this theme of character building is still present in today's younger nurses. The belief that nursing offered this was a factor in a number of this group of participants taking a nursing course at university. It may be related to women's perceived lack of control and personal power in the world at large and the perception that nursing can assist individual women to feel more powerful and in control. Studies still find that dependency and passivity are expected of women, and "normality in women is that of the neurotic, with a childish incapacity to self governance" (Holden and Littlewood, 1991:151). As Calkin (1988:151) points out:
Power and control are commonly linked explicitly or implicitly and often sensed as negative forces - especially if the role incumbent feels powerless. Yet in sources such as Plato's Republic, power is clearly linked with providing energy for individual growth and development in the creation of good for society. Some feminist writers refer to this as empowering . . .

Within this social context it is interesting that Kersten et al (1991:32) found in their research that many of those people who chose nursing had emotional needs which they hoped to meet through nursing (52.4 per cent) and hopes that nursing would provide personal growth for them (21.7 per cent). These emotional needs included such basic factors as self esteem, self concept, and a sense of accomplishment.

**Being Educated**

The experience of learning about nursing was quite different for Group B than Group A. Group B participants were educated within a university system and it was notable that their experience was described in rather bland terms with little or none of the emotional intensity of Group A participants describing their hospital training. In fact, three Group B participants expressed disappointment at their experience of university as they believed they would have found the experience of training in the hospital based system personally beneficial, particularly living in the nurses home. The friendships made at university seemed to be more transitory and not as vital or intense as they were for Group A participants. In spite of this, these women and the other participants in Group B believed that being educated in a tertiary institution was much superior to being trained in the hospital system, as it meant that they were on a more equal footing with other health workers in terms of knowledge and status.

Jane:  
*I have not really kept up with my friends from uni, we have scattered everywhere, I have made deeper friendships at the hospital than I did at uni.*

Celia:  
*I would have liked to live in the nurses home. I think from what I hear it was a lot of fun and you made excellent friends. At uni it was very*
competitive and people were always comparing marks and saying what did you get? Looking back on uni I can understand it better now, but at the time it was just an intellectual exercise, especially as we had so little 'prac'.

Anne: Going to uni was good but I was glad when it was over and I could earn some money. It was a hard slog and I had to study quite hard.

The issue of the educational experience of tertiary trained nurses seems to be important, but is underdeveloped in this piece of research. The experience as students and the transition to registered nurse need further investigation, particularly in the light of the reality shock experienced by participants when they began work.

Reality Shock

While the experience of being at university was enjoyed by most participants in this group and just tolerated by a few, the descriptions were all fairly bland. All however, were clear and vivid in describing their initial experiences as beginning nurses after they became registered and the impact that these experiences had on them.

It was in this area that the most emotionally intense data were collected from this group. One participant (Lily) had been registered for seven years and was working as a clinical nurse specialist in a high dependency unit. She was considerably more experienced than the other participants in her focus group. As some of the participants expressed their anxieties regarding some of their experiences, she was able to empathise, offer her own experience and give advice. This participant was helpful to the others in validating the experiences that newer graduates were having, and was encouraging that the process that she referred to as "really learning what nursing is about" was one that can be negotiated and managed through experience and practice.
The following excerpts from the data demonstrate the experiences Group B participants had in coming to terms with their new role and learning to fit in.

Lily: *It was very difficult at first because everyone was watching us to see what these new breed of nurses would be like. It took a while to be accepted, you had to prove yourself and that was hard. But one of the hardest things was having to cope with really sick patients and worrying that you might do something wrong. You just had to keep asking more senior people and at first that really made my self confidence suffer, it took me about a year to eighteen months to feel I could cope and be generally O.K.*

Anne: *I really feel at sea at times especially as an agency nurse. I get into trouble because I can't keep up. I get behind on my showers or something and they get cross and say you must work faster and be efficient. I never have time to talk or listen and that gets to me, it is more important to get the work finished by ten o'clock, not talking or teaching or things like that.*

Melanie: *My first ward was a surgical ward and it was very busy. I used to worry about how I would cope and what I would do if something happened like an arrest or something like that. It was terribly stressful and exhausting and I was put in charge on lates quite early on. I often bluffed my way through situations with patients, it has got much better though.*

Patricia: *Nursing is very much about getting work done. The talking to patients gets fitted in around the work and I don't think that is right, we weren't taught like that.*

Anne: *Last week I got sent to a surgical ward and I had five patients going to theatre. I checked a pre med with a senior girl and she told me to give it and I gave it and it was the wrong time. I felt terrible but I got into trouble and she didn't, it wasn't very fair, I thought.*

Joyce: *Nothing at uni really teaches you about how it will be, the reality is much different to the way you are taught. It was a bit of a shock even though I*
had done holiday work and that in private hospitals during uni breaks.

Uni teaches you the ideal and I suppose that is good.

It was apparent that these participants were or had been experiencing difficulties in fitting into their new role. Participants had to learn to accommodate differing values in the hospital setting to those of the educational institution in which they had been taught. The issue of the way in which patient care is approached is a good example of the conflict this group of participants have had to deal with.

The ideals and values espoused in educational settings in relation to patient care, often seem in direct conflict with the requirements of the clinical setting where there is an emphasis on getting tasks done. Kramer (1974) described the experience of the reality new nurses encounter in clinical settings as 'reality shock'. In further work, Kramer and Schmalenberg (1977) identified conflicts and difficulties new nurses experienced, such as those described above in relation to making judgements about medication, and neglecting communication with patients in order to conform, fit in and be accepted.

Horsburgh (1989: 613-616), in a natural fieldwork study, described five major themes in relation to the adjustment of new graduates to the workplace. These are:

1. That new graduates were compromised between the values instilled through their nursing education and workplace demands. The emphasis on tasks at the expense of continuity of care led to dissatisfaction and guilt.

2. Role confusion and little feedback on their progress as newly registered nurses coupled with needing quickly to fit into the system, which means having to maintain the status quo.

3. “Within hospital settings there was no identifiable component of practice specific for the new graduate” (Horsburgh, 1989:613). Rather, it was
expected that nurses would rise to the occasion as required, and that individual situations would dictate responsibilities.

4. New graduates experienced difficulty in managing unplanned or unexpected events and some responsibilities such as supervising staff and administering medications.

5. New graduates had to adjust to working rostered duties, and to be accepted and recognised as a member of the nursing staff.

All these themes were touched on by Group B participants and are important issues for new nurses. While Group A also described a painful fitting in process, their experiences occurred as raw recruits with scant or no knowledge of nursing practice. Group B participants all described going through a difficult process as beginning clinicians although they had three years tertiary education in nursing knowledge and practice, and in the ideals and values of the profession. For this group their initial experience was one of dissonance. The content of their educational experience and its relationship to practical experience in the hospital is important. Further examination and understanding of the transition from student to registered nurse and the upheaval of the reality shock experienced by new clinicians may be helpful in making sense of how this role change impacts on individuals and how best to assist them in this shift. It may also be important in looking at ways in which the ideals and the real life practice of nursing might be brought into greater congruence.

Stepping Off to A New Career?

As there has been an enormous shift in women’s roles and the expectations women have in relation to paid work over the last twenty years, I asked Group B participants whether they had aspirations towards a career other than nursing. (Hardy and Hardy 1988:182) describe how the predominate belief up until the mid 1960s was that; “women’s place was seen to be in the home” or perhaps in a caring profession. Yet,
by 1990, 4,172 female registered nurses out of a total of 50,330 were working outside of the profession in New South Wales (N.S.W. Health Department 1992:3). Whether this is an increasing trend is not known due to the lack of retrospective statistics, but 8.29 per cent of the total N.S.W. population of female registered nurses working outside of the profession is significant and bears watching.

About half of Group B participants thought that they may seek another career in the future. One participant, for whom nursing had been a third choice, was most definite that she would use nursing as a stepping off point into another career.

Patricia: *Don’t get me wrong, I do like nursing and it has given me a lot but I still want to be doing something in the sports medicine or physical education area. Also I like the idea of being more autonomous and not always having to answer to someone else all the time, which in nursing you always seem to have to. I will look to going to uni next year full-time if I can get in and I will work part time on nights to earn enough money, lots of people do.*

Celia: *I do not think that I will always be a nurse. There are more choices and I hope I will do some other things besides just nursing.*

Others were more sure that they would find nursing satisfying in the future and that they had no plans to have another career.

Lily: *I am very happy at the moment. I have never thought of changing to something else, but if I did I think I would stay in nursing and do work in health promotion, you know working with healthy people rather than sick ones.*

Simone: *At the moment I can’t imagine myself doing anything else. I especially like the shift work because it gives me time off when others are working. I like going shopping on a Monday morning.*
None of the participants in Group B had children. However none of them, they believed, would discourage a child from going into nursing.

Conclusion

The analysis of the data obtained from the two groups was rich and dense. Many issues were raised, and some were discussed in some depth, e.g. the character building aspect of nursing for both groups and reality shock for Group B. Other issues, such as the need for reparation and the educational experience of the participants in Group B and its relation to their experiences in the hospitals were not so deeply explained or understood.

In the process I became aware of how similar all the groups were in some respects. In the main all the focus groups yielded data with similar themes. Group B had some reasons for choosing nursing that were not evident in Group A and appear to be related to the particular economic climate of the late 1980s. Group B also experienced the reality of nursing at a different point in their lives, i.e. as registered nurses, not new student nurses as did Group A.

Part one of this chapter has outlined how the data were managed in terms of content analysis and has also described in detail the validity and reliability (or adequacy) of this analysis. In the second part of the chapter the participants have spoken for themselves through the use of verbatim data and connections have been made with the literature and with the social and political processes that impacted on the participants and on nursing as an occupation.
CHAPTER FOUR - DISCUSSION AND CONCLUSION

Overview
The main aim of this research was to gain a greater understanding of why women go into nursing and of the impact that nursing had on them as individuals. These questions were explored through two focus groups with women trained in the hospital setting and three groups with women trained in tertiary institutions. This chapter will discuss the main findings as well as outline the limitations of the research and the implications for further research.

The main differences and similarities between the two groups of participants have been presented in the previous chapter and the discussion here will focus more on the dilemmas that nursing poses for women. Issues such as personal autonomy, character building and the valuing or otherwise of caring were all raised by participants and are examined here, within a social context. It was interesting that many participants were reluctant to talk about the reasons that nursing remains predominantly a women's occupation. This, and the question to the hospital trained nurses about whether they would do it all again appeared to evoke some discomfort. This chapter will also discuss the story telling that took place within all focus groups as a form of communication.

Romance and Resources
Both groups spoke with little hesitancy regarding the reasons they had gone into nursing. Group A participants felt that they were more constrained in their choice of occupation than were the participants in Group B. Some Group A participants had aspirations other than nursing but due to a lack of resources or social and parental attitudes did not pursue them. Only one of the participants in Group A described attempts to follow through on her original ambitions and incorporate these in her life. Sarah, who had wanted to be an Egyptologist or a marine biologist (but lacked the
resources) has used nursing to finance her in exploring both these fields since she became registered. A number of the participants with other initial aspirations have now worked their way into positions of seniority and have moved into areas such as nursing education and industrial relations. There were also participants in Group B for whom nursing was their second or third choice, though this was usually due to a lack of the necessary grades for other courses.

Many Group A participants appeared to have very idealistic notions regarding nursing prior to their becoming student nurses, seeing it as providing drama and romance in their lives. This was in contrast to Group B participants who were more pragmatic in their view. The employment situation of the 1980s appeared to have influenced many of the Group B participants in their decision. These younger women clearly were concerned about employment opportunities and nursing was thought to offer security of employment. During the depression of the 1930s nurses and teachers experienced very little unemployment (Power, 1978:5) and the belief that this would continue to be so was an influence in choosing nursing in a difficult economic climate. This expectation of ready employment and job security has not been realised for recent nurse graduates and two of the Group B participants described periods of unemployment or erratic employment since graduation.

**Reparation**

Reparation as an issue came up when a participant in Group A focus group one mentioned that her mother died when she was a child and I asked whether this loss might have influenced her choice of career. Initially the participant said 'no' but then became quiet for sometime. After reflection, she raised the question again and acknowledged that by going into nursing she felt that she would gain the power to help others, in contrast to the situation in her childhood, when she had not been able to help her own mother. The participant thanked me later and said that she had been unaware
of how her mothers death had influenced her own life and that this had given her some personal insight she had not had before. Because of this revelation I asked the participants in subsequent focus groups if any of them had experienced the loss of a close family member in childhood and without exception at least one participant in each focus group had. The theme of a need for reparation related to the death of a parent or siblings in childhood seemed relevant to a number of these Group A and Group B participants as an influence in choosing nursing as a career. It seemed that most of the participants who experienced bereavements during childhood were not particularly aware of how this loss was an influence in choosing nursing until it arose during the focus groups. This area could be explored in further research as it may be an important reason why some people choose nursing.

Caring as Women’s Work - A Dilemma

Both groups of participants reported that going into nursing offered the opportunity for them to express their compassion for fellow human beings in a useful and tangible way. It was interesting that while participants found it easy to articulate this ideal of caring and concern for others, the area they appeared to experience difficulty with was the question of why nursing is generally still women’s work. Participants found this hard to explain and I was very aware of their hesitation and seeming reluctance to explore the issue in any depth although I came back to the question several times during each focus group.

As N.S.W. Health Department figures show, nursing remains a predominantly a women’s occupation (N.S.W. Health Department 1992:3). There were 50,330 women as compared with 3,915 men in the registered nursing work force in N.S.W in 1990 and nursing continues to have a relatively low status as an occupation (Beal 1988 and Watson 1990). The seeming paradox between the admirable desire to care for others and the lack of status that nursing suffers appears to be related to the roles and valuing
of women in our society. Caring is viewed as women's work, women's work is not valued and is considered less important than the work of men.

Watson (1990) suggests that;

... as it stands now, caring is either women's work, and therefore invisible and not valued, or it is something to fear because it can threaten human power, oppose control and domination and make one vulnerable to human dilemmas one cannot change. It reminds us that we are all equally human, equally in need of others and equally vulnerable to forces we cannot always control, no matter how deeply we are socialised to accept the male oriented view of the world (Watson 1990:63).

Watson cites the lack of caring as a basis for health care policy as evidence for this and the neglect of caring and the invisibility of women's work as a moral failure of the patriarchal values of our society. Watson argues the need to move away from the hierarchal tradition of accepting the unequal status of different types of health care workers and the differences in the types of health care people receive related to their socio economic status. This would include a shift away from linear thinking, from the dualism of seeing disease as the enemy to be sought out and conquered, to a new (or rather old) consciousness where the ill person is understood in relation to their environment, their relationships and the need to restore harmony in the person and the environment. If this movement towards a caring morality could be realised, she believes that we would look forward to a change in the entire system, in which the caring of nurses will emerge as the lasting force that will change the face of health care and perhaps be "the health science of the twenty first century" (Watson 1990:65).

Beal (1988) takes a more traditional approach and suggests that it is through the already established structures in society that nurses and their work will gain the recognition they deserve. In Beal's view, nurses need to promote the importance of their work
through participating in political processes and becoming a force to be reckoned with. The move to professionalisation is viewed as important but has been difficult to achieve in nursing because of the traditional ways in which women and nursing have been viewed and because of the ways in which a profession is defined. Cahill and Palmer (1989) suggest that in these times of budget constraints and the pressure on health care services to deliver high quality care, that nurses “must come to terms with the strengths and limitations of the profession” and through forming alliances with physicians, “enhance their positions within the organisation” (Cahill and Palmer 1989:29-30). Their suggestions as to how these alliances should occur appear to accept the reality of a system which is unequal (a one-sided alliance).

In a study conducted by Seymour and Buscherhof (1991), nurses were clear that they wanted to be appreciated for the work they did, to be held in high esteem and to have the respect of others. However they were highly ambivalent about their role as Care givers to patients and about their contract as employees.

    Their employers however, are part of a society accustomed to regarding work done by women as ‘gifts’. Historically all work traditionally done by women has seemed to require less ‘thanks’ than the work (not gifts) of men. The very altruism which nurses have long expressed unwittingly feeds this confusion (Seymour and Buscherhof 1991:123).

This ambivalence and confusion related to caring is important not only from the point of view of society which gives conflicting messages about its value and importance, but it is also of concern for the individual nurse, how she makes sense of her work, its usefulness and value and her own sense of worth and self determination. This can be seen in the ambivalence of many participants in Group A as to whether they would go nursing again and in the comment by one “that nursing was a thankless job and that there was little credit for brains” in spite of the satisfaction of caring for others.
Gordon (1991) describes how the women's movement in the 60s and 70s aimed to:

...transfigure reality by bringing women into the (mostly male) mainstream without forcing them to become like men (Gordon 1991:45).

The vision was of valuing relationships and one another, respecting and celebrating differences between people and working toward a more equal and caring society. Instead, many women have taken on the traditional values of competitiveness and personal power within hierarchal structures to create a "hybrid equal opportunity feminism - an ideology that abandons transformation" (Gordon, 1991:45). Transformative nurse feminists such as Benner (1984, 1986,) and Diers (1986) have expressed the need to revalue caring, and to raise the awareness of nurses, the public and politicians in a revaluing of caring and cooperative attitudes. Perhaps until caring for others is able to emerge as a basic value in our society, demonstrated through all facets, from government policy making to our individual daily encounters with one another, nursing will be regarded as women's work and therefore under valued and misunderstood. Or even more detrimentally, the caring nature of nursing may change with resource cuts leading to a pressure for efficiency in the performance of tasks and procedures at the expense of quality patient contact. This was the experience reported by some Group B participants.

The reluctance of participants to discuss why nursing is still predominantly women's work was interesting. Most of the participants said they had never thought about it and I felt they were uncomfortable when I raised it. As we were unable to explore this in depth it is only possible to speculate as to the reasons. The apparent lack of connection made by participants between nursing, caring and the predominance of women performing these roles seems to be worth further investigation.
Character Development and Oppression - an Uneasy Alliance

The other common theme shared by both groups was the belief that nursing built character. Nursing according to participants, taught them self discipline, the ability to manage and cope with a number of tasks simultaneously, and to deal with difficult and demanding situations in an outwardly calm and composed way. Nursing also taught them to appear and often feel humble and meek in the face of authority. This seems to be another paradox in that these participants were expected to manage and to keep themselves under control in very taxing situations such as the death of a child, and yet simultaneously be submissive and passive, particularly to those higher up in the hierarchy. This was demonstrated by Anne in Group B who was told by a more senior nurse to administer medication which resulted in a medication error. Anne bowed to the authority of a more senior nurse and followed her instructions, rather than taking the initiative to check.

This lack of assertiveness and personal power was reflected by other participants. Kay and Linda in Group A described how they lost their sense of being individuals, and felt taken over by the demands of fitting in and Chris described how it was not acceptable to stand up for yourself "even if an injustice was done to you". None of the participants in either group described more senior nurses as being kind, compassionate or understanding of them as student nurses or new registered nurses. Instead they had to prove themselves as being worthy in an atmosphere that was frequently critical and judgemental and with little praise or positive feedback on their performance. Although the student nurse or newly registered nurse may feel frustrated and undervalued she cannot express this. Instead the frustration is turned back and expressed within her own circle as "horizontal violence" (Speedy 1987:24) and is seen in such behaviour as "self criticism and in fighting" (Roberts 1983:21). Roberts refers to this as an aspect of oppressed group behaviour.
Oppressed group behaviour occurs when a dominant group has the power to identify and then enforce norms and values. Characteristics of the subordinate group are undervalued by the dominant group. This scorning of the characteristics and values of the subordinate group often means that those in the subordinate group begin to internalise the values of the dominant group and to believe that they want to or should be more like them. This conflict sets up a process in the subordinate group in which lack of self esteem and feelings of worthlessness and self loathing are experienced. Subordinates can move into being marginal dominant group members by taking on, acting out and espousing the values of the dominant group. They will however, continue to be female, black, Jewish or what ever characteristic it is that distinguishes them as being subordinate and a such can never be full group members.

Miller (1976) describes women's passivity and submissiveness within a synthesis of traditional female role attitudes and feminist attitudes. She describes women as being in a constant and permanent state of inequality. Dominant groups in society define subordinates as inferior and then operationalise this definition. Subordinate roles are those that no dominant wants to perform. Dominants have the power and authority to influence and perpetuate what society believes is important in all aspects of its functioning, from law and order to science and to the role of the biggest subordinate group - women. The belief or ideology, according to Miller (1976), is that subordinates innately lack the ability to perform the highly valued and well guarded functions of the dominants. In fact, subordinates are expected and encouraged to develop personal characteristics such as submissiveness, docility, passivity, dependence and lack of initiative. Subordinates are usually assigned tasks that are not highly valued and these include caring and nurturing others both in a physical and psychological sense.
Miller goes on to develop her thesis that the very values that the dominants dismiss as not being important or as not having status are the values that sustain humanity:

Women's psychological characteristics are closer to certain psychological essentials and are, therefore, both sources of strength and the basis of a more advanced form of living (Miller, 1976:27).

**Story Telling**

As I listened to the tape recorded interviews and transcribed them I became aware of how nurses are great story tellers. They are custodians of many, many anecdotes and experiences which are unique to nursing. These stories could be viewed as just a collection of 'war stories', but as I listened I realised that they may have a function for the storyteller and that there could be a meta purpose for these stories.

This is one of the many stories told during the data gathering process. It was told with a lot of feeling by Susan in Group A and it is included at some length to demonstrate the power and intensity these stories have. It is also included at this point to give a focus to the literature which follows.

*I was desperate to leave school, I hated it and when I heard about nursing I jumped at it.*

*My aunty took me on the first day and left me on the door step of the nurses home.*

*I was absolutely terrified you know, it was very scary and I didn’t have a clue what I was supposed to do.*

*I think one of the reasons I work in the community is because my years in the hospital were so dreadful I still get the shakes when I think about it.*

*Right from the start the matron took a dislike to me, she hounded me day and night.*

*I never knew what I did to upset her but she treated me terribly, worse than the lowest of the low.*

*She used to check all my exam results and go over my paper with a fine tooth comb and tell me off about wrong answers even though I did well.*

*One night I was late back after being out and she caught me and she tried to get me to*
tell who I had been out with and she hounded me and hounded me for three days and said 'you must tell me, you must tell me' but I wouldn't, I just wouldn't. She told me I might be dismissed if I did not tell her and in the end she made me shift rooms to the room beside her flat and she watched me like a hawk and knew all my comings and goings. She used to go in to my room when I wasn't there and go through my things, letters and stuff, I know she did. . . . Lots of other people noticed the way she treated me and they thought it was terrible too but she was the matron so who could I complain to? I was never a bad girl.

Viney and Bousfield (1991) refer to these stories as narratives. People use narratives to create meaning in their lives regarding events which have impacted on them and which they need to make sense of. Narratives have a number of psychosocial functions which include maintaining a sense of identity. They also help the teller to make sense of what can seem senseless and extend to the narrator a feeling of personal power over an event or situation. Narratives provide links between what has happened, what is happening and the future. Telling a story has implications in making links between the wider social and political realms and individual experiences. Because these stories are told to others and they are designed to persuade, they can be useful to the teller in maintaining their self esteem and allocating blame away from herself.

The other two important aspects of narratives are social and cultural. The social aspect of the narrative is “its context, the sources of confirmation or validation for it and how it allocates power” (Viney and Bousfield 1991:758). Culturally narratives are “information which is shared through them and the values which are implicit in them” (Viney and Bousfield 1991:758).

Discourse analysis and narrative analysis have been used particularly in literary and linguistic research but also increasingly in the field of social science research, for
example, in a study investigating the power relations in a mental hospital and in a medical clinic (Lupton, 1992). As Lupton (1992) describes, there are a number of methods of analysing narratives from very structured and rule governed to ad hoc analysis which is focused on context. The process of analysis in contemporary research takes the social, political and cultural dimensions in the story into account.

As I listened to the participants talk I noticed how often they used stories to illustrate their experiences. As a nurse I was struck by how often I had heard (and told) similar stories, about injustice, powerlessness and lack of control over our lives as beginning clinicians as with Group B, or in Group A as new student nurses in a hospital twenty or so years ago. While many of the stories were very familiar to me in terms of the situations which were described I became aware of the intense emotional experiences which underlay the participant accounts and wondered about the possible function of these narratives.

Susan described her experience of being a student nurse and the relationship which developed between herself and the hospital matron. In this relationship Susan experienced the humiliation and degradation of being singled and harassed by a person with more power and status than herself. Susan could never identify what the matron’s motives or behaviour towards her were really about, but what was of most interest to me was that through the telling of the story, Susan was telling her listeners that she was a good and honourable woman and had remained so in the face of intense provocation over which she had no control.

The idea of moral being or of moral adequacy is described by Baruch (1981) who developed a framework for establishing the accomplishment of moral adequacy. Baruch studied how parents with sick children who face the likelihood of their child needing prolonged and involved treatment for heart disease or hare lip and/or cleft
palate, need to establish themselves as moral and exemplary parents. One of the ways of establishing their moral credibility was through the use of the atrocity story. The function of the atrocity story is, according to Baruch (1981:292), "a universal means by which enduring and pervasive inequalities (in the doctor/patient relationship) are redressed." These atrocity stories involve a 'mishap' with the health professions where the parents feel that their competence or intelligence has been disregarded or doubted.

The stories that other participants in both groups told had atrocities as their overt theme and underneath was always the same persuasive message, that participants did what they could in the face of an enormous, powerful and frequently harsh system which disregarded the participants' situation, intelligence, needs and feelings. I did not specifically ask participants to recount stories as did Baruch (1981), Lupton (1992) and Viney and Bousefield (1991). These stories arose in the context of discussion within the focus groups. This was an unexpected event which may be useful in attempting to understand people's experiences within hierarchical systems and could be worth further exploration in a nursing context.

Nursing is primarily caring for others and nursing work is carried out predominantly by women. The reasons why nursing is women's work are historical, cultural and social and are complex in nature. All the participants in this research described the desire to care for others and acknowledged that in learning how to be a nurse, they entered a powerful process which impacted strongly on them as individuals. Group A participants were moulded as young student nurses and moulding also occurred with Group B participants as new registered nurses, when they had to learn to accommodate different values than those they had been taught at university. A number of the participants in this research were ambivalent about their work as nurses. This was apparent in the participants' acknowledgment of the personal satisfaction they get from nursing and their recognition of the importance of the work they do, whilst at the same
time feeling that their caring and their expertise were not recognised or validated by the hospital hierarchy or society. The lack of validation caused participants to feel undervalued as people. If nurses feel disempowered and undervalued professionally and personally it is difficult to envisage how they can empower the patients they care for.

Research Limitations, Implications for Further Research and Conclusion

Project Limitations

A limitation of this research was that data were collected solely through the use of focus groups. Academics in qualitative research such as Corner (1991), Murphy (1992) and Wilson (1987) recommend that more than one method of data collection be employed. The data collected for this research may have been strengthened through the use of multiple methods such as questionnaires or unstructured in-depth individual interviews. The use of multiple methods of data collection may have substantiated the validity of the research to a greater degree though time and resources precluded this approach.

Potential participants in the research were approached through a net working system and friends and colleagues participated together in focus group interviews. This lack of anonymity may have had implications for the quality of the data collected. Concomitant with this, the lack of a facility in which to conduct the focus group interviews meant that they were not conducted on the neutral territory which Kahn and Manderson (1992) and Murphy (1992) recommend. Due to the difficulties experienced in getting women to participate, the numbers in two of the focus groups were less than the numbers recommended in the literature (Basch 1987). Particularly for Group B this may have effected the depth of the information obtained and could account for the lack of development of some the categories such as the experience of being educated. Also
due to the nature of the research and the small numbers involved, this research is not able to be generalised to a population.

**Implications for Further Research**

There are a number of implications arising out of this research. Some of these relate to the area of social attitudes to women’s work, others are more specific to nursing and nursing education.

Nursing is traditionally a women’s occupation. The participants in this research found it difficult to articulate the possible reasons for this or its impact on them. This area might be further investigated as might that of whether and why societal attitudes are changing in relation to nursing as women’s work. In terms of workforce planning qualitative information as well as demographical details about women who are choosing to work in service based occupations would assist in identifying the specific characteristics of this group and the beliefs and attitudes underlying their choice of career. Further investigation of the personal conflicts and limitations experienced by nurses in their work could also be valuable in identifying the issues that lead to attrition, as over eight per cent of registered nurses in New South Wales presently work outside of the profession (N.S.W. Health Department, 1992).

Further research into the response of individuals to the experience of going into nursing and the process of learning to be a nurse would have implications for the future development of nursing education. This area appears ripe for further investigation in the light of the reality shock experienced by Group B participants when they began to practice as registered nurses.

The number of participants in this research who had experienced the loss of a family member in childhood was surprisingly high in both Group A and Group B. This
research identified a perceived need for reparation as a reason for undertaking a nursing career but further investigation of this phenomenon could contribute to a deeper understanding of its significance.

The use of story telling among nurses has not been identified in the literature as one of the ways in which nurses communicate to others their experiences and often their distress related to these experiences. Story telling as a vehicle for relating experiences and feelings was a significant feature in the research and warrants further investigation in terms of its meaning and its use.

Conclusion

Chapter one of this thesis discussed the reasons for undertaking this research and outlined how the literature was utilised. It also introduced feminism as the philosophical and epistemological underpinning of the research. In chapter two, the method by which this research was conducted, its advantages and disadvantages and the role of the facilitator in the data gathering process were described in detail. This chapter also examined each of the five focus groups interviews conducted and described the demographical aspects of the groups as well as my experiences of each group. Chapter three went on to relate the findings from the data and incorporated relevant literature from a wide variety of sources. This chapter also outlined the method by which data were analysed and addressed issues related to the validity of the method. In this final chapter the research findings have been discussed and literature in the area has been used to gain further insights and understandings of the participants' feelings and experiences related to nursing and of nursing as women's work. The limitations of this thesis and the implications for further research have been outlined.

This thesis has examined the reasons behind twenty five women choosing nursing as a career and how they have perceived the impact of the experience on them personally.
Out of the data it became clear that participants experienced a psycho-social and intellectual process in training and practising as a nurse and through this process developed views of themselves, the world and their place in it. Participants were able to articulate the personal growth they gained through the experience of nursing. They also described the impact on them personally of a profession rife with contradictions and paradoxes, for example the dilemma of caring. The data from this research have been interpreted in terms of some of the historical and socio-cultural issues related to women and in particular the way in which women are perceived in a society which is based primarily on patriarchal beliefs and values. This research demonstrates that these values and beliefs have profound effects on the lives of women, on how they value (or don't value) themselves and on how they make sense of their work. The philosophical and epistemological underpinnings of this report lie in the realm of feminism and therefore of social and political justice for women.
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Informed Consent to Participate in Research

This research is being carried out by Barbara Bowler, candidate for the award of Master in Nursing at the University of Wollongong. It has the approval of the Human Experimentation Committee of the University.

The project will investigate nurses attitudes, beliefs and motivations in relation to being a nurse. Participants (all Registered Nurses) will take part in one group interview with five other women. The interview will last for approximately two hours.

1. The interview will be audio taped.
2. You may withdraw from this research at any time.
3. I undertake to maintain all material offered by participants in the strictest confidence and to ensure anonymity of participants in the research report.
4. Participants will undertake to maintain all material shared in the group interview in the strictest confidence.

Signature of Participant _________________
Date: ____________________________

Signature of Interviewer ________________

Please do not hesitate to phone me if you wish to discuss any concerns you have either prior to or after the interview. Barbara Bowler phone: (02) 557 4231
Guideline Questions

Group A

Warm Up
1. What can you remember about your first day as a student nurse?
2. Did you find anything out about being a nurse on that first day? What were some of the rules? How did you understand the rules? What made you obey the rules?

Why Nursing Prompts
3. Describe the influences that were significant in your decision to become a nurse.
4. What did other girls who were leaving your school do afterwards?
5. How was becoming a nurse viewed by your teachers, family and friends?
6. What did you know about nursing before you started? What had you been told? What were your fantasies about being a nurse?

Prompts on the Reality and the Impact of Nursing on Individuals
7. Was the experience of nursing what you had expected it to be? How? If not, what had you not expected?
8. How did you feel as a nurse initially? Later?
9. Do you believe that nursing has had any effect on you as a person, or that you changed in any way(s) because of becoming a nurse? If changes did occur what were these and how did they happen?
10. Describe how nursing effects your self esteem and feelings of personal satisfaction?
11. Describe what you think nursing is?
12. Explain why you think nursing remains predominantly a women's occupation.
13. What is it that keeps you nursing?
14. Would you encourage a child of yours to be a nurse? Why? Why not?
15. What else is important for you about being a nurse?
Group B

Warm Up

1. Encourage participants to describe 'life before nursing'.
2. What did you know about nursing before you undertook a nursing course?

Why Nursing? Prompts

3. Describe the influences that were significant in your decision to become a nurse.
4. What did your teachers, family and friends think about you becoming a nurse?
5. What were your fantasies about being a nurse?
6. Did you consider other careers? Which ones? Why nursing?

Prompts on the Reality and the Impact of Nursing on Individuals

7. Was the experience of nursing what you had expected it to be? How? If not, what had you not expected?
8. How did you feel as a nurse initially? Later?
9. Do you believe that nursing has had any effect on you as a person, or that you changed in any way(s) because of becoming a nurse? If changes did occur what were these and how did they happen?
10. Describe how nursing affects your self esteem and feelings of personal satisfaction?
11. Describe what you think nursing is?
12. Explain why you think nursing remains predominantly a women's occupation.
13. What is it that keeps you nursing?
14. Would you encourage a child of yours to be a nurse? Why? Why not?
15. What else is important for you about being a nurse?
16. How likely is it that you will keep practising as a nurse for the rest of your paid working life? Describe any ideas or plans you have for other career paths.
Part of this project was understanding my own motivations for going into nursing and how nursing influenced my personal development.

The first time I remember saying that I would be a nurse was when I was four years old. I had two aunties (my father's sisters) who were both nurses. My parents, my sister and I had a family lunch together every Sunday with my grandparents and these aunties. I remember that I was Aunty Bev's favourite niece, and how she was always very kind to me and stuck up for me when I was out of line, although she could be quite stern and hard with my sister Jenny who is eleven months younger than me.

Both my aunts lived at home with their parents. Bev was in her mid twenties and Junette a few years younger. There were frequent discussions about which of them was working when, with whom on which ward and gossip about other people who I assume were nurses as well. I enjoyed watching as they starched their veils and painted their shoes with whitener and I was often asked during these times by one or other of them "what are you going to be when you grow up Barbara?" "A nurse" I would reply. I can still remember the smiles I received especially from Aunty Bev and the gratification I got from knowing I had given the right answer.

I was curious about what my aunts actually did as nurses and I wondered why they needed to wear the clothes that they did. I found out that these clothes were called a uniform and I got my own one for Christmas when I was four. I remember asking Bev if she gave people injections and she said that she did. I was impressed and looked forward to when I could give real injections.
I was a very inquisitive little girl and this was viewed as being a problem in my family - "little girls should be seen and not heard" was a common family saying frequently directed at me. I also liked listening to adult conversations which often ceased when I was noticed to be in the vicinity "little pigs have big ears". I gradually came to believe that there were lots of grown up secrets especially amongst women, and that my aunties' secrets had to do with being nurses and with working in a hospital.

On our way home from our Sunday lunches we drove past a hospital, often it was early evening, there would be lights on in the wards and I would catch a glimpse of a nurse moving about or a patient sitting up in bed. What was happening in there? Why did people lie in bed? Did they go home at night or stay the whole night? Did they stay there forever or go somewhere else? What was happening to them? What did nurses do to them? Was it true that some people had to stay in bed all of the time (bedridden was my family's term)? How did they go to the toilet?

As I got older I would ask my aunties questions like these but their answers were generally unsatisfactory. They seemed to be very vague and not too sure or keen to tell me very much. This did not deter me but only increased the mystique that I felt surrounded nurses and hospitals.

Aunty Bev became seriously ill and I remember visiting her in hospital when I was ten. She lay in a high bed with white covers. On a locker next to the bed there was a jug and a glass and I think there may have been a Bible as well. The room was pretty bare and smelt very strongly. I didn't know what is was then but it was probably 'the hospital smell'. There was a floor to ceiling window through which my sister and I had entered her room as we were not supposed to visit because we were too young. We only stayed a few minutes and Bev did not say very much. My grandmother talked a lot and asked questions about clean nighties, who had visited and what the doctors
had said. I felt scared in the room, I had never seen my aunty in bed before and everyone seemed to be awkward and uncomfortable. I kissed Aunty Bev goodbye and left through the window. That was the last time I saw her. She was 33 years old when she died. I did not attend her funeral, my grandmother said that it was not a place for children.

Bev’s death was a terrible blow for my family. My grandparents never really recovered. For years Bev's room was kept as a shrine, on visits my grandmother would take me to the room and often give me something, a piece of Bev's jewellery, a scarf or piece of clothing and always before we left, a look at her nursing medals.

How could I have not become a nurse? I never considered being anything else. In a way my destiny was set in concrete when Bev died. I attempted to understand her loss and to heal my grief and my guilt by comforting myself that I would be just like her. I would keep my promise to her and be a nurse. I would be not just be a good nurse but a very good nurse, I would be selfless and dedicated. I would also help to ease my grandmothers terrible pain for her daughter's loss by in some way recreating Bev, so my grandmother could touch me and have something of her daughter close and tangible. I can now understand why I have always been such a responsible person, I started very young, trying to take the responsibility for my grandmother's anguish and trying to make it better for her and for all my family. Of course I did not have access to these deeply personal insights as a child or really even as a young woman. Healthy introspection and self understanding did not begin until I was in my thirties.

I am 39 now and have been a nurse for over 20 years. Nursing has been good for me and bad for me. It has taken me all around the world and into peoples lives in some of the most poignant and intimate moments in their existence. I am a very good nurse just as I had promised. But nursing has also constrained and frustrated me. At first as a
young woman I felt the anger and resentment of always being at the beck and call of the hospital, at missing out on parties and good times because I had to be on duty. Now my frustration is not so trivial, but is related to a sense of powerlessness I feel as a nurse. Because of the way our world works there are many things that as a nurse I cannot change with my patients. I see things happening to them that I have little influence over, for instance, an abused woman being prescribed benzodiazepines to keep her anger 'under control'. I have become aware in the last few years that I have a great deal of experience and skill in the field I work in and often more than the people who have the mandate on knowledge and power. Carrying out my commitment to helping patients manage their lives in ways that are more helpful and satisfying for them is often blocked or thwarted.

This time is a transition period for me because I doubt whether nursing can provide me with the credibility and authority that I need in order to practice in a way that really helps patients make the changes they want to make and take control of their lives. I am not convinced that nursing can provide what I need in terms of satisfaction. Nursing, which is such caring work is also a political act. Now that I know this I cannot 'unknow' it, so I am constantly confronted in my work with the tension of this awareness and my sense of relative powerlessness to initiate change in any real and profound way.

The experience of writing this has been salutary for me. I have realised that I think of myself as being a nurse and not as doing nursing. At some level my identity as an individual is closely connected with me - the nurse. The nurse is part of my being. My aunties used to ask what I would be not what I would do. This simple recognition gives me a greater depth of understanding of how valuable the feminist research paradigm can be. As Griffith in DeVault states "Analysis does not end but begins with the recognition of their (ie the researchers') own emotion" (DeVault 1990:105).