TRANSFORMING NURSING EDUCATION:
A LEGITIMACY OF DIFFERENCE

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ABSTRACT

In 1973 two trial pre-registration nursing education programmes were piloted in New Zealand polytechnics. These represented an alternative to traditional hospital-sited schools of nursing. The establishment of nursing education in the tertiary sector marked a radical challenge to the cultural heritage of apprenticeship-style nursing training associated with paternal and medically-dominated health institutions. This thesis offers a Foucauldian and feminist poststructuralist analysis of discourses employed by fifteen senior nursing educators in the comprehensive registration programmes between 1973 and 1992. The women employed to teach in the comprehensive programmes faced unique challenges in establishing departments of nursing, in developing curricula that would promote a reorientation of nursing and in supporting candidates to attain their nursing registration. Through semi-structured interviews and discourse analysis methods, a set of unique characteristics shared by this group of early leading comprehensive nursing educators has emerged.

The women’s narratives were underpinned by discourses that centre around the valuing of education as a vehicle for emancipation and an upholding of a legitimacy of difference in nursing educators’ work. The participants upheld the importance of clinical practice skills and drew on their own student nursing experiences as incentives for reforming nursing education. These nursing educators conceptualised an idealised type of graduate, and commonly employed an heroic metaphor to describe their experiences as senior comprehensive educators. Their engagement with such discourses and their shared characteristics demonstrate unique re-constitutions of power, knowledge and relations with their colleagues and clients throughout the education and health care sectors. I propose that these traits characterise the women as strategic and astute professionals who successfully negotiated the construction of comprehensive nursing programmes as a legitimate and transformative preparation for nursing registration.
Abbreviations

ADN: Advanced Diploma of Nursing, a one year post-registration polytechnic-based course, established in 1985.

APNZ: Association of Polytechnics in New Zealand.

AQR: Association for Qualitative Research.

CHEs: Crown Health Enterprises.

CNEP: Comprehensive Nursing Education Programmes.


ICN: International Council of Nurses.

I.C.s: Interviewer comments.

HEC: Human Ethics Committee.

NACNE: National Advisory Committee on Nursing Education.

NCNZ: Nursing Council of New Zealand, the professional nursing registration body.

NERAC: Nursing Education Review Advisory Council.

NERF: Nursing Education Research Foundation.

NZNA: New Zealand Nurses Association (now defunct public sector professional union for nurses).

NZNO: New Zealand Nurses Organisation (amalgamation of NZNA and NZNU, since 1993).

NZNU: New Zealand Nurses Union (now defunct private sector professional union for nurses).

NZQA: New Zealand Qualifications Authority.

RePIENs: Review of the Preparation and Initial Employment of Nurses.


RHAs: Regional Health Authorities.

SANS: School of Advanced Nursing Studies, Victoria University which offered one year diplomas in specialist nursing fields until 1985.

S.C.s: Sensitising concepts.

TTU: Tutor Training Unit.

Chapter One: Introducing the research

Not a fairy tale

Once upon a time, a middle class pakeha school leaver went to a selection interview for her local comprehensive nursing programme. She was interviewed by two dynamic women who were very enthusiastic about the polytechnic-based programme where they taught nursing education1. The two nursing educators really seemed to listen to what the schoolgirl said; they took her questions seriously and respected her comments2. When she explained that she wanted to travel overseas, one of the women responded by saying that the world would be her oyster if she traveled as a registered comprehensive nurse. Nobody had said anything quite so romantic to the schoolgirl before. Their infectious zeal for the opportunities comprehensive registration would provide made the schoolgirl very excited, and she left the interview happy and hopeful that she would be selected for the coming intake.

Just over three years later the schoolgirl had become a Registered Comprehensive Nurse (hereafter R.Cp.N). She was bonded as a new graduate to work at a place called Tokanui Hospital in rural Waikato, in the central North Island3. When the letter arrived informing her of this, she sought out a map to see where it was. There, on a rather old map it said “Tokanui Mental Asylum”. Within just a few hours of her arrival at the nurses’ home at Tokanui, a registered clinical

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1 I have used the term “polytechnic” and sometimes the more colloquial “polytech” to include all technical institutes, institutes of technology and community colleges where comprehensive nursing courses have been sited since 1973.

2 I refer to all registered nurses who have been employed to teach in comprehensive nursing programmes or in hospital-based schools of nursing as “nursing educators”. This term is used to generalise the distinctions that have otherwise been made between institutions where staff have been referred to by other titles, for example as “nursing tutors” and “nursing lecturers”.

3 Between 1976 and 1985 the Department of Health offered comprehensive students a supplementary grant of $10.00 per week over and above the Department of Education’s tertiary bursary provision. This bond was offered in exchange for the students’ agreement to work within the public sector for up to two years after their registration (N.Z. Department of Health, 1988: 11).
psychologist offered the nurse prescription drugs to help her settle in to her new home. Within a week she was left “in charge” of what was called the “low functioning psycho-geriatric unit” of about 30 very ill elderly patients. The staff working with her comprised Tokanui-based psychiatric nursing students, untrained nurse aides, and a registered general and obstetric nurse who had been dressing one of the unit’s older gentleman’s increasingly gangrenous toes with “friar’s balsam” (an iodine-based alcohol used to dry and toughen skin). The new graduate understood this to be an utterly ineffective and potentially painful form of treatment.

Each day her most important job was to organise the medications for the patients. These were rainbow-coloured mixtures of psychotropic drugs; and there were drugs to combat the side effects of these drugs and drugs to treat any patient’s underlying physiological medical conditions. Occasionally a patient became acutely distressed or agitated. On these occasions it was her job as a trained nurse to follow the doctor’s prescription, and inject their tight gluteal muscles with a tranquillising drug, sometimes with one or two of the aides or students sitting on the patient to hold him or her steady. The nurse understood that this was a form of assault. Some days the more able-bodied patients tried to run away from the ward, and sometimes it was the nurse’s duty to follow them, climbing fences and running across paddocks after the “escaping” elderly patients. She had to try to lure these men and women “home” with a cup of tea and a cuddle.

After requesting a transfer to a different unit, the nurse was ordered to give injections of the contraceptive drug Depo-Provera to a young woman with an intellectual disability whose menstruation was too difficult for the nursing staff to manage. The nurse found this repugnant; because when she was a student nurse she had studied feminist literature which linked that drug to cervical cancers (for example Greer, 1984: 149-154).

4 Throughout the dissertation I assign the term “patient” to refer to the variety of people who are cared for by registered nurses throughout the health sector. Such nomenclature is politically loaded by implicating sickness and dependence, but my decision is based on the lack of effective alternatives, for example “client” or “consumer” is often assumed to imply a direct fee-paying relationship.
Many of the patients at Tokanui identified as Maori, and spoke Te Reo as their first language. Similarly a large number of the staff were fluent in Maori. The nurse tried to fit into this culture by learning to say “Come and get your medicine” in Maori. She understood the irony of learning that particular phrase, for the focus on drugs had everything - and nothing - to do with caring for the people she was working with.

She tried to fit in at Tokanui, but many of the staff were wary of the nurse. Her medal was different, she was from outside the local area, and she sometimes talked about doing nursing differently. The nurse was lonely, and wanted to make friends, so she stopped volunteering suggestions and rarely if ever questioned the ways things were done. Instead, she began to drink too much and she would spend nights awake thinking about the ways she was being a bad nurse. She was ashamed that the way she was working was so terribly different from the ways she had been taught to care for people in her training.

The two groups of people who made her feel less lonely and miserable were the handful of trainee intern medical students who came for three-month training in psychiatric medicine, and the visiting local polytechnic comprehensive nursing students. Amid the frequently changing groups, many shared the nurse’s dismay and shock that such a place continued to exist in the mid-1980s in the Aotearoa New Zealand health system. Two of the medical students encouraged the nurse to apply for permission to leave Tokanui because they saw how unhappy she was, and after ten months of employment, the nurse’s request to transfer to the local general hospital was approved and she left.

During the months she remained at Tokanui, the nurse looked forward to the times when nursing students from the polytechnic were coming to work at the hospital: she even gave them a nickname as a term of endearment, calling them “techies” to distinguish them from the hospital-based nursing students. After about four months of listening to her chat about and to the students in this way, one of the bilingual staff ventured to inform her that “teke” translates to female vulva in Maori (Ryan, 1997: 294 and 738). The nurse stopped using the term, but could
not stop the embarrassment she felt about the inestimable offence she may have caused.

This is not a fairy tale because it is based on things, people, and places that really existed. I was the young nurse, and this is the story I have chosen to tell to explain why I was initially motivated to embark on a dissertation into the field of nursing education. It is a story that offers a way of understanding history; it is my way of telling the story of the women who had filled me with joy and excitement about what my life might be like as a registered comprehensive nurse. It is a story of the teachers who taught me how to become one. It is also a story that explains the problems encountered by polytechnic-based staff and students over the years, and the sometimes terrible mismatching of nursing education with the hard realities of graduates’ employment in places such as Tokanui Hospital.

As an insider, it is a fitting way to introduce this thesis. This is not a fairy tale. It is a narrative which weaves realities with long-buried memories. As such it is presented as the foreword to this thesis to give a taste of the much more complicated and detailed narrative which tells a story of the working lives of a group of women who wanted to reorganise nursing education in Aotearoa New Zealand. They shared the belief that such change might come about through their promotion of comprehensive nursing education which represented a radical shift from the ways nurses had been prepared in this country for the past century⁴. So in a way, this text is a particular historic narrative concerning comprehensive nursing education and it retells some of the experiences of nursing educators who worked to develop these programmes. It is by telling this story of comprehensive nursing that I am able to present an analysis of the particular discourses which dominated nursing educators’ experiences over the first two decades of the transfer process.

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⁴ The training of nurses in general (that is, medical-surgical focused) hospital-based apprenticeship programmes were established in New Zealand at Wellington Hospital in 1883 (Burgess, 1984: 61, 223). On the 12 September 1901 the organisation of training was formalised through the introduction of a pre-registration state examination and the passing of the Nurses’ Registration Act, which represented the first stand-alone nursing statute in the world (Ibid; New Zealand Nursing Review, 2001: 13). Psychiatric nursing education began to prepare nursing for registration through hospital-based schools in that specialist field from 1944, and the first psychopaedic hospital-trained nurses were registered in 1963 (Hunt, 2000: 57).
Throughout this thesis I refer to nurses and nursing educators as women because these occupations have always been dominated by women and because all the participants in my study were women.

It is not a fairy tale because there are no evil witches, dragons or villains to fear or loathe. There are many battles to be fought, but there are never real victories or catastrophes, just outcomes, resolutions and compromises that have made the nursing educators’ – and their students’ – lives more or less difficult. There were no handsome princes or knights in shiny suits of armour to rescue the women involved in developing comprehensive nursing programmes. Rather it is a story of women who acted in what I identify as wise, strategic, pragmatic and even heroic ways because they understood that they must look after their students, their colleagues and themselves in conditions of sometimes-remarkable difficulty. And it is a story of the ways the nursing educators have judged their successes by the positive difference they have made in some people’s lives, while at the same time they demonstrate their understanding of the realities of existence without any “happy ever afters”.

This dissertation presents a narrative of the ways nursing educators have managed to develop comprehensive nursing in the 20 year period since 1973 when the first trial programmes commenced in Wellington and Christchurch and 1992 when the first pre-registration nursing degrees commenced. The text that I present has emerged from my experiences of meeting with a group of nursing educators who held senior roles in a range of comprehensive programmes throughout Aotearoa New Zealand. While the text is imbued with the stories and reflections of the fifteen women I interviewed, the thesis has woven through it my own story of being a Christchurch Polytechnic comprehensive nursing graduate and University of Canterbury doctoral student. Before I introduce the nursing educators who have been the participants in this research, I need to explain a little more about my positioning in the following narrative.

I enrolled for the Ph.D. within a university context where there was no department that studied nursing education, and I was not a nursing educator myself. As a consequence I have come to think of myself as an “onsider” looking and listening
from the sidelines towards the field of nursing education. I believe that such positioning has been advantageous to my research. As someone who had not participated in the organisation of comprehensive programmes, I had an outsider's "distance" which allowed me to question the "taken for granted" issues that the participants understood about the programmes the women worked in (Rice and Ezzy, 1999: 58; Merriam, 1998: 75). At the same time, I worked through my dissertation with a sense of isolation and a constant nagging concern that came from being detached from those who might otherwise help me clarify my understandings of what was "going on" in nursing education. I had been apprehensive that I could develop ideas about what I might think were of great significance, which those "inside" the system of nursing education would think were fundamental, taken for granted or inconsequential. I found it hard to engage in speculation while feeling isolated from such a community, and while I could discuss ideas with friends and fellow students, I most often relied on reviewing ideas and hunches in an authorial dialogue with myself by computer (Taylor and Bogdan, 1998: 169-170).

I understand that I have not been a complete outsider to the field. As a graduate of the 1982-1984 Christchurch Polytechnic comprehensive programmes, I had a wealth of assumptions, ideas and knowledge about nursing, and the ways nurses were being trained, that had significant negative and positive implications for my work. In this regard I remain mindful of the advice given to qualitative researchers, for example from Taylor and Bogdan, that

In traditional research, bias was to be avoided at all costs. In our view, this is impossible. Rather than act as though you have no point of view, it is better to own up to your perspective and examine your feelings in this light.

(1998: 161)

My memories of my studentship, the nursing educators who had worked with me, my experiences as a comprehensive graduate, and my critical theorising about the politics of nursing education as a university student have had important consequences for "the quality and the richness of [my] data and analysis" (Smith, L.T., 1999: 137). The work has also been influenced by the supervisors who have
overseen my emerging dissertation. I enrolled for the Ph.D. with Dr. Liz Gordon, an educational sociologist, and when she resigned at the end of 1996 to become a Member of Parliament, Dr. Elody Rathgen and Ms. Missy Morton took on supervisory roles, and introduced me to the challenges of Foucauldian and feminist poststructuralism and qualitative research methods. When Missy left the Department in 1998, Dr. Daphne Manderson took over this role, and afforded me a supervisor who is herself an experienced comprehensive nursing educator. I believe that my work reflects the diverse range of disciplines that each of these academics is expert in.

I have offered the preceding explanation to introduce myself as simultaneously the author of this text, the analyst of the participants' narratives and a registered comprehensive nurse. I also believe it is equally important that the participants are introduced at the beginning of the dissertation, so that the reader might begin to develop a sense of the individuality of the women who participated in this research. Confidentiality issues prevent me from describing the sorts of characteristics that are commonly cited to aid the reader to understand some aspects of the people's identities. This includes their age, qualifications, and, for example, what sized location they live in or whether they have children. Using anonymity allows participants to speak freely, but also relates to the Foucauldian idea that identity of particular individuals is of less importance than the study of the roles people adopt through constraints and freedoms created from discourse (Foss, Foss and Trapp, 1985: 200).

What I present in this introduction is a single comment that each of the women offered as a reflection on their own development as a nurse or nurse educator. Most commonly these relate to their studentship, although a minority offer a comment in relation to their registered nursing practice or continuing education as a comprehensive nursing educator. Each of the quotations is followed by the name of the women and the first line number in the transcript of their interview where the comment can be found. While these comments can be understood to reflect a specific incentive or quality that imbues their work as nursing educators, they only represent a cursory introduction to the rich and complex characters of the women involved in the study that are explored over the following chapters.
Introducing the participants

The first group of participants I introduce all offered comments about aspects of their own nursing training under the apprenticeship-style, hospital-based, schools of nursing. For example, the first comments refer to the women’s introduction to nursing training. The experience of being a hospital patient gave Liz insight into the relationship between the standards of nursing training and the qualities of nursing care graduates could offer patients like Liz.

[My experience as a patient] was a key [event]... Through the period that I was training, I was not impressed with some of the teaching, so that started to show me why I hadn’t been impressed with some of the nursing.

(Liz, 303-)

Emily’s work in comprehensive nursing programmes has been underpinned by a commitment to the principle that nursing is equally as honourable, complex and challenging as the profession of medicine.

[After I had made the decision to be a nurse] I remember saying to people over the road... that I was going to be a nurse. And I remember them saying, ‘Oh we could imagine [my sister] as a nurse, but you are too bright to be a nurse’. And it was the first time I ever had a sense of what does that mean, ‘too bright to be a nurse’. It’s a load of rubbish.

(Emily, 1634 -)

Maria offered a particular comment about the merits of holding a “student” rather than a “worker” identity which accompanied the transfer of nursing education from hospitals to the tertiary education sector.

Very early in my career as a nurse I thought how ridiculous it was and how undervalued the word nurse was. How you used to arrive on Sunday night to enter into the training course and you were Miss [Family Name] when you walked in the door, and the minute you were shown your room you were called Nurse [Family Name]... I felt that the title ‘nurse’ really had to be earned and that the person should see themselves as a student of nursing.

(Maria, 180-)
In listening to Anne, I understood that her passion for providing comprehensive students with excellent nursing education was partly inspired by her witnessing high attrition rates among students of hospital programmes.

*I started nursing at [City] Hospital.... We were a big class, and we had sixty-nine students when we started and twenty-something when we finished... Something needed to happen in nursing education.*

(Anne, 122-)

The following three women reflect upon aspects of their classroom-based nursing training. Meeting Kate left me with an understanding of how her experiences as a trainee nurse had encouraged her to become an educator herself. This is reflected in the following comment about her preliminary school of nursing experience.

*I always knew I wanted to move into nursing education... I probably got caught when I was in ‘Prelim’ and one of the [nursing educators] knew I was being slack [because I had higher than the minimum entry qualifications]... She was very astute... Her way of dealing with me was to get me to give a lecture to my classmates on ascending and descending pathways of the nervous system ... I learned very early that I was quite good at teaching, or explaining things in a way that people could understand.*

(Kate, 45-)

My interview with Cathy gave me an appreciation of her strong commitment to an alternative organisation of nursing education that had been fuelled by her experiences as a student.

*[The comprehensive programme I taught in] didn’t have a great medical involvement. Because we wanted to give emphasis to nursing... In the hospital-based programme we had medicine, surgery and obstetrics, but we didn’t get much of the nursing. In the old traditional environment surgeon so-and-so came in and gave this lecture, and then you had quarter of an hour on nursing. And I wanted to reverse those things.*

(Cathy, 2375-)
When I met with Beth I gained a strong impression that her work as a senior comprehensive nursing educator was driven in part by the desire to encourage excellence among nursing educators - both for their students and to advance the profession as a whole.

I was concerned that most people went into nursing education by default, with little preparation. There wasn't a clear pathway which said to you, once you became a registered nurse, if you really got interested in education you could go down that pathway and do that course.

(Beth, 1230 - )

Unlike classroom experiences, student’s clinical experiences provided clearly evocative reasons for some of the nursing educators’ enthusiasm for a new form of nursing education, as the four subsequent comments demonstrate. As I interviewed Helen I glimpsed how some distressing student experiences had left her with a very powerful legacy in her identity as a nurse. One of the comments she shared with me was:

I still dream about some of the experiences that were horrific. Once I was left alone after less than eighteen months [as a student]. The whole ward was under-fives, and I was the only nurse on duty in this ward. And there was a baby, a spina bifida baby, very young, who was just in a cot, because you just didn’t have what you’ve got now. And I remember standing over this cot in the middle of the night, crying, because I did not know whether this baby was alive or dead. And I didn’t know what to do.

(Helen 637- )

With a career history that demonstrates an enduring commitment to nursing education, Gwyneth reflected that “both out of practice and education [she had developed] a passion for nursing education that was inflamed because of my own experiences” (478- ).

As a student I worked outside my level of knowledge and skill. I can’t truly say that I knew that there should be a better way. I did it because that was the way you did it. But I knew there was something really screwy in the system that put us in that kind of vulnerable state. ... I can remember I was in charge of a men’s surgical ward... [and it was my] first night shift as a senior [nursing student]. And a patient ... got up, out of his bed, and
made me a cup of tea... He made me a cup of tea! And he said, 'It’s OK'. He said, 'The ward is quiet, everybody’s asleep except me'. He sat with me in the office, and we had a cup of tea, until I simmered down. How horrendous is that?... I can remember writing out my resignation three times, actually physically writing out my resignation. It would always get ripped up. But I actually wrote it three times.

(Gwyneth, 409-)

Olivia held a fundamental belief in the importance of nursing candidates not being assigned to nursing patients without a sound and complete prerequisite understanding of their care needs.

I was a student nurse at a time when the hospital was very short of registered staff. For three hours in the afternoon we didn’t have any registered staff on duty in an acute surgical ward. We had this sick gentleman who’d had surgery, but he was vomiting and I could tell he wasn’t well, although his doctor had seen him in the morning. So I rang the house surgeon, who examined him and said, 'He’s developed a paralytic ileus'. He must have seen the look on my face because he said 'Do you know what that is?'. I said 'No, I haven’t got any idea what that is', so he proceeded to tell me, which was very kind of him. But those sorts of situations should never occur.

(Olivia, 518-)

Jane reflected on her own nursing training as motivating a belief that comprehensive programmes should offer a positive and supportive learning environment for students.

I know in myself as a student if you got shifted, if you got put on what was called 'emergency' and you could be sent anywhere from day to day, it was pretty traumatic.

(Jane, 502-)

Delia and Tracy offer generalised reflections on how they regarded their nursing training, while Rachel and Fiona reflect on the legacy of their preparation for their work as nurses or nursing educators. From comments such as the following, I gained a strong sense of Delia’s emphasis, as a senior nursing educator, on creating a democratic and less institutionalised learning environment.
If you did something naughty in the hospital-based training, everybody believed that you got put on night duty. I myself was quite naughty. I never got put on night duty, but held truly to the belief that you would.

(Delia, 820-)

By talking with Tracy, I was reminded that some of the comprehensive educators were impassioned about the potential life opportunities that nursing education programmes could offer to nursing candidates.

I had no education background when I came nursing, I didn’t know how to learn, I was a rote learner. But I was convinced and my family was convinced that education was the way. Nobody in our family had ever been to secondary school I mean, it ties [up with] social mobility. Education was the way to go. ... [My nursing education] gave me an understanding that anybody could learn anything, and that learning was exciting.

(Tracy 869-)

Fiona’s reflections on her first staff nursing experiences help to convey the sense that her work in comprehensive nursing programmes had been motivated by desire to promote more patient-centered forms of clinical nursing practice.

I remember as a new registered nurse, saying to someone in the change room ‘When I put my hat on my head, I actually put my initiative up in my locker where my cap normally sits’. ... And if I didn’t use the procedure cards, if I didn’t follow the routine, if someone having a hysterectomy had needs that were perhaps a bit different from the standard hysterectomy care, and you tried to do that, you actually got into trouble.

(Fiona, 314-)

Rachel reminded me in her interview of the diverse and rich range of skills that nurses acquire from their nursing education.

...When I became a Head of Department who was both a nurse and a woman I was not regarded as knowing anything about management. [My response was to study management at post-graduate level, during which] I was astounded when... [we were taught]... the basics of communication skills [that] we teach to our first year nursing students. [The other
students] had never heard of it before. It really brought home to me... the
depth and the expectations that we have of nursing students and of
nurses.

(Rachel, 316-)

Having introduced the women in this way it is important that I continue to
integrate their participation across the thesis, not only in the chapters that present
my findings and where their reflections dominate the text, but also in my
discussion of the theoretical and methodological sections of my work. This is to
show that the women have not only taught me about the discourses that form the
context in which comprehensive nursing have developed, but that my interactions
with them have encouraged me to reflect upon epistemological issues and
qualitative research techniques. By including participant and personal reflections
throughout the first few “methodological” chapters, I have sought to break down
the divisions and boundaries that otherwise separate the components of the
dissertation, for instance between the authority of theorists and the narrative
voices of the participants. As such, this represents the first component of my
efforts to present this thesis in a Foucauldian genealogical style, whereby
traditionally-marginalised histories and the voices of the people involved, provide
the foundation for new research.

The focus of the thesis

This work seeks to explore the discourses that a group of women who were
involved in the transfer and settlement years of comprehensive nursing education
programmes (hereafter abbreviated to CNEP) have drawn on to make sense of
their employment experiences. I sought to learn about how they worked to
develop nursing education and to prepare candidates for registered nursing
practice within the changing political, economic and social contexts of the
Aotearoa New Zealand health and education sectors in the period between 1973 -

This thesis is a forum in which I explore my developing understandings of Michel
Foucault’s genealogy thesis and the feminist “histories of the present” as they cast
light on changes in nursing in New Zealand, through interviews with comprehensive nursing educators. It includes the extent to which the women in my study were able to maintain the values they personally held about how nursing education should be organised, as well as what and how it should be taught. Such ideals are examined against the explanations of their pragmatic responses to achieve the outcomes they desired, namely the successful registration and practice of their students as comprehensive registered nurses. The tenet of this thesis offers an enlightening representation of how the nursing profession has developed in the late twentieth century in ways that involve coherence and unity at the same time as individualism and heterogeneity, and reorganisation of power relations. It also documents the significant challenges that CNEP have posed to the discursive regimes that have prevailed in the organised social construction of nursing education and nursing practice over the past century.

The context of my project

The development of nursing in Aotearoa New Zealand has been documented in a variety of ways. Early nursing academics, mostly based at the School of Advanced Nursing Study (hereafter SANS) at Victoria University in Wellington, published historical and contemporary commentary though national conference papers and the New Zealand Nurses’ Association Journal. These include Fieldhouse, 1973, Penny, 1970, and Whiteman, 1971, while others documented the adequacy of hospital-based nursing preparation within the state sector, for example Bohm, 1973. A third source of publications by early nursing academics has been directed to international or non-nursing audiences (for example Boyd, 1971 and Salmon, 1970, 1974). More generalised commentaries on the development of nursing education in Aotearoa New Zealand are dominated by the contributions of Marie Burgess (1984), Bea Salmon (1982) and the New Zealand Nurses’ Association (hereafter NZNA) (1984). Before the advent of nursing-specific degree-level programmes (which commenced at Massey and Victoria Universities in 1973), nurses took the opportunity to research nursing education and work through alternative disciplines. Examples of this include a sociological study of student nurses’ role perception (Penny, 1968) and the selection and
attrition patterns among student nurses from an educational perspective (King, 1969).

Literature can be separated into various groupings regarding the preparation of registered nurses through schools of nursing based in public hospitals. Some publications have documented institutional concerns about hospital preparation for nurses to meet the needs of the changing health sector (for example Carpenter, 1971; New Zealand Department of Health, 1969; Nurses' and Midwives' Board Report, 1964 and Reid, 1965). Also as a consequence of the transfer of nursing education, there is a range of studies of the histories of hospital-based nursing schools, mostly written to commemorate their closure. These include histories of the general nursing programmes at the Auckland School of Nursing (Brown, Masters and Smith, 1994), and Christchurch Public Hospital (Campbell, 1997), as well as the psychiatric hospitals at Seaview in Hokitika (Seaview School of Nursing Reunion Committee, 1992) and Sunnyside in Christchurch (Harraway, 1992). Other authors have examined the history of particular hospitals including church-funded health providers (Everton, 1987, and Belgrave, 2000), and institutions that specialised in caring for patients with particular needs, including the development of psychopaedic nursing6 (Hunt, 2000).

Other contemporary nursing literature has presented historical reviews of aspects of the nursing profession. Contributions from Rodgers concerning early nursing training programmes (1985 and 1987), Rayna’s thesis on the historical development of nursing practice (1983) and Filshie’s tracing of the struggle for professional status for nurses (1985) are notable in this field.

The changing organisation of the health sector in Aotearoa New Zealand has been documented in general (for example, Bryder, 1991; Davis, 1981; Fougere, 1978, 1984 and Hay, 1989) and in regard to specific socio-political issues (for example Bowie and Shirley, 1994; Davis, 1992; Davis and Dew, 1999, and Dow, 1995). Similarly, there have been generalised reviews of the New Zealand tertiary

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6 In Aotearoa New Zealand, the term "psychopaedic" was coined as a substitute for the unpopular nomenclature operating in the United Kingdom, which referred to people with intellectual disabilities as "mentally retarded" and qualified nurses in this field as "mental deficiency nurses" (Hunt, 2000: 54-56).
education sector (Boston 1988; Butterworth and Tarling, 1994; Patterson, 1991 and Stevens and Boston, 1994) and the development of polytechnics as sites of education in the post-war period. These include histories of the Auckland Technical Institute (Keir, Maloy and Moses, 1985); Christchurch Polytechnic (Hockley, 1990) and Hawke’s Bay Polytechnic (Moss, 1996). (See also Hurrell, 1996).

The development of CNEP since 1973 is an important symbol of the ways that nursing has grown as a profession within this country, and this is reflected in the breadth of literature that accompanies this transfer. Early reviews of CNEP by nursing educators and academics include articles by Christensen, 1976; Kinross, 1975 and Shadbolt, 1975. The establishment of comprehensive programmes has been carefully reviewed for the efficacy of registered nursing preparation by both the state sector and professional nursing bodies. Notable examples of this include the Board of Health Report, 1974; New Zealand Department of Health, 1988; Hutchings, 1982; New Zealand Nursing Education Review and Advisory Committee (hereafter NERAC), 1983; NZNA, 1984; Taylor, et al., 1981 and Walton, 1989). Alternative literature considers the merits of tertiary sites for CNEP development, for example, Brown, Masters and Smith, (1997) and reviews of nursing education epistemologies, for example, Peters, (1998). More specific documents have examined particular aspects of the preparation of comprehensive students for registered practice in Aotearoa New Zealand (for example Allen, 1992; De Vore, 1993; Forbes, 1990; Horsburgh, 1987; Mayson and Hayward, 1997; Murchie and Spoonley, 1995; Pearson, 1998 and Perry, 1985).

The deregulating of the tertiary education sector and the formation of the New Zealand Qualifications Authority (hereafter NZQA) under the Education Amendment Act of 1990 has lead to the flourishing of nursing as an academic discipline and a proliferation of tertiary institutions where nurses pursue undergraduate and postgraduate study. In this context, my research represents a contribution to the field of nursing-generated research concerning the historical emergence of professionalised nursing in Aotearoa New Zealand. A major contribution to this field has been the Oral History Archive of the Nurses’ Education Research Foundation (hereafter NERF) project. This is a series of
audio-taped interviews with teachers and administrators who were involved in both the hospital-based and polytechnic-sited forms of nursing education between 1970 and 1985 (Langridge, 1993). As I explain in Chapter Five, I have utilised this archive in my own work.

More particularly, the past decade has witnessed a flourishing array of theses, often presented by nursing educators, which have explored aspects of comprehensive nursing educators’ work. These include Booth, 1997; Bride, 1998; Clare, 1991; McCallin 1993; McEldowney, 1995; McManus, 1994; Papps, 1997 and Walthew 1999. In addition Yvonne Langridge’s (1993) dissertation concerned with nursing education in the light of neoliberal reforms across the health and education sectors, and Gay Williams’s (2000) dissertation regarding the reflections of a group of nurses who have offered significant contributions to professional development, are important. All of these offer significant connections with my own field of research, and the significance of these will be discussed as they pertain to my emergent findings throughout the chapters that follow.

The specifics of comprehensive nursing education within Aotearoa New Zealand aside, the idea of such a project seemed the logical extension of the literature that is available about issues which broadly frame this field of study. Internationally there is a rich and diverse group of academics who have published an array of texts which examine aspects of nursing education. The wealth of North American nurse education academics which is too extensive to recount began with Heidergerken’s 1952 research into student nurses’ evaluation of their preparation for qualified practice (Pugh, 1983: 62). In Britain, Celia Davies, John Humphreys, Geoffrey Hunt, Judith Lathlean, Christopher Maggs, Kath Melia, Sam Porter, Anne Marie Rafferty and Jane Robinson are notable and prolific commentators who critically review aspects of nursing education.

Australian nursing academics, for example Helga Kuhse, Jocelyn Lawler, Annette Street and Deirdre Wicks lead a flourishing literature that considers what can be broadly understood as a sociology of nursing education. In addition, significant contributions from a feminist poststructural perspective are offered by Kenway
and Watkins (1994) and by nursing academics interested in Foucauldian theory (O'Farrell, 1997).

A range of texts consider the unique experiences of groups of women educators from feminist poststructural theoretical standpoints. A variety of literature that has been informative to my research include the following: Bloom 1998; Kenway, et al, 1993; Middleton, 1993; 1998; Munro, 1998; Theobald, 1993; Weiler, 1988 and Weiler and Middleton, 1999. Other literature similarly informs the particular field I have studied by offering feminist and other poststructural examinations of the relationships between nurses and the medical profession, for example Mackay, 1992; Wicks 1999; Willis, 1994 and Witz 1992, 1994.

There have also been enlightening critiques of education and work, and analyses of the specific example of nursing within the context of the health sector. Much of this literature has articulated problems concerning relations of power - either between nursing and other staff, and/or nurses and the people they are employed to nurse. For example, these include reviews of neoliberal reform and managerialism with regard to nursing (Armstrong, 1993; Brannon, 1994; Humphreys, 2000; Owens and Glennerster, 1990 and Traynor, 1999) and the unique ethical dilemmas that face registered nurses (for example Dixon, 1990; Hunt, 1994a, 1994b), and Kuhse, 1997).

My work is situated amid the diverse and rich range of this literature.

**My research processes**

The way this thesis is presented reflects the complex journey I have traveled in order to complete it. The next chapter attends to the contextual political, social and economic organisation of Aotearoa New Zealand, and how I have understood the provision of health and education services within this changing environment. As such, it reflects my initial project goal: to explore with comprehensive nursing educators how they understood their work within the potentially constraining and emancipatory reforms across the public sector. I began my research with the belief that the concept of professionalism would be a useful heuristic device for
exploring women’s understandings of agency, authority, status, and power. It was
with questions of professionalism in mind that I made an informed decision to
employ “professionalism” as an opening conduit to explore the complex field of
nursing education. I considered it likely that in talking about their understanding
of the term and their views about professionalism and nursing, nursing educators
might reveal some of their own understandings of the relationships between their
identity and the context in which they have worked.

Before I had been able to interview anyone, my first supervisor left the university
and I was confronted with the need to rearrange my work into a project which
other academic staff could oversee. The question of supervisors aside, my
growing interest in qualitative research methods facilitated my reorganisation
towards interviewing women nursing educators with open-ended questions
concerning their experiences in comprehensive programmes. By this stage the
idea of a structurally focused historical review of nursing education using the
reflections of nursing educators as a data collection strategy, was waning. I
became attracted to exploring meaning through language, but my previous study
and knowledge around the sociology of education remained. To this end I
developed semi-structured questions and a timeline, duly noting particular socio-
political events, and these became the basis of my interviews. To acknowledge
this structured historical foundation to my work and more importantly to the
context in which comprehensive nursing education has developed, Chapter Two
reviews the timeline reading of history.

As I began to meet with participants my approach changed. The processes of
reflection, reading, discussion with colleagues and supervisors, and finding that
the women offered me new questions rather than specific answers about CNEP,
attracted me to poststructural epistemologies. The influence of Michel Foucault
and feminists such as Chris Weedon and Vivienne Burr forced me to see questions
about fields of nursing education, nursing work, my project and myself as
researcher in a new light. Principally this concerned understanding discourse as a
foundational tool for the review of power, knowledge, language and subjectivity.
An explanation of these epistemological foundations is provided in Chapter Four.
Because of this, my thesis is more disjointed than I originally hoped, but I believe
that the transparency and careful account of my methodology presents a strength and a uniqueness that my dissertation would otherwise lack.

The field of research

My work is principally concerned with the experiences of comprehensive nursing educators across Aotearoa New Zealand from 1973 to 1992. I have talked about times before and after these dates, as I have about hospital-based nursing education and the experiences of comprehensive graduates, only to the extent that they are relevant to my particular field of enquiry. The gradual region-by-region development of comprehensive programmes between 1973 and 1986, and the concomitantly erratic sequencing of closure of hospital schools of nursing only completed in 1991, also make this research unique (Hunt, 2000: 307). The conditions within which nursing educators have been employed to establish and develop comprehensive programmes have involved complex forms of negotiation with both the health and education sectors. This has been made particularly complicated by the positioning of the participants and their colleagues in relation to each of these two institutional contexts. To the polytechnic staff, the newly appointed nurse educators were perceived as “outsiders” who had moved into the tertiary sector from the distant health sector. Conversely, to the health sector, these women often had an identity as “insiders” from their past employment in the local health institutions as student and staff nurses and/or as teachers in the nursing schools. But their identities changed drastically. Once employed by polytechnics, these participants were constructed as “outsiders” because they were identified as employees of the education sector. Such convoluted politics of identity proved enormously challenging to the women in my study. More generally, this thesis also provides a commentary on how a group of women nurse educators worked to develop a new form of nursing preparation for the specifics of an Aotearoa New Zealand context.
My choice of method

I wanted to explore a relatively small field of education, namely comprehensive nursing and the women who developed the programmes, and to present a detailed study of how individual educators drew on particular discourses to reflect the complexity of their lives in the particular health, education and broader political contexts. Certainly the choice of topic was of personal interest to me. In relation to my personal experiences as a nursing graduate, I wondered if the complexity of my existence at Tokanui was anything like the “nitty gritty” experiences of the women employed in polytechnics who taught entry to practice nursing students. I could only envisage enacting such research by talking with a group of nursing educators about what CNEP had been like for them.

My role as researcher

My understanding that I am part of what creates this research project is consistent with the poststructuralist consideration of partial truths (Denzin and Lincoln, 1994: 578). That I am an implicit part of the text, and that it is the way I interact with the data and the participants themselves, makes this research unique and fraught with ethical and methodological challenges (see Wilson, 1996). One of the most important ways this occurs is because of my own identity as a nurse educated within the comprehensive system. On one level this dissertation represents a revisiting of my own past experiences. As Foucault elegantly explains, “each of my works is part of my own biography” (Horrocks and Jevtoc, 2000: 7). In essence, the text presented here is unavoidably imbued with my authority, as my understanding of this research project continues to evolve. I recognise that the analysis will never be anything but partial and incomplete. Despite this, I believe it is purposeful and revealing. Exploring the ways women nursing educators have engaged with, challenged and reorganised discourses that construct nursing education and nursing work for their students and themselves reveals much about the relative power, knowledge and authority this occupational group can make to nursing and nursing education in Aotearoa New Zealand.
My use of a qualitative method has provided me with rigorous yet flexible strategies for exploring how nursing educators have deployed particular discourses to make sense of the development of comprehensive programmes and their roles within them. Ultimately my use of qualitative methodologies comes from a desire to explore with a group of women their reflections and understandings of what their lives have been like as nursing educators and to reconstruct their ideas into a document which is unique and unable to be replicated. Open-ended questions posed to participants have yielded some recurring themes as well as dissonance of responses and reactions to my enquiry (Taylor and Bogdan, 1998: 8, 9). By use of a rigorous qualitative method and discourse analysis, I am confident that the most significant discourses employed by the participants have been presented. The details of the method I have employed in this endeavor are discussed in Chapter Five.

The thesis structure

My style of presentation

One of the frustrations of writing is the presumption that the work has to be written and read in a linear manner; that is, beginning at the top of the first page, and the sequential building up of meaning as sentences are formed into horizontally presented lines and pages. I have chosen to confine my writing within this format, although there are provocative feminist texts that have challenged this view (for example in the bifurcated text of Patti Lather and Chris Smithies’ (1997) Troubling the angels: women living with HIV/AIDS, and the poetry of Laurel Richardson (1997: 131-144). These alternative textual constructions challenge the traditions of western textual forms that perpetuate modernist organisations of formal written language.

I have followed conformity in the style of my dissertation. My text moves sequentially between accounts of history, theory and method before examining the substantive research material proper. It is artificial to understand any of these chapters or topics in isolation. While I write about them in a sequential and
delineated fashion, this is only because the limitations of written forms of language necessitate such separation. Indeed it is my belief that theories of knowledge are most effectively understood as a much less tidy reality.

A preview of the chapters

Chapter One refers to this present introductory chapter, the purpose of which is to provide a brief account of the field under review, and the approach taken to complete my particular research project.

Chapter Two presents a review of the political discursive formations that have formed the structural context to the development of comprehensive nursing education. The organisation of the welfare state’s health and education sectors, and the challenges posed to each by the neoliberalisation of Aotearoa New Zealand since the mid 1980s are reviewed here.

Chapter Three examines the dominant and emerging socio-political and cultural discourses that form the context in which comprehensive nursing education has become established in this country.

Chapter Four is concerned with the epistemological foundations to my dissertation. This involves an exploration of the bases of social constructionism, Foucauldian forms of historical discourse analysis and the usefulness of feminist poststructural responses to Foucauldian theory.

Chapter Five offers a review of the strategies I put in place to learn as much as I could from the nursing educators regarding how they reflected upon and made sense of their experiences in CNEP. It details the methods I have employed to complete the thesis as well as pertinent reflections concerning how it felt to engage in this research.
Chapters Six through to Nine represent the substantive body of my research. Each is grounded in the discourses the participants employed to describe their work as nursing educators. The women's narrative comments are linked to the discussion of discourses that has already been foreshadowed in the first three chapters. In each chapter I present a range of the comments offered in my meetings with participants that explore the discursive practices that the women commonly employ to support their work in CNEP.

Chapter Six offers a review of the first two of these discursive practices, each of which can be understood as a discourse. Here I am interpreting the term "discourse" to refer to a particular core belief principle from which specific language, values and actions are motivated. I refer to any such actions as discourse as practice, or more commonly discursive practices. These are the shared belief in education as emancipation and the valuing of a legitimacy of difference. These discourses represent the epistemological bases for particular discursive practices the women enacted in their endeavors to have CNEP accepted throughout the health and education sectors.

In Chapter Seven a second “pair” of discourses with which comprehensive nursing educators engage, are presented. As such “experiential reasons for change” and “primacy of practice” are foundations to the reflections that the participants offer concerning their subjectivities as comprehensive educators. Both centred around ontological issues, namely the experiential reflections regarding their own nursing preparation and their enduring valuing of nursing as clinical work. As such, they are related to the experiences of the participants themselves and to their values about nursing as an ontological construction.

Chapter Eight moves away from the discourses that act as incentives and values for CNEP development, to reflect instead on the descriptions offered by participants to describe how they hoped graduates would enact comprehensive nursing values. To present this coherently, I reconstitute the traditional Weberian term of “ideal type” into a discourse the participants employ to capture the social construction of comprehensive graduates. Furthermore, this chapter teases out the
relationships between what the nursing educators constitute as ideal and realistic portrayals of comprehensive graduates.

Chapter Nine offers a review of a particular discursive practice employed by nursing educators to make sense of their experiences in the first two decades of CNEP development. There is a specific range of metaphorical and reality-embedded language that the women use to convey the magnitude of their achievements in CNEP, as well as the accomplishments of their students. This discourse, the appropriation of heroism as a shared identity, connects these recent reforms in nursing education with the legacy of a militaristic discourse which has pervaded nursing language for more than a century.

In Chapter Ten I discuss the composite effects of the discourses employed by nursing educators. It is my central thesis that my analysis of discourses offer rearrangements of power which seek to build collegial relationships with the people they work with. These rearrangements work towards empowerment and illness prevention, as opposed to power as a force of dominance, elitism and control. The women I have interviewed seek to work from a holistic and patient-centred paradigm, in ways that reconceptualise traditional organisation of professional knowledge and practice. Nursing educators uphold the importance of a style of nursing care that reflects research-based, and critically-regarded forms of clinical practice.

The significance of the discourses that frame comprehensive programme development is not merely that they are upheld by nursing educators, but that they allow a range of views to be held by the individual participants without having to conform to particular doctrine of their professional discipline. The women I have interviewed employ a mixture of "pure" and pragmatic responses to the needs of the particular context in which they have been employed as senior nursing educators. It is with this in mind that I now begin the explanation of my research, by looking at the political discursive formations that frame and illuminate the dissertation.
Chapter Two: Political Discourses

Political discursive formations

The next two chapters describe the contextual discourses that provide the backdrop to my dissertation. It is necessary to explain the political, economic and cultural trends that have influenced the development of comprehensive nursing in Aotearoa New Zealand. Such an overview is an important prerequisite to understanding the emergence of comprehensive nursing education as a legitimate means of preparing people for registered nursing practice. To this end, the dominant political discursive formations that have informed the ways Aotearoa New Zealand society has been organised are reviewed, because their legacies continue to inform the ways New Zealanders understand aspects of their society. To complement this discussion, the chapter which follows examines a particular group of discourses concerning the health and education sectors, women’s work and professionalism and vocationalism, which form the backdrop to the women’s explanations of their work as nursing educators.

The first section of this chapter reviews the organisation of the welfare state and the neoliberal political projects. Beginning with social democracy, I explain the ways health and education provision has been organised by politically potent agents – government and influential state sector agencies, as well as industrial, economic and international influences – before I move on to a precis of neoliberalism’s influence across the same institutions.

In the second section I present a chronological account of a number of significant events that have characterised the history of Aotearoa New Zealand over the 1973-1993 period. This represents a more elaborate explanation of the information noted in the timeline that I used as a “prop” in my interviews with nursing educators (this can be seen in its original form in Appendix Two).
In a traditional historical interpretation, this text can be read as a review of how social democratic and neoliberal political theory manifests as particular events which imbue our reflections of history in particular ways. At the same time, from a Foucauldian archaeological approach, I offer this chapter as a way of understanding the discursive relations against which comprehensive nursing education has been introduced.

In this regard, I am employing the term “discourse” to refer to particular communities of language, values systems and practices that people engage with, as expressed in language and other forms of texts. Through such engagement, discourses are continually reorganised, and by reading them, evocations of historical constructions of power and knowledge can be considered. I have chosen to employ the Foucauldian term “discursive formation” to refer to the political organisation of the social welfarist and the neoliberal regimes as they have broadly impacted on Aotearoa New Zealand. I am also employing the term to refer to a cluster of discursive statements and practices that are united in language, connected by commonalities that are constantly negotiated and reassembled, and that share common themes (Foucault, 1972: 31-39). More succinctly, Linda Alcoff proposes that discursive formations represent “the conditions of possibility for webs of belief” (1993: 99). I thus understand discursive formations to constitute a foundational context formed by a state-imposed social structure such as a welfare state or neoliberal political regime. While I offer explanations of particular terms as they arise through my work, I explain in greater depth how I have employed Foucault's *œuvre* in the following chapter. Furthermore, a detailed discussion of the meaning of discourse and how I have employed the methodological tool of discourse analysis, is offered in Chapter Four.

**Social Welfarism**

A discursive formation concerning social welfarism refers to the principles which inspired the development of the social democratic welfare state in this and many other industrialised countries, to achieve particular social goals of equality of access to a minimum standard of living. Since the first Labour Government was
elected to office in 1935, a welfare state has provided New Zealanders with health, education, housing and welfare support to all citizens, funded by a government-managed Keynesian system of progressive taxation (Barnett and Barnett, 1999: 220-221; Kelsey, 1997: 19-24). Core values within this discursive formation of welfarism have centered around the notion of equality of opportunity and egalitarianism, based on the rights of all citizens to be treated fairly and valued equally within their society. Social welfarism also upholds the importance of democracy and a discourse of citizenship rights. Participation within the democratic political process is an intrinsic component of this formation, and at the same time, the emphasis upon democratic freedom and citizenship entitlements and responsibilities are integral values. The provision of a free, universal education service represents an explicit manifestation of this formation. Free access to state health sector services have an indirect, but no less important connection to this formation of social welfarism.

Welfarism and education services

With regard to the discourses that were potent in the settlement of a social democratic system, Hugh Lauder reflects that the welfare state has been based on "enlightened liberal individualism" from which the system of free, secular and compulsory education has been organised in Aotearoa New Zealand (Lauder, 1990: 35). Clarence Beeby, the Director General of Education during the first Labour Government, embodied the goal of this social welfare system of education in his famous dictum:

The Government’s objective, broadly expressed, is that every person, whatever his level of academic ability, whether he be rich or poor, whether he live in town or country, has a right, as a citizen, to a free education of the kind for which he is best fitted, and to the fullest extent of his powers…

(Beeby, 1992: xvi)

Beeby’s debt to the American philosopher and educationalist John Dewey is apparent in the emphasis placed upon freedom and citizenship in the above comment (Jones, et al., 1995: 65-108). Dewey’s contribution to the way education
was organised in this country can most effectively be understood through what has been called the liberal theory of education, a model which assigns integrative, egalitarian and developmental functions to education (Bowles and Gintis, 1976: 21-22; Freeman-Moir, 1997). The liberal democratic discourse originates in freedoms sought by seventeenth century philosophers such as Thomas Hobbes (1588-1679) and John Locke (1632-1704).

This liberal model, which assumes conditions of a capitalist welfare state, suggests that the presence of educated citizens supports the labour market and economic growth by adding to national prosperity, the reproduction of the system of welfare security and the individual’s personal fulfillment (Whelehan, 1995: 26-28). Education is understood to benefit individual students by increasing their knowledge, understanding and/or skills that they acquire through a formalised learning process. By these components, the liberal theory of education represents a pragmatic rhetoric of liberalism and personal freedom while extolling the virtues of capitalism and the role of education as a preparation for people to participate in the paid workforce (Jones, et al, 1995: 72). Education in Aotearoa New Zealand has simultaneously been grounded in a discourse of meritocracy. This refers to a system of assessment and achievement throughout education, based on the belief that educational success is attained through the combined effort and talents of individual students (ibid: 84-93).

The end of World War Two marked a burgeoning appreciation of the benefits of technical education for people employed in skilled trades. Here the role of Clarence Beeby under the influence of Deweyian ideas had some impact on the developments in reorganising technical high schools into Technical Institutes where technicians and apprentices began to come for work-related adult education and training (Beeby 1992: 239-248). These sites flourished as alternative tertiary education providers until the early 1970s when student numbers began to languish with the downturn in the national economy. A fundamental characteristic of these institutions was their emphasis upon the acquisition of practical skills. Staff were employed to teach in this branch of tertiary education judged on their careers in the field and their technical competence of the subject-being taught, as well as their attainment of prerequisite qualifications.
The welfare model of education was able to prosper under the welfare state, yet by
the 1960s evidence began to mount to support the idea that equality of opportunity
was not being achieved. The Hunn Report of 1960 and the Currie Report of 1962
identified disproportionately high rates of Maori educational failure (Jones, et al.,
1995: 175-176; Openshaw, et al., 1993: 72-75). At the same time, escalating
demands upon the education budget, and the increasing perception that the
centralised Department of Education was an expensive and inefficient
bureaucracy, prompted political pressure to revamp the system.

Critical discourses concerned with education have challenged the principles of
equality and emancipation that have long been promoted as features of the welfare
state education system in New Zealand. Notable among these is the body of work
offered by Paulo Freire, the Brazilian educationalist who promoted mass literacy
programmes in his country. His work was regarded as politically radical for being
premised on people's critical understandings of their situation, their oppression as
illiterate poor and their development of generative words to stimulate literacy
initiatives (Crotty, 1998: 148). This form of critical consciousness or
conscientization is associated with praxis, meaning "reflection and action upon the
world in order to transform it" (Freire, 1972: 28). The continual process of review
and reflexive practice becomes a catalyst for ongoing learning and emancipation.
Freire's work also offered dynamic understandings of the relationship between
students and their teachers, as a dialogue where, according to Crotty:

... learners and educators are regarded as 'equally knowing subjects'
(Freire, 1972b: 31). The educator is the students' partner as they engage
together in critical thinking and a quest for mutual humanism. With a
pedagogy of the oppressed... the teacher/student dichotomy vanishes. The
teacher is not merely the one who teaches, for the teacher is also taught in
dialogue with the students. And the students, while being taught, also
teach.

(Crotty, 1998: 153)

Freirian theory has been significant in offering educationalists new ways of
understanding and reorganising their ideas about welfarist models of education in
general, and pedagogy and the relationships between teachers and their students.
Other critical challenges to the dominant welfarist discursive formation include criticisms of the gendered and racial ethnic biases throughout the education sector, and in response piecemeal innovations underpinned by liberal democratic discourse were implemented with nominal success. Examples of these initiatives include the “Girls can do Anything” campaign in the early 1980s and the introduction of Taha Maori into the school curriculum (Fry, 1985: 187-191; Jones et al., 1995: 116-119, 183).

An important innovation in the education sector has been the establishment of Maori language immersion based education in Te Kohanga Reo and Kura Kaupapa Maori schools in 1982 and 1985 respectively (Bishop and Glynn, 1999: 74, 81). These were established in response to the awareness of the welfare state schooling’s failure to provide an equality of opportunity for Maori alongside their pakeha peers (Smith, G., 1990 and 1992). Kohanga Reo and Kura Kaupapa operate from a critical educational pedagogy, influenced by the Freirian conscientization model that seeks to empower students by resisting the hegemony of particular pakeha-dominated discourses. The success of these initiatives represents a potential model for educators, including nursing educators, to strive for emancipatory pedagogies in their own work. Of more direct connection to nursing education is the employment of the traditional Maori education principle of “ako”, which emphasise a fluidity between teacher and learner status (Bishop and Glynn, 1999; Metge, 1986). This concept is closely aligned to the Freirian view of shared teaching and learning, and as I will demonstrate in Chapter Six, has been successfully utilised by participants to account for their pedagogical discourse in the comprehensive education programmes.

Such developments aside, the welfare state continued to provide a free, secular and compulsory education sector, from early childhood to tertiary level for a full half century after the establishment of a social democracy in Aotearoa New Zealand. It was not until 1984 that a radical and far-reaching reorganisation of education provision was proposed and partially implemented by the incoming Fourth Labour Government.
Welfarism and health services

Understanding issues of health and illness in twentieth century Aotearoa New Zealand has been dominated by principles of positivistic scientism (MacDonald, 1999: 116). By this I am referring to the enduring legacy of biomedical beliefs about health and illness, and about the objective and rational measures by which disease can be assessed and treated. The pervasiveness of this discourse is perpetuated by the continuing dominance of medical sovereignty (as discussed below), and medicalised models of secondary care.

While a welfarist discursive formation has implications for the health and education sectors, in order to understand the context within which nursing educators worked to develop comprehensive programmes, an awareness of the discursive authority of medical sovereignty is vital. By the term “medical sovereignty”, I am referring to the cultural authority that has traditionally been accorded to members of the medical profession, both as individuals and as an occupational group (Starr, 1982). The historical valuing of medical knowledge represents a type of hegemony, by which practitioners have been regarded with kudos and reverence. This is closely associated with the ways in which the Aotearoa New Zealand state has historically sanctioned a high degree of medical autonomy from the welfarist provision of health care (Fougere, 1974). Medical hegemony has been critically reviewed in a variety of ways, from Marxist (for example Illich, 1977 and Navarro, 1976) to poststructuralist and Foucauldian theorising (for example, Peterson and Bunton, 1997; Turner, 1992, 1995).

Prior to the establishment of a social security system in 1938, this country’s health sector was characterised as a professionally-stratified labour market, with medical practitioners assigned the highest status. The medical profession’s sovereignty was born out by their affluence, cultural authority and power to oversee the institutional organisation of the health service (Belgrave, 1991: 7-8). An important aspect of this status was the medical profession’s tenacious ability to remain independent from obligations to be employed by the state through the Department of Health (ibid; also Hay, 1989). Since the end of World War Two,
Aotearoa New Zealand has had a curative model of health care, and goals of quality and equal access to health care services have dominated civil society (Blank, 1994: 67, 74). Health services have been organised under Keynesian and Fordist principles to attend to the needs of both capitalism and civil society (Barnett and Barnett, 1999: 220-222). Medical cultural dominance and financial independence from the state has, however, continued to prevail. In the 1970s and 1980s, dominant understandings of health and illness have been challenged by competing discourses, for example from neo-Marxist and various feminist, and non-medically based treatment movements. Some have had significant destabilising effects, while others have emerged to reinforce medical authority.

In the post-World War Two era internationally, the suggestion that “medicine is one of the pillars of peace” prompted the United Nations to establish the World Health Organisation (hereafter WHO) in 1946, to which New Zealand was a founding member (Lee, 1998: 4, 307). By the 1960s, increasing numbers of developing nations became members of the WHO and the contrasts between the relative quality of member states’ health care became starkly apparent. At the same time, developments in forms of primary prevention and treatment techniques (including pharmacological and diagnostic innovations) prompted the WHO to begin co-operative planning for a global eradication of disease (Norris, 1994: 131). In 1976 the WHO set a world-wide initiative to work towards the goal of “Health for All by the Year 2000”1 (Lee, 1998: 17-18). As a signatory to this, New Zealand became politically and morally oriented to work towards such a goal within the nation’s health sector. This marked an important challenge to the dominant curative focus (as sited in secondary health care institutions) by broadening the dominant social construction of health care to include primary health care. Despite many changes across the health care sector, there remains a strong link between the WHO and the New Zealand state health care system (Dow, 1995: 230-235). The diversification of the health service during this time,

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1 The World Health Assembly adopted resolution WHA 30.43, which called "on WHO and national governments to seek the attainment of all the citizens of the world by the year 2000 to a level of health that will permit them to lead a socially and economically productive life" (Lee, 1998: 18).
in line with such an international movement, was achievable, while the Keynesian economy remained buoyant and the country prosperous.

By the 1970s the ethos of a health-focused discourse was stimulated by fiscal demands, including the realisation that the state could not achieve the welfarist principles of equality and entitlement that were central to it. Incentives for a shift towards primary and preventative health care were further promoted by the need to contain the expenditure of health services. The early 1970s were characterised by a range of serious challenges to the national and international economy (such as oil crises and the United Kingdom’s entry to the Common Market) which undermined New Zealand’s previously secure system of trade relations (Barnett and Barnett, 1999: 221; Blank, 1994: 76). In this country, the government responded with attempts to stimulate the economy though a series of energy and primary production initiatives which were largely unsuccessful (Kelsey, 1997: 23-24; Pearson and Thorns, 1983: 20).

The reorganisation of the health care sector also coincided with a burgeoning variety of health care specialist occupations such as pharmacists, speech and language therapists, dieticians, physiotherapists, radiographers, and occupational therapists (Gabe, Kelleher and Williams, 1994; Norris, 1994). Their specialist forms of knowledge to complement the traditional boundaries around medical care served to challenge the traditional bipartite system of health care associated with medicine and nursing. Indeed, these developing professions served to challenge the assumed authority of the medical profession in the organisation of health care services. At the same time the development of para-health professions has had implications for the breadth of care undertaken by nurses (Avery Jack and Robb, 1977: 31-32). They have done this by representing alternative specialist forms of knowledge and potential advice for patients inside and outside secondary health care settings. While they had always been offered outside the welfare provision, by the mid-1980s there was an increased acceptance of a range of health therapies (such as acupuncture, chiropractic and herbal medicinal treatments) by the Aotearoa New Zealand state health sector (Dow, 1995: 232).
An increasing legitimacy of what became known as complementary forms of treatment was associated with the growing open-mindedness of health care providers to look beyond the limits of the bio-medical paradigm (Davis and Dew, 1999: 25; Dow, 1995: 239-232). It becomes apparent in this historical overview that in part a willingness to consider and accept challenges to the traditional medicalised epistemology is associated with the social awareness of the flaws in claims of medical treatment strategies. Since the 1960s, the medical profession’s cultural supremacy had been immeasurably undermined by consumers’ objection to the iatrogenic (or medically induced) consequences of new medications, perhaps beginning with the effects of thalidomide drugs on foetal development in the 1960s.

Overall, I have described the ways that the discursive field of health welfarism has been challenged by a range of developments over the past decades. Where the welfarist belief in a free and accessible health care system provided by the state was once upheld as a cornerstone of Aotearoa New Zealand nationhood, this has been challenged by politics, activist groups and forms of knowledge. Where there was once unity in the valuing of the welfare state, there is now diversity through the fractured identities of different consumer groups, health care workers and organisations who provide a variety of forms of health care. In other words, an acceptance and respect for a legitimacy of difference can be understood to be closely connected with the constantly evolving welfarist discourse of wellness and disease. While medicalisation and welfare remain culturally embedded for many New Zealanders, these very legacies as well as the forms of challenge represent catalysts for the ways the nursing educators I spoke with make sense of their experiences in CNEP.

**Inequalities under welfarism**

The period when nursing education transferred from the health to the education sector was pervaded with social justice issues regarding race, gender and class. Particularly in the health and education sector, the late 1960s and 1970s witnessed an exploration of the ineffectiveness of equality in opportunities of access to institutions and services. Perhaps more importantly, evidence increasingly
indicated unequal outcomes on the basis of race, gender and class identity (for example, Blank, 1994: 72-76; Codd, et al, 1985; Kelsey, 1997: 19-22; Walker, 1973). The first group of challenges to the efficiency of the welfarist discourse and infrastructure, therefore came from mounting evidence that the rhetoric of equality of opportunity was mere rhetoric. Groups of citizens most in need of welfare support often had the least access to it and patterns of poverty were higher among Maori and Pacific Islanders than the pakeha populations. At the same time, through an awareness of middle class capture, groups of citizens least in need of welfare services were increasingly understood to benefit most - through service and employment opportunities - from such provisions. Combined with the local impact of an international economic crisis, these trends set the scene for the economic and political restructuring of the welfare state.

The Neoliberal Experiment

Changes that have occurred throughout the Aotearoa New Zealand state sector and civil sectors since the Fourth Labour Government’s election in 1984 can best be understood as representing a neoliberal discursive formation. The politics of neoliberalism is centrally concerned with a radical rejection of social welfarism on the basis that it had spurred civic dependence upon the state, it was inefficient, and it denied individual rights and freedoms. Neoliberalism is grounded in the classical liberal economics offered by theorists such as Hayek (1899-1993) that focus on the freedom and dominance of the capitalist market, and the superiority of the free market as a form of political economy (King, 1997: 14; Lauder, 1990; Marshall, 2000: 190-191). As a discursive formation, neoliberalism offered a systematic reorganisation of the state from the ways the welfare state had offered support and services to its citizens. The move was constructed as changing from a perceived large and bureaucratically sluggish civil service to a small strong state whose role was to fund and monitor standards for services. At the same time, these services had shifted to a management and business-orientated deregulated and competitive focus. Accompanying these reforms, neoliberalism assumed a model quite different from the egalitarianism and community focus of the welfare state. Instead, individualism became the core discursive principle from which
assumptions about possessiveness, individual responsibility, competitiveness and consumerism were promoted.

**Neoliberal reforms in education**

The introduction of a managerial discourse into education has led to devolutionary and decentralising reforms, as well as obliging those who are employed in the education sector to focus their work around the principles of competition and efficiency. Neoliberal reforms also heralded the development of a “user pays” system of tertiary education, in line with the commodifying of educational credentials and individualist ethos (for example, Codd et al., 1985; Lauder and Wylie, 1990; Peters, Marshall and Massey, 1994). Increasing concerns about chronic high rates of unemployment have prompted a focus on employment-oriented schooling and an increased valuing of science and technology-based curricula. State and industry-allied initiatives based around school/work links to help senior students have emerged. A focus on these training-based employment initiatives has been encouraged through the ascendancy of a discourse of new vocationalism in the Aotearoa New Zealand curriculum (Jones et al., 1995: 83).

A neoliberal educational provision also brought a discourse of rights into focus. There has been a reconstitution of the rights of tertiary students to gain the appropriate knowledge and skills that are directly related to a variety of employment opportunities, from trades and service work to professional forms of education. The “user pays” ethos in post-compulsory education involves students paying part of the costs of their courses of study, but they may be eligible to borrow finance from a Government student loans scheme and/or receive a targeted student allowance. These initiatives demonstrate the commodification of education as an important component of the neoliberal discourse. Associated with this is the promotion of a discursive statement concerning education as a private good. The implications of this transformation have been significant. To quote one commentator:
The model presaged an élite student body, under heavy pressure to recoup the costs of their education and repay their loans, who would make instrumental demands on course availability and curriculum content. Student choice of training options would be driven by speculative labour market signals and pursuit of careers that they considered most likely to rescue them from debt, rather than subjects they were interested in or best equipped for. High-pressure, high-cost professional courses were predicted to become the domain of an even narrower élite. ... Women, Maori and Pacific Island students whom market forces serve least would be left with a particularly invidious choice.

(Kelsey, 1997: 329)

This ideological and financial reform has been the single most radical change of the tertiary education sector since the welfare state was first established. It has prompted vehement opposition from students and staff throughout the tertiary education sector. A second neoliberal education initiative has included the overhauled organisation of the tertiary education sector, deregulating educational providers, establishing a system of educational attainment through the New Zealand Qualifications' Framework, and assigning and overseeing the educational standards to the NZQA (Kelsey, 1997: 219-224). These changes provided the context within which nursing education programmes were able to move from a three year diploma course to a degree status attainable through a revamped curriculum taught over the same time frame.

Such changes in the education sector have had significant consequences for the development and organisation of nursing as a full time tertiary education-based programme. By constructing nursing students as consumers of entry to practice nursing preparation, critical challenges have been made to the ways such programmes are conceptualised and delivered in the educational marketplace. Furthermore, since early 1991 the new post-compulsory sector initiative of Industry Training Organisations has threatened the fundamental basis of tertiary-sited nursing programmes with a return to on the job apprenticeship-style forms of learning (Butterworth and Butterworth, 1998: 216-217; Education and Training Support Agency, 1992; Kelsey, 1997: 223; Smelt, 1995).
Neoliberal education reforms across Aotearoa New Zealand have allowed groups with a non-traditional view of schooling the opportunity to develop alternative education funded on an equal basis with mainstream schooling services. This represents the enactment of neoliberal education discourse, where competition, choice, and freedom from state prescribed approaches to education are accessible. Kura Kaupapa and Kohanga Reo have flourished under these reforms, but their success has been co-opted by neoliberal advocates as a notable example of the merits of neoliberal education reform. Maori educationalists including Linda Tuhiwai Smith (1992) have, however, challenged this on the basis that such innovations pre-dated any such reform, and that their relative success is significantly outweighed by the disproportionate levels of educational failure experienced by Maori across Aotearoa New Zealand.

**Neoliberal reforms in health**

When the most radical of health reforms were implemented under the second term of the Labour Government, there was no public mandate to support this institutional reorganisation of the health care system, and the serious challenge it offered to welfarist beliefs in egalitarianism and citizenship rights (Kelsey, 1997: 42-44). The welfarist discourse of health and health care that continued to imbue the Aotearoa New Zealand cultural psyche was of a free and accessible complete provision of all one’s health care needs. The reorganisation of the health sector by neoliberal ideals involved the restructuring of hospital and associated health services (with the exception of primary care services) to regionalised area health boards (Barnett and Barnett, 1999: 223-224). The later National Government moved further away from a welfare model by introducing a managed market, organised around a funder-provider split and the replacement of Area Health Boards with Crown Health Enterprises, justified on the basis of their potential efficiency and fiscal prudence (ibid, 224-227).

It was not only the public who were bewildered and angered by the emphasis on new efficiency that was to limit their access to health services. Health care professionals, including large proportions of the medical, nursing and allied health care staff employed by the welfare state, were confronted by a system of
management within which fiscal efficiency was to dominate the priorities of service provision. For most of these people, the provision of health care, like education and welfare support, had been the unquestioned rewards and their contributions back into the democratic welfare state society. Unprecedented levels of industrial action by workers in the health and education sectors are testament to such public and professional resistance (Kelsey, 1997: 142; New Zealand Nursing Journal (hereafter NZNJ²) March, 1988 pp. 6-14; NZNJ, Nov. 1988, pp.16-18; NZNJ Aug, 1989 pp.15-21). In relation to emergence of a distinct nursing literature, the rhetoric of a partnership model to understand professional relationships with patients coincided with the employment of a neoliberal discourse of partnership in management policy. Yvonne Langridge (1991) examines the impact of such a perceived “mis-alliance” between the rhetoric of neoliberal partnership and the development of nursing education. By 1996 the level of public and professional concern about the poor performance of the health sector under neoliberal reforms partly accounted for the election of a coalition government and the subsequent softening of some of the more extreme forms of neoliberal health policy (Barnett and Barnett, 1999: 224)

An important aspect of this era of reform involves the neoliberal reiteration of the importance of health maintenance and the prevention of illness as a form of individual and personal responsibility. Over a similar time scale, an international charter, signed in Ottawa in 1986, formalised the WHO-lead emphasis on health promotion, and served to clarify Aotearoa New Zealand’s responsibilities to a new public health discourse throughout health care services (Hyde, 1999: 256). These developments served to reconstitute the importance of medicine as an agency of social authority, albeit through a model that rejects welfarist discursive principles of egalitarianism and social security (Barnett and Barnett, 1999; Osborne, 1997).

A significant change has been the mainstreaming of people with psychiatric and/or intellectual disabilities through community-based models of care. As well as

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² "The New Zealand Nursing Journal" is used to refer to the official publication of the New Zealand Nurses' Organisation, and formally the New Zealand Nurses' Association. The journal's title has changed many times – including "Kia Tiaki" and "Nursing New Zealand". I have chosen to refer to it by this name for the sake of simplicity.
challenging how these health and identity issues are socially understood, these changes have had important implications for health care workers including nurses by deinstitutionalising their traditional models and sites of work (Davis and Dew, 1999: 9; Levien, 1999). These initiatives were prompted by both the fiscal motivation of efficiency and cost effectiveness, as well as by a discourse of rights for people who face such health challenges.

At the same time, public discourses about health have shifted as neoliberal rhetoric has pervaded the social services. The increasing ascendancy of the cultural values that underpin New Right politics are becoming stronger in Aotearoa New Zealand as members of the dominant middle classes reject the perceived inadequacies of the contemporary health sector services, and choose to “exit” by paying for private medical care through insurance schemes. Based on a sociological theory of organisational decay developed by Hirschman (1970), Geoff Fougere has adopted the terms “exit” and “voice” to refer to alternative responses by the New Zealand public to perceived unsatisfactory health services (1974). The “exit” model of responses to health reforms “involves leaving the organisation or switching to a competing product” (Fougere, 1974: 8). Alternatively the “voice” model of response involves “any attempt at all to change, rather than escape from an objectionable state of affairs... by petition to ... management in charge, ... appeal to higher authority... or actions and protests... to mobilise public opinion” (ibid). As a consequence, now more than one third of the population has private medical insurance, and the health sector has become increasingly constructed as offering private and public forms of health care, based on the ability to pay on a fee for service basis.

What I have presented here is simply one way of understanding the context in which comprehensive educators worked to develop programmes for pre-registration nursing candidates. A similar yet different presentation is offered below. It reflects the material I presented in the timeline I offered to participants to facilitate our discussion.
The Timeline

My timeline began with the identification of the 1964 Curriculum Planning Committee of the Nurses' and Midwives' Board (the forerunner to the Nursing Council of New Zealand, which was established in 1971) which recommended a systematic reorganisation of nursing preparation in New Zealand over the following few years. It proposed:

By 1970, the pattern of basic nurse education in New Zealand should be directed towards three main streams: a degree programme, a general three year programme and a community nurse programme.

(Nurses' and Midwives' Board, 1964: 2)

The Committee outlined the "adopting [of] progressive patient care [and] nursing practice based on patient assignment" as important components of a desired, "major change in the attitude, philosophy and practice of nursing" (ibid, 3-4). At the same time, the Committee requested "the integration of psychiatric concepts" [and] "the importance of public health principles in the basic curriculum" (ibid: 4). The recommendations also included the need to, "prepare clinical experts, teachers, administrators, consultants and research workers... by considering the future and function of the Post-Graduate School in association with a Nursing Department of a University". These recommendations emphasised the need for specialist preparation for future nursing educators, and represented an early valuing of nursing research (ibid, 3). While such rhetoric foreshadowed the later developments in registered nursing preparation, this document was merely utilised as the blueprint for the development of Community Nursing programmes3.

In the following year, a Canadian nursing academic, Ms. Alma Reid, was commissioned by the University Grants' Committee to "assess the desirability and feasibility of introducing university nursing education [at entry to practice and post-registration level] to New Zealand" (Reid, 1965: 3). Her work indicated that such a development would strengthen the profession in a variety of ways (Reid,

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3 The second tier of nursing training has a complex history of qualifications and training periods, for example, which are beyond the scope of this thesis to explore.
1965, 6-8). The report received mixed responses by key groups including medical practitioners, university staff, hospital administrations and nurses themselves. Over the next few years, discussion about the relative benefits of a tertiary-based entry to practice system of nursing education remained informal and uncoordinated across both health and education sectors throughout New Zealand. (Carroll, 1984: 75).

In 1966 a publication by the WHO Expert Committee on Nursing Education established universal criteria for the preparation level of nurses for the health sector. This report articulated an important change in emphasis in nursing work related to international socio-cultural and political developments and technological innovations with a need to emphasise nursing’s focus on health and prevention of illness (1966: 6-7). It also advocated the establishment of nursing preparation within the higher education sector, specifically “either in a university or through a pattern similar to that serving other professions” (ibid, 17). As such, these recommendations represented a paradigmatic challenge to the status quo of training nurses in the hospital sector, and more importantly, it internationally sanctioned, orchestrated and co-ordinated the concept of nursing preparation. The Committee supported a definition of nurses that had been proposed by the International Council of Nurses (hereafter ICN). This regarded a nurse as:

... a person who has completed a programme of basic nursing education and is qualified in her own country to supply the most responsible service of a nursing nature for the promotion of health, the prevention of illness and the care of the sick.

(WHO Expert Committee on Nursing, 1966: 9)

This definition was subsequently adopted by the ICN as the criteria for the conferment of the title of “first level” nurse. Since that time, New Zealand registered nurses have since been categorised as “first level” nurses (New Zealand Nurses’ Association, 1984: 16).

In New Zealand, the 1969 Review of Hospital and Related Services included a critical review of the hospital-based preparation of nurses. The document
recommended that the majority of nurses should be prepared through a three year technical institute-based programme, incorporating psychiatric, psychopaedic and obstetric nursing into a single "comprehensive" first level qualification (New Zealand Department of Health, 1969: 88-89, 65). Like its predecessors, it prompted debate across groups of New Zealand nurses (Carroll, 1984: 76). In combination, these reports were to foreshadow the legitimacy of the report that was to finally sanction the transfer of nursing training to the tertiary education sector.

Two years later, the Carpenter Report was published by the Department of Health and presented to the National Government in February 1971. As a WHO short term consultant, Dr. Carpenter reviewed nursing preparation in the New Zealand context during a three month consultation position from the University of Toronto, where she was the Director of the School of Nursing. Her recommendations involved the trial of first level nursing education within the general system of state tertiary education, and the concomitant transfer from the hospital sector (Carpenter, 1971, 5). She recommended that this be complemented by the development of university-level post-registration courses, and a freeing up of the links between these tertiary institutions to promote the cross-crediting of nursing-based credentials (Carpenter, 1971: 24-28). Helen Carpenter's Report was widely disseminated and favourably received by groups of nursing, medical and student nurse organisations over the next few months (New Zealand Department of Health, 1988: 6).

The government responded by enacting Recommendation 1.6 of the Report with the appointment of a committee to consider and recommend the most suitable site for the development of nursing within the education sector. While the Committee was investigating the options, the New Zealand Nursing Association began a campaign to pressure the government to make an early decision to execute the Carpenter Report's recommendations. This was known as "Operation Nurse Education", and involved an extensive political and publicity campaign including deputations of association members to lobby Members of Parliament throughout the country. The "1.6 Committee's" recommendations, which were published in September, 1972, were accepted almost in full by the National Cabinet. The following month, the Cabinet agreed to trial the pilot programmes of

Within a few weeks the National Government was ousted from office and replaced by the third Labour Government under Prime Minister Norman Kirk. The new Government upheld the previous government's decision, and pilot programmes began in Wellington and Christchurch in early 1973, at their regional polytechnics. Concurrently, financial support began to shift from the health to the Vote: Education budget to support these initiatives. Thus the gradual transfer of nursing education commenced. Each year from 1974 onwards one or two further polytechnic-based programmes were established throughout Aotearoa New Zealand. At the same time, there was a winding down of many of the hospital schools of nursing on a regional basis. However, neither process was particularly coherent or sequential. A suspension of the development of comprehensive programmes in 1976 and 1977 occurred while the government awaited evaluation reports on the efficacy of the new programmes (New Zealand Department of Health, 1988: 10). The reluctance of hospital staff to close their schools was evident by the transfer not being completed until 1989 when the final general and obstetric registration students qualified and 1991 when the last hospital-prepared psychopaedic nurses were registered (Hunt, 2000: 307).

As part of the 1.6 Committee's recommendations, the trial programmes were established concurrently with the appointment of a multiple disciplinary Advisory Committee of "representatives of interested and affected groups" (New Zealand Department of Health, 1988: 9). The National Advisory Committee on Nursing Education (hereafter NACNE) was chaired by staff from the Department of Education to monitor the transition of nursing preparation from hospitals to polytechnics. In the following year the Board of Health published a report (1974) which reviewed the national state of nursing education. It made the specific recommendation that "health agencies be asked to plan to ensure that gradually, over a period of ten to twelve years, all professional nursing services be provided by nurses registered under the Nurses' Act 1971" (Board of Health, 1974: 7). This signified an important recommendation, namely that the health care sector make preparatory changes to complement the complete transfer of nursing training from
the health to the education sector (ibid, 7-11), including a proposal that regional health authorities should replace hospital boards within the next four years (News Zealand Official Yearbook (hereafter NZOY), 1975: 142).

In 1980 NACNE was replaced by the Nursing Education Research and Advisory Committee (NERAC). NERAC was established under the auspices of the Department of Health with a similar brief to its predecessor: "to act as a forum for co-ordinating views and facilitate communication" between key players in nursing education (New Zealand Department of Health 1988: 36-37). The reorganisation of these committees represents an important aspect of the transfer of nursing education within the state. This involved a transfer of responsibility to the health sector for the standards of comprehensive nursing education, while at the same time there was a concomitant transfer of funding from Vote: Health to Vote: Education to support CNEP (New Zealand Department of Health, 1988; Grant, 1990).

As part of the Labour Government’s quest for a second term in office under Bill Rowling, Kirk’s replacement, a White Paper proposing the first major restructuring of the health sector was published in 1975. With Labour’s defeat by National under Robert Muldoon, the Labour Party’s ideas about rationalising the health sector were abandoned for years to come. One of the final pieces of legislation passed by the Labour Government, an Amendment to the Nurses’ Act of 1971, was passed in 1975. This legally granted the right for graduates from student-based three year courses to register as comprehensive nurses in Aotearoa New Zealand. Two years later, the legislation was rewritten, and this later (1977) Act remained unaltered for thirteen years. The 1977 Act repealed the 1971 statute and the 1975 Amendment to allow hospital-training male nurses to register in the same general and obstetrics programmes as their female colleagues. This legislation also reorganised a two tiered system of nursing education through registration and an eighteen month enrolled nursing programme to replace community nursing training (NZOY, 1983: 152). In 1977 the New Zealand media was dominated by political,

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4 The 1977 legislation also changed the titles of other groups of nurses: those with general/ maternity registration became general and obstetric nurses (hereafter RGONs); and enabled male nurses to gain obstetric and midwifery qualifications. It also allowed nurses with RGON and psychiatric or psychopaedic registrations to adopt the title Comprehensive Registered Nurses (NZOY, 1979: 123-124;
religious, gendered and cultural debates following the Royal Commission into Contraception, Sterilisation and Abortion. In 1978 the National Government was re-elected for a second term and returned to power for a third term in 1981.

During 1981 a Department of Education committee under A.J. Taylor published an evaluation report which reviewed comprehensive nursing since the pilot programmes had begun. It concluded that the programmes were, on the whole, successful at achieving the goals sought through the transfer of nursing education (New Zealand Department of Health, 1988: 18-19; Taylor, et al., 1981: 171-173). By this time the comprehensive programmes had been operating for eight years, and there were nine courses available nationally in Wellington, Christchurch, Nelson, Auckland, Hamilton, Invercargill, Palmerston North and Manukau. In 1982 the National Government responded to the complex array of health service providers by passing the Health Amendment Act which remodeled the Board of Health into a more efficient review and advisory body (NZOY, 1984: 152; NZOY, 1985: 156). In the same year, an OECD report on education was published, which chronicled the egalitarian achievements of education under social democracy (Dale, et al. 1994: 69).

As a follow-up to the Health Amendment Act of the previous year, 1983 witnessed the formation of the Area Health Boards Act, although it was not until 1985 that the first Area Health Boards were finally established (Boston, et al. 1991: 271). Of importance in this legislation was the new focus on health promotion and primary health care that was clearly influenced by the tenor of the WHO’s policy (Bowie and Shirley, 1994: 300). Furthermore, 1983 witnessed the establishment of population-based funding formulas for the allocation of resources to the health sector.

The poor financial state of the Aotearoa New Zealand economy due to stagflation and the perceived ineffectiveness of the welfare state justified, in the view of a

NZOY, 1983: 152). My thesis does not attend to this alternative group of nurses assigned comprehensive registration. Therefore my use of the term comprehensive registered nurses, comprehensive graduates, etc. refers specifically to graduates of the three year polytechnic-based entry to practice programmes.
group of powerful politicians and Treasury officials, an abrupt shift in the relationship between the state and civil society in the mid-1980s. Following the lead of the American and British political regimes under Reagan and Thatcher, the Labour Government under Finance Minister Roger Douglas and Prime Minister David Lange introduced a neoliberal based restructuring of the welfare state. A consequence of this was the reorganisation of the health sector to concentrate on targeted forms of secondary care, the orientation of health care providers to remain financially buoyant, and an increasing medical and social expectation that individuals must take responsibility for their own health status (Grace, 1989). This shift in emphasis developed to promote less public reliance on the provision of state health care. This prompted a flourishing of the private health insurance industry and the decision to split funders and providers of health care in an effort to mimic private sector managerial practices. As medical techniques and technological developments assist health professionals to care for people who have complex forms of illness, there was a realisation during this period of the increasing acuity of treatment provided in secondary care health services. The rising costs and demand for technically qualified health care staff gave added incentives to rationalising “inefficient” forms of health care provision (Blank, 1994: 34-38).

1984 represents the turning point in the way I have framed the period under review. With success at the snap election, the new Labour Government heralded a philosophical change in the organisation of the New Zealand state sector. The political entitlements of women were acknowledged with, for example, the establishment of a Ministry of Women’s Affairs. Changes in industrial relations were heralded by legislation which changed union membership from compulsory to voluntary in this year. Furthermore, the Health Services Personnel Commission was established over the same period. Its role was to negotiate employment conditions, remuneration and career structures between the state and groups of nurses and other health sector employees (Carey, 1984: 27; NZOY, 1984: 152). This year also marked the completion of the first decade of nursing education in the tertiary sector and the establishment of a twelfth CNEP course nation-wide. Simultaneously, twenty-three hospital schools of nursing continued to prepare nurses for single registered practice in the fields of general (namely medical/surgical and obstetrics), psychiatric and psychopaedic nursing (NZOY, 1984, 153).
In 1986 a group appointed to consider possible directions for health reforms presented a Ministerial Report *Choices for Health Care* and recommended the implementation of "managed competition". This report echoed the recommendations presented in a UNICEF/WHO report published the previous year (Fougere, 1994: 111). Under a burgeoning neoliberal concern for efficiency and accountability in the health sector, NERAC was replaced by a Review of the Preparation and Initial Employment of Nurses (RePIEN). A steering committee of RePIEN conducted a workshop in September, 1986, and through a wide consultative process, a series of developments in nursing education and work were planned. The next year, a National Action Group was set up by the Health Department and supported by the Nurses’ Association to promote the advancement of nursing and nurse education within the context of a rapidly changing health and social context (NZNJ: November, 1987 supplement; NZNJ March 1993: 31). 1987 was also the year Labour was re-elected for a second term and David Caygill heralded revolutionary reforms in the health sector by promoting *Health: A Prescription for Change*. The market reforms as advocated in this document were reiterated in more radical terms by the splitting of funders and providers of health care, a move that had been promoted by the Treasury-backed Anderson Report. Also in 1987 the Council of Trade Unions was formed in response to dwindling industrial authority, and in October the New Zealand economy was severely damaged by the share market crash (Kelsey, 1997: 36).

In 1988, neoliberal reforms continued to restructure both the health and education sectors as in all other public sectors. Aotearoa New Zealand society existed in a state of tension between the neoliberal direction of reforms and the deep seated valuing of social democratic principles in the national culture. In health care provision the Gibb’s Report recommended “the precedence of market-led strategies … over [the] social obligations” of public health system, with a funder-provider split between Area Health Boards and a National Health Commission (Cherrington, 1988: 2). The final re-organisation of Hospital Boards into replacement Area Health Boards was spurred by the appointment of Helen Clark as Minister of Health in January of 1989 (Fougere, 1994: 110). In this same year, a Royal Commission on Social Policy reported that “the majority of people wanted a return to priorities
of full employment, and improved state-funded education, housing, health and other social services” (Kelsey, 1997: 211). It was dismissed by politicians committed to a free-market as “large, confused, ineffectual... [and thus] a monument to the inefficiency, intellectual wooliness and political ineptitude that typified the welfare state” (ibid).

The passing of the Labour Relations Act (1987) and subsequently the State Sector Act in April 1988 introduced the explicit mimicking of private sector management and employment practices by publicly-funded institutions. This development was resisted by unions, particularly in the health sector (Dalziel and Lattimore, 1999: 81; Kelsey, 1993: 60-61; NZNJ; January 1988, 5, 8-9). As a consequence, labour relations were disrupted by a series of nationwide public sector strikes in the months preceding the passing of the State Sector Bill into law (NZNJ, March 1988: 6-14). The State Services Commission established the Lough Committee that directed compulsory education services towards managerial and accountability foci, and removed the “special status” for education which had been upheld by the previous social democratic mandate (Dale, 1994: 72).

A hui in Christchurch which formulated the principle of cultural safety in relation to nursing education in 1988 was followed by the publication of Kawa Whakaruwhau two years later. In 1992, the Nursing Council of New Zealand formally adopted cultural safety as a compulsory component of nursing education curricula. Also in 1989, the Labour Government replaced the Department of Maori Affairs with a policy-oriented Ministry and a temporary Iwi Transition Agency to deliver state services to Maori (Boston, et al., 1996: 147). 1988 had witnessed the Hawke Report’s reconceptualisation of post-compulsory education and training (PCET), and later in 1988 and in 1989 Learning for Life: One and Learning for Life: Two policy statements plotted the reorganisation of the tertiary education sector. This heralded the advent of user-pays practices and management culture throughout the tertiary sector (Grace, 1990: 185).

By 1990, the health sector was challenged by the Cartwright Report, which had been prompted by news of the earlier “Unfortunate Experiment” concerning medical malpractice through unethical cervical cancer research (Bunkle and Coney,
1987; Coney, 1988 Tully and Mortlock, 1999: 172). The same year saw the passing of a Nurses’ Amendment Act which allowed midwives to practice independently of medical supervision. Also in 1990, National defeated Labour and Jim Bolger became Prime Minister. The change of government did not slow the pace of reform, and in 1991 Simon Upton’s Green and White Paper floated the idea of Regional Health Authorities and “managed competition” between private and public health care providers (Fougere, 1994: 107-8). In addition, part charges in health services were unsuccessfully trialled with the advent of “Kiwi Cards”, which offered financial support to low income health consumers. The health sector was further restructured with the appointment of Sir Ron Trotter to oversee the National Interim Provider Boards (Kelsey, 1993: 33). In the education sector, Study Right and the New Zealand Qualifications’ Authority (NZQA) were established. The NZQA document *Designing the Framework* introduced the idea of unit standards - a “...’seamless’ system...” which organised a systematic structuring of all qualifications, including degrees and “collapse(d) the distinction between education and training” (Peters, Marshall and Massey, 1994: 262).

In 1991, Ruth Richardson’s “mother of all budgets” cut welfare benefits by between 2.9 and 24.7 percent and marked a discursive shift from universal to targeted provision of health and tertiary education services (Dalziel and Lattimore, 1999: 91). In 1991, too, the Employment Contracts’ Act (hereafter ECA) abolished national award coverage and compulsory unionism. They were replaced with individual employment contracts and a system of industrial relations which destabilised the power of trade unions across the country (Douglas, 1993; Kelsey, 1993: 180-181). As a consequence of the NZQA, 1992 heralded the development of degree-level qualifications from previously diploma-level three year comprehensive programmes. The National Action Group met for the last time in May of 1992 before being disbanded through the reorganisation of the public sector (NZNJ, March 1993: 31). Also in the health sector, “Community Services Cards” replaced the “Kiwi Cards” to provide targeted assistance to health care users (Kelsey, 1993: 85). In the same year an enquiry into the so-called “bad blood” scandal involving flawed laboratory blood screening practices assigned partial responsibility to the health sector’s recently introduced devolutionary and restructuring processes (ibid: 61-63).
Although the years 1993 and 1994 were beyond the self-imposed scope of my research, I offered brief accounts of events from these years to contextualise the discourses that frame the work of educators involved in comprehensive nursing programmes. In 1993, the Health and Disabilities Services Act was passed, which articulated a profit-orientation among public hospitals (Bowie and Shirley, 1994: 316). Also, the Department of Health was replaced by a small policy and auditing oriented Ministry of Health. The health care sector was reconstituted with the formation of Crown Health Enterprises (CHEs) and Regional Health Authorities (RHAs). Their formation was marked by “...concerted opposition...” from nurses and medical staff (Kesley, 1993: 34).

The cultural safety curriculum component of the comprehensive programmes was widely debated in the national media, prompted by claims of unfair assessment and political correctness by a comprehensive nursing student at Christchurch Polytechnic (Chapman, 1993: 31; also Horton and Fitzsimmons, 1996; Murchie and Spoonley, 1995). In 1993 the continuously uncertain post-ECA labour market prompted the two major nursing sector organisations, the NZNA (serving public sector nurses) and the NZNU (representing private sector nursing workers) to amalgamate into the New Zealand Nurses’ Organisation (hereafter NZNO). New Zealand celebrated the centenary of women’s suffrage, and Jim Bolger was re-elected as Prime Minister to lead the National Government for a second term of office. 1994 witnessed a political and public debate about professional whistleblowing, prompted by a registered psychiatric nurse who “leaked” confidential information about the release of a dangerous patient (Hubbard, 1994: 16-22; O’Connor, 1994: 2). The Nursing Council developed a draft code of conduct in a move “to extend its professional role” in the same year (NZOY, 1995: 185). During the same year, the Todd Taskforce articulated a restructuring of the state organisation of tertiary education sector whereby students would shoulder the responsibility of up to 50% of their course costs (Stevens and Boston, 1994).
Discussion

Two alternative discursive formations have been commonly constructed as political forces. These are the social democratic welfare state and the neoliberally reformed state, which form the context for the first two decades of comprehensive nursing programme development. Alongside the chronologically recounted events over the 1960s to 1990s period that I discussed, they form the backdrop to the attempts by nursing educators to promote comprehensive nursing education as a legitimate discourse. But before a review of the discursive statements the participants employed in this power struggle against the traditional apprenticeship discourse is reviewed, it is necessary to examine further the social and cultural discourses that impact on how nursing education can be understood.
Chapter Three: Social and Cultural Discursive Developments

This chapter describes a group of social and cultural discourses that have been dominant over the 1970s to 1990s, and that inform the establishment and development of comprehensive nursing education. These prevailing and shifting discourses run parallel to the alterations in discursive formation from social democratic welfarism to neoliberalism. In particular, they form a backdrop against which comprehensive nursing education discourses emerged to contest the dominant discursive construction of apprenticeship models of nursing training.

I explore the employment-related discourses of professionalism and vocationalism and how they connect nursing with the traditional medicalised organisation and philosophy of the health care sector. Two particular challenges are discussed. The discourse of “New Nursing” presents a major challenge to traditional ontologies of nursing practice, as does the emergence of managerialism within the neoliberal state sector. Other discourses which will be examined include the potency of rights discourses and identity politics including the racial/ethnic rights debates over the status of tangata whenua and the role of the Treaty of Waitangi. A second form of identity politics is discussed regarding women’s rights. A pragmatic settlement between competing feminist discourses has been the acceptance of difference across diverse forms of feminist ideologies since the 1990s. Two forms of dominant feminist discourse are subsequently discussed. These are liberal and radical feminisms.

A second facet of this chapter presents discursive topics that complement the epistemological and theoretical foundations of this thesis. Beginning with feminist poststructuralism, I review Michel Foucault’s theorising on the subjects of medicine, health care provision and education. These are offered as a bridge between the descriptions I give of the material context in which discourses of nursing education have been played out by nursing educators, and the subsequent discussion of particular discourses that have accounted for the development of comprehensive nursing education. As such, I offer explanations of these
discourses to establish the “conditions of possibilities [they have provided senior nursing educators] for webs of belief” concerning the establishment of comprehensive nursing education as a legitimate discourse in this country between 1973 and 1992 (Alcoff, 1993: 99).

Contemporary discourses

Discourses of professionalism

Emerging debates concerning professionalism have been interpreted as revolutionary developments in the ways modern societies have manifested since the Second World War. To the structural functional sociologist Talcott Parsons, the development of professions “... has displaced first the state, in the relatively early modern sense of that term and, more recently the ‘capitalistic’ organisation of the economy...as the crucial structural development in the twentieth century” (1968, p. 545 in Watson, 1993: 2). More recent debates around discourses of professionalism concur that professional projects have coincided with the development of capitalism. Such debates associate the emergence of professional status with male-dominated and highly prestigious occupational groups.

Much of what has been written about professionalism has focused on the nature of what constitutes professional status. “Ideal types” have been employed to measure, judge and legitimise the conferring of professional status (and its associated power) on occupational groups. There are well-documented ranges of criteria through which occupational groups can be judged to be professions. Such definitions of professions centre on multiple criteria, and commonly include the following qualities. The professional is most likely to engage “…in a full-time occupation that comprises [the person’s] principal source of income”, and there is an assumed “strong motivation or calling as a basis for his [sic] choice ... and [the individual] is assumed to have a stable lifetime commitment to that career” (Schein, 1972: 7-9, italics in original). “The professional possesses a specialised body of knowledge and skills, which are acquired during a prolonged period of education and training” and is skilled at making “…decisions on behalf of a client based on general principles, theories or prepositions ... by universalistic standards...” (ibid).

There is an assumption that professionals “have a service orientation...imply[ing] diagnostic skill, competent application of general knowledge to the special needs
of the client and an absence of self-interest” (ibid). Furthermore, professional service is based around “the objective needs of the client... independent of sentiments that the professional may have about the client... (ibid). Thus the relationship rests on a kind of mutual trust between the professional and the client. The professional is assumed to know better what is good for the client than the client himself [sic]” (ibid). As a consequence, professional occupational groups “demand... autonomy of judgement of [their] own performance” (ibid). Furthermore, “professionals form professional associations with admission criteria, educational standards, licensing and other formal entry examinations, career lines... and areas of jurisdiction” and although they tend to have great power and status in the area of their expertise... their knowledge is assumed to be specific” (ibid). Finally, groups offer their professional services “…but ordinarily are not allowed to advertise or seek clients out” (ibid. Also Abbott, 1988; Skrtic, 1995a and 1995b).

Alternative traits or qualities to characterise professionalism are proposed by other commentators (for example, Freidson, 1986; Seigrist in Becher, 1994). Examples of these are the regard for notions of professional competence and the role and authority professions hold in the capitalist market and the related “symbolic capital” linked to such authority (Larson, 1977). Other examples include the “jurisdiction” that professional groups maintain and retain over their work (Abbott, 1988), and the relationships accorded to professions by the state (Shalem, 1990).

Feminist commentary regarding the sociology of professionalism has questioned the patriarchal assumptions which have arguably made such “criteria” unachievable for women (for example, Davies, 1983; Oakley, 1984). Others have viewed the use of the term “professionalism” as a patriarchal construction and expound the idea that women-dominated occupations are inevitably unable to conform to the aspirations expected within many masculine-dominated professions. Often this is related to understandings of institutional “glass ceilings” and/or the obligations and choices many women make to take time away from paid employment through childbearing and child care commitments. Furthermore, some forms of feminist critique concur with the views of socialist, Marxist and other critical theorists that the power bases upheld by professional groups manifest as elitist cultural authority, political acumen and financial affluence in ways that are exploitative to non-professional groups (Oakley, 1984; Porter, 1992; Salvage, 1985). Thus while some
feminist reviews construct “professionalism” as a sought-after and under-achieved occupational quality for women, other groups of feminists regard the paternalism, elitism and connotations of power inherent with this term a less than desirable form of status.

The importance of education programmes as preparation for professional workers has been identified as a core variable by researchers across a variety of disciplines. Beyond the general view that professional knowledge and skills are attained during a prolonged period of education and training, I understand that the location and nature of the educational experience are important considerations in the professional identity of occupational groups. For example, Taylor (1997) draws on the work of Eraut (1992) and Schön (1983) to iterate that the special nature of professional education is based on the unique forms of professional knowledge shared between teachers and their students.

In the health sector, medicine traditionally represents the archetypal profession. It is associated with life saving powers, a prolonged university-based education and training, and the elitism and high levels of remuneration awarded to doctors for their skilled work. Numerous authors have presented accounts of the rise of medical professionalism, and much of the early literature sought to describe the core qualities of these workers (for example Abbott, 1988; Freidson, 1970 and 1983). Other commentators have reviewed the perceived effects of doctors' “occupational imperialism” or cultural “sovereignty” over the structure and provision of health services throughout western societies (Illich, 1977, also Larson, 1977; Navarro, 1976, Starr, 1982 and Witz, 1992). Michel Foucault’s 1963 publication The Birth of the Clinic: An Archaeology of Medical Perception drew on historical medical texts to propose a quasi-structural model of the relationships between medicine and various dominant institutions throughout society. Of particular pertinence is his review of the clinical gaze as a strategy for the continuing power/knowledge dominance by medical staff over their patients (Armstrong, 1997: 20-21).

While allied health workers have been drawn into comparing their relative worth with medical colleagues, the nature of nursing as a profession has been debated internationally. Most of the literature in this field originates from North American academic contexts. For example Garmanikow, 1978; Marquis et al. 1993, Porter,
1990, Rosenow, 1982 and Salvage 1988, all debate the potential “usefulness” to nurses of regarding nursing as a profession. Katz proposes that nursing constitutes a semi-profession, where qualified nurses are positioned hierarchically between untrained nursing staff and medical staff. He suggests that the role and status of nurses is in part constituted by the nurse’s role as a “...buffer between the professional’s and the layman’s world and between the hospital and its environment” (1969: 60). Theorists such as Game and Pringle (1984), Kenway and Watkins (1994) and Watson (1993) associate professional status in nursing with the ideological and physical shift to tertiary education-based sites of learning, and the shift to specific nursing (rather than medically-based) epistemologies of practice. An alternative group of nursing theorists embrace the professional status of nurses as a catalyst for examining a diverse range of issues confronted by nursing students and their qualified colleagues (for example, Moloney, 1992; Schrivarian, 1998). Other commentators have suggested that a preoccupation with notions of professionalism diverts nurses’ attention from attaining freedom to practice nursing beyond the medical model and outside the confines of patriarchal constructions of nursing practice (Oakley, 1984; Porter, 1992; Salvage, 1985).

Discursive understandings of the powerful status of professions in modern society are bolstered by the status and roles of the groups with whom they work (Abbott, 1988). As a consequence, Celia Davies proposes the idea that the medical profession’s rational and authoritative status is reinforced by their authoritative relationships with nurses (1996). In the Australasian context, nursing research has focused on this and similar socio-political constructions of nursing professionalism, and reflects on the increasing body of nursing knowledge as a form of academic discipline and research epistemology. The Australian nursing theorist Deirdre Wicks advances a sophisticated thesis to explain the relations between doctors and nurses in both historical and contemporary contexts. Such relationships involve the balancing of components of power that traditionally subjugate nursing, and the agentic potential for nurses to resist such power. She draws on Gramscian understandings of hegemony, countered by Foucauldian "common-sense" understandings of discourse to avoid the tendency to rely on dichotomous systems of power relations (Wicks, 1999: 25). By drawing on Gidden’s theory of structuration, Wicks theorised the discourses nurses employ to renegotiate a sexual division of labour between themselves and the male-dominated medical profession.
Recent research in this country has explored the historical relationships between nurses and the medical profession. Belgrave explores the nature of pre-welfare state affiliations between medical practitioners and nurses, and notes that an important quality of nursing identity emerged as "...the inculcation of attitudes of discipline and obedience" (1991: 21). His account depicts volatile relationships between medical and nursing staff which were later calmed by the establishment of the welfare state. More recently, nurses' prescribing rights have been resisted by doctors, and other intra-professional struggles have emerged, for example in the professional boundaries between nurses and midwifery education, qualifications and licensing authorities (Tully and Mortlock, 1999).

Discourses of vocationalism

Having considered the debates about the ways professionalism is played out with regard to nursing, I found it equally necessary to preface my analysis of discourses concerning the development of comprehensive nurse education by reviewing the notion of vocationalism. I propose that discourses about vocationalism are almost as potent as those of professionalism, when considering nursing and nursing education. Constructions of vocationalism have always underpinned many of the cultural assumptions about nurses, their education, and the work they do.

The notion of vocationalism has two distinct cultural meanings. One involves its use by educationalists, most apparently in the 1960s and 1970s, to refer to the decisions faced by school leavers about their employment opportunities. In the contemporary neoliberal British context, state-organised systems of education and training are prefixed by the term, including VET (Vocational Education and Training); NCVQ (the British National Council for Vocational Qualifications) and NVQ (National Vocational Qualifications). Here the term "New Vocationalism" appears to relate to a range of neo-liberal inspired education and training programmes that are closely linked to employment opportunities (Ainley, 1990; Dale, et al., 1994).

The alternative meaning associated with the term "vocationalism" is of interest to this research project by the very nature of its complexity and intangibility. In general terms, this second meaning of vocationalism has been associated with a literal "... calling from God to follow a particular path in life", historically into the
priesthood or other forms of devout service (Ainley, 1990: 5). This belief is especially important to nursing, given the powerful historical legacy of nuns who work as nurses, both internationally (for example, Mother Theresa) and in the context of Aotearoa New Zealand (for example, the French colonial Sister Aubert\(^{1}\)). Magali Safatti Larson identifies vocationalism as an intrinsic and unique component of work ethic that has its origins in nineteenth century capitalism. She reviewed Weber’s theory which proposed that combined with an “entrepreneurial orientation”, vocationalism gave rise to the “specifically bourgeois economic ethic” that is shared by professional groups (Larson, 1977: 61). Specifically, she suggests that Weber viewed vocationalism “... as the ethical basis for the modern division of labour”. Furthermore, Emile Durkheim also considered the principle of vocationalism, concentrating on the importance of free choice, and depicting a calling as “the categorical imperative of the moral conscience ... assuming the following form: ‘Make yourself usefully fulfill a determinate function’” [sic] (ibid, italics in original).

A more recent review has considered the notion of secular vocations and the interconnections between vocationalism and professionalism (Robbins, 1993). However, vocationalism continues to have quite a different meaning from professionalism. While vocationalism can be understood as an innate or learned characteristic of a person with implications for how they engage in their chosen field of employment, professional discourses centre on the conferring and use of the term as a limited construction of people’s identities. This is interesting to this research project because of the implications such assumptions might have for nursing and nursing education. At the same time, the scientific and cultural authority and elitism of professions in a capitalist society is contrasted by the degree of moral authority and elitism associated with people who follow a vocation.

From my reading of the literature, I understand the notion of vocationalism or calling, to have a strong connection with nursing. Historically, the associations

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\(^{1}\) It is not clear, however, whether Suzanne Aubert was a qualified nurse. Biographer Jessie Munro (1996) discusses the possibility that some of Aubert’s claims, including having trained as a nurse with the Sisters of Charity in France and later with Florence Nightingale, provided listeners with “a fertile blend of provable fact, possible fact, inflated fact, and also fiction-that-thought-it-was-fact, fiction-that-wished-it-were-fact” (Munro, 1996: 34-35, italics in original). Whether qualified or not, she undoubtedly worked successfully as a visiting and hospital-based nurse among poor rural North Island Maori communities using herbal and leaf-based medicines (ibid: 117-120).
between caring work and Christian doctrine are most easily understood through the narratives of maternalism, purity and heroism (for example, Ehrenreich and English, 1973; Hollway, 1984). With the formal organisation of nursing as a training and occupation, the discourse of vocationalism gained legitimacy through the views of Florence Nightingale, who “...stressed the importance of the personal character of the nurse rather than training or skills. In her view, the good nurse was kind, compassionate and patient. Such a nurse is born not made” (Mackay, 1992: 6; Nightingale, 1969). The discursive power of this idea brings into question connections between what constitutes a “good nurse” and a “good woman”. It also makes explicit the discourse of vocationalism as an essentialised innate feminine attribute (Garmanikow, 1978; Wicks, 1999: 128).

Post-modern feminist critics are concerned with the legacy of these historical associations. Mackay’s work with British nurses suggests that such views remain. A group of her participants, for example, identified their shared belief in the idea that nurses are “born not made”; and “frequently” such participants explained that nursing was “something [they had] always wanted to do” (Mackay, 1992: 7). Essentialist beliefs such as these are echoed in the discursive statements employed by a minority group of participants to suggest that vocationalism remains a potent discourse with regard to comprehensive nursing education. Comments from Gwyneth and Fiona reflect a vocational attraction to nursing.

> I had wanted to be a nurse, it was what I wanted to do... And loved nursing but was bright at it too. It just naturally fell into me. It wasn’t something I had to particularly strive for.

(Gwyneth, 244-)

> It was what I always wanted to do.

(Fiona, 26-)

Vocationally related attitudes have also been reported by research into nurses’ attitudes to their work. Brian Francis, Moira Peelo and Keith Soothill’s research found that four clusters of nursing attitudes became apparent concerning their employment in the National Health Service (hereafter NHS). These included the discursive statements “Nursing, but for how much longer?”; “Nursing: battling it out” (ibid: 66) and “Nursing: ’just a job’“ (ibid: 67). A fourth group of nurses held
a significantly different view. Francis, Peelo and Soothill describe their collective attitude as remaining in “nursing come what may”. The authors elaborate thus:

It seems little will deter them from continuing in nursing and, further, they make few demands upon the system. Compared with other nurses they do not bemoan the pay, poor promotion possibilities, lack of training opportunities, etc. Quite simply, nursing is their life whatever the trials and tribulations.

(1991: 66)

In research that examines the modern forms of professional identity, Magali Sarfatti Larson identifies the importance of non-monetary rewards, specifically the notions of esteem and fulfillment “... bound up with ... an essential dimension of the self”, which emanates from an ideology of vocationalism or calling (1977: 227). She extends this understanding of vocationalism to the notion of rewards which is implicitly connected with issues of choice and individual subjectivities. Larson suggests that the stronger the notion of vocationalism, the stronger the possible social control within a profession. Alternatively, “the erosion of the ideological notion of calling tends, therefore, to undermine a powerful element of social control within a profession” (ibid: italics in original). Her thesis offers an important idea to complement the exploration of associations between discourses of professionalism and vocationalism. This idea combines the traditional qualities associated with vocationalism with questions about the pleasure, satisfaction and other benefits that can be experienced by people engaging in nursing work. A sense of vocationalism, the notion of “calling” can be associated with the stereotyped historical image of nurses as obedient to the medical profession and to an altruistic commitment to “serve the sick”. This raises many important questions for the work of my thesis. One is: how do nursing educators make sense of the professional and vocational discourses of nursing for their own sense of identity, and for the students enrolled in the comprehensive programmes they established? Another is: if notions of vocationalism remain an important aspect of nurses’ and nursing educators’ identities and subjectivities, what implications does this have for the power/knowledge couplet for nursing educators? (McWilliams, 1999). Through an examination of the discursive statements commonly employed by nursing educators, the chapters which follow will consider answers to these questions.
Discourses of vocationalism are closely linked to feminine constructions of heroism. In a biography of Joan of Arc, Marina Warner offers the comment that in embodying heroic qualities, she demonstrated “sincerity, a calling, bravery, and loyalty to her innermost convictions, in the face of terrible ordeals” (Warner, 1981: 9). Warner proposes that she represented the “pre-eminent heroine because she belongs in the sphere of action, while so many feminine figures or models are assigned and confined to a sphere of contemplation” (ibid). Indeed, heroic status is implicitly about action in the face of adversity; it is about performance and embodiment. A metaphor of heroism can be used as a heuristic device to explore the intersection of subjectivity with identity as nurses and nursing educators face shifts in forms of nursing work, nursing education and nursing power/knowledge. The brave pioneering spirit and commitment to duty are commonly associated with nursing figureheads, like British nurses Florence Nightingale and Edith Cavell. This has implications for a sense of nursing history in this country (Baly, 1986; Pickles, 1997). For example, in Canterbury the work of a pioneering district nurse, Nurse Maude, and the Nurses’ Chapel at Christchurch Hospital extend the legacy of nursing heroism in the Aotearoa New Zealand context (Ciaran, 1990; Cocks, 1980; Friends of the Chapel, 1989).

I suggest that textual statements concerning heroism, professionalism and vocationalism form part of a complicated discursive field amidst which comprehensive nursing education as an emerging discourse has developed. Alongside the field of welfarism with its shifting values and theoretical foundations, these discourses form a useful context to study the development of comprehensive nursing programmes. Of particular importance is the continued construction of a binary between professionalism and vocationalism. While I have separated the two concepts to review their historical portrayal, as a poststructural theorist I pursue the breaking down of the potential dichotomies between the two terms. The literal and figurative forms of the “place” of nursing in Aotearoa New Zealand society has been troubled and complicated by the constant reorganisation of these discourses in relation to health and education. I now turn to challenging new social discourses to gain a clearer picture of this place of nursing.
Challenges to traditional ontologies of nursing practice

New Nursing

A particularly pertinent development in the organisation of nursing work and professionalism concerns the development of a new model of nursing practice. While my discussion focuses on the importance of the British development of a theorised model known as New Nursing, it is important to acknowledge the influences of North American nursing epistemologies, for example, through Virginia Henderson's work (Salvage, 1992: 11). Historically, hospital schools of nursing had focused their students' work around the tasks necessary to ensure the smooth organisation of the work environment and those that based nursing work around obedience to the medical profession and nursing hierarchy. The traditional discourse of medicalised nursing concurrently constructed patients as child-like and powerless, and nurses by their underlying feminine and maternal predisposition to caring work in relation to their nursing identity (Kuhse, 1997: 13-31; Salvage, 1992). This dominant discourse also promoted a particular construction of nursing identity, where the ability to perform nursing work was arguably more important than a foundation of knowledge, and character was more highly valued than intellect (Rafferty, 1996: 23-41).

New Nursing emerged in Britain in the 1970s and it centred around the nurses' primary duty to focus on the individual needs of their patients. New Nursing encouraged a new loyalty towards patients, and a holistic model of patient care instead of the earlier bio-medical focus and orientation to work centered around the needs of the medical profession (Salvage, 1992: 11-12; also Witz, 1994). The model emphasised the importance of a relationship between theory and practice across a diverse range of nursing contexts. New Nursing also advocated new ways of working with people in health care settings, where the nurse would work in a power-sharing partnership and/or an advocacy role to support patients in their care (Kuhse, 1997; Tully and Mortlock, 1999: 175-176).

New Nursing was also connected to the development of nursing education in the tertiary sector, related to the premise of patient rights to be cared for by an all-qualified nursing workforce. In the United Kingdom these changes were prompted
as components of the “Project 2000” policy initiative which heralded the transfer of nursing training from traditional apprenticeship-based schools of nursing to a system of university degree-level entry to practice nursing preparation (Witz, 1994: 27-29). At the same time, these initiatives were accompanied by the fostering of nursing as a legitimate field of post-graduate academic study. This reconstitution of nursing as an academic discipline and a professionalised and degree-conferred programme of education has worked to resist historical discursive understandings of nursing and nursing education. These include challenges to the historic construction of femininity as innate criteria by which women were able to engage in nursing work (Davies, 1996; Muff, 1982; Street, 1992: Chapter Four; Tully and Mortlock, 1999: 176; Witz, 1994: 39).

Managerialism

The neoliberal reforms throughout Aotearoa New Zealand since the mid-1980s have emphasised the need for efficiency and a business-like ethos to pervade the range of state services. A key component to this model has been the promotion of managerialism. A useful definition of this term is offered by Michael Traynor in his recent text which examines the complex relationships between nursing and managerial discourse under the neoliberal-reformed British health sector. He cites Pollitt’s work to explain managerialism as ideology.

... the world should be a place where objectives are clear, where staff are highly motivated to achieve them, where close attention is given to monetary costs, where bureaucracy and red tape are eliminated. If one asks how this is to be achieved the managerialist answer is, overwhelmingly, through the introduction of good management practices, which are assumed to be found at the highest pitch and most widely distributed through the private sector.

(Pollitt, 1993: 7; italics in original, cited in Traynor, 1999: 13-14)

The State Sector Act of 1988 has been the most pervasive and enduring example of managerial political discourse in Aotearoa New Zealand. This legislation oversaw the appointment of Chief Executive Officers (hereafter CEOs) who were hired on fixed term performance-related contracts to run government departments. The criteria for such positions emphasised management and efficiency-related skills and many successful CEOs moved between disparate government agencies “from transport to social welfare, from forestry to education... and from Treasury to
labour, health and prisons” (Kelsey, 1997: 139). This quality of employment flexibility represents a significant discursive statement concerning managerialism; managers have generic skills for overseeing any organisation. The managerial ethos imposed throughout the state sector under neoliberal reforms sought CEOs and other senior decision makers who would not be distracted by vested interests or subjective concerns about aspects of their brief. Quite simply, their role was to manage the organisation efficiently and effectively. In this way, managerialism marks a distinct change from the traditional organisation throughout the health sector, where senior staff (typically a triumvirate of medical superintendent, chief nurse and general manager) would collectively and with specific institutional knowledge, oversee their hospital administration. The strength of managerial discourse has worked to both undermine and promote the comprehensive nursing education over the past two decades. The ways in which these forms of power/knowledge have functioned will be examined throughout the rest of this dissertation.

Rights discourses and identity politics

Rights discourses

I believe there are three particular constructions of rights discourses that influenced the values upon which comprehensive nursing was conceived and enacted. By a discourse of rights I mean a coherent system of values that uphold individual entitlement to moral or legal control and freedom. A discourse concerned with citizens’ entitlement has origins in a social democratic formation, but of interest here is a reconstitution of a rights discourse under neoliberal political theory.

Consumer rights

An important component of the promotion of a free market is the notion of consumer sovereignty. In regard to comprehensive nursing education, two groups can be understood as consumers. Firstly there are patient rights – particularly concerning the right of health services’ consumers to be cared for by skilled, knowledgeable and qualified nurses across the breadth of the health sector. This discourse oriented the public sector health providers to a business-like ethos that neoliberal advocates felt had been lost under the welfare state, and specifically, where patients had been traditionally cared for by unqualified nursing students
from hospital schools of nursing. At the same time, this emergent rights discourse has been utilised by consumer groups to negotiate for greater consultation and involvement in their health care experiences in response to the traditional authority of the range of health care professionals (Davis, 1981: 161-164).

The second group of consumers is the students of nursing programmes. As fee-payer clients of the education sector, there has been a cultural shift towards students’ demands for optimal learning experiences to prepare them for their forthcoming careers. Emily explained an important facet of this, when she reflected on the consequences of a user pays ethos that she had observed in an overseas context.

_The [nursing educators] set up a whole lot of extra courses, to give the students extra support, in order to make sure that they pass. Because they are not allowed to fail. And the obligation in that was justified in terms of, ‘Well I am paying a fee so I have to pass’._

(Emily, 1327-)

Comprehensive students gained clinical experience throughout the health sector while holding an extra-numeracy status (that is, their presence is not taken into account in the allocation of staff to particular worksites) and under the constant supervision of registered nurses, either hospital staff or comprehensive nursing educators. This way, neither patients nor students jeopardised their rights to safe and effective clinical experiences. While the discourse of consumerism has only gained momentum since the neoliberal reforms of the late 1980s, the fundamental principle of patient and student access to optimal health sector experiences has coincided with the transfer of nursing preparation to the tertiary sector.

**Tangatū whenua and Treaty rights**

The principle of tino rangatiratanga or sovereignty over life and lands was agreed to by Maori tribal leaders and the pakeha representatives of the British colonial powers with the signing of the Treaty of Waitangi in 1840. It was only in the late 1980s that the state formally acknowledged that over the intervening one hundred and fifty years successive governments had denied Maori any such freedom. The majority of Maori land had been lost by extortion to representatives of the Crown, and the welfare state, which had promised equality of opportunity, but had systematically failed to provide equal entitlements and opportunities to Maori
citizens (Kelsey, 1997: 22-23). While the fourth Labour Government’s move to honour the Treaty by promising to settle outstanding grievances has been stalled by bureaucratic disorganisation, initiatives in separate Maori education have been highly successful (Jones, et al., 1995; Poato-Smith, 1994). Before the Treaty became a focus for widespread political and civil debate, Maori have sought education-based solutions to the consistent evidence concerning poor attainment, and in particular the endemic failure of Maori students throughout the education sector compared with their pakeha peers.

There is similarly important evidence throughout the health sector of this inequality. For example, evidence from rates of morbidity and mortality, smoking, suicide and institutionalised treatment for mental illness, show that Maori experienced poorer health status and a shorter life expectancy than pakeha (Mason, 1996; Reid, 1999a: 88-90). Combined with a renewed awareness that the Treaty of Waitangi obligated the state to work towards combating such inequalities, successive governments since the early 1980s have supported initiatives in Maori health care (Cunningham and Durie, 1999; Reid, 1999a and 1999b). For example, affirmative action policies have been trialed with some success to encourage more Maori (as well as male and Pacific Island people) to enrol as nursing students over the past decade. The scale in which these developments have occurred, and their efficacy at improving the health status and the participation of Maori in the health care services, remain open to debate.

Feminist discourses

Discourses concerned with women’s experiences - their participation, identities, status and power within families, paid work, education and in the health sector - differ on the basis of assumptions each holds about the world. Three discourses of feminism are particularly relevant to the context in which comprehensive nursing education has contested the authority of apprenticeship models of training for nurses. These are liberal, radical and poststructural forms of feminism. I review the first two of these below, while the last is dealt with in the second section of the chapter.

Liberal feminists emerged within the social democratic discursive formation by drawing on social constructions of gender relations to consider the historical and
contemporary inequalities between men and women. Unless deliberate efforts are sought to work towards gender equality, liberal feminists identify the dominance of a masculine hegemony across the education system. The liberal feminist thus promotes the principle of equality of opportunity in education, training and employment as a strategy for the attainment of true equality between the sexes (Jones, et al., 1995: 118-119; Middleton, 1982). An example of this in relation to nursing education might involve liberal feminist efforts to gain gender equality through women nursing educators’ appointments to senior leadership and management positions at polytechnics in order to access greater authority and control over their programmes. Another example concerns the general status of nursing as a profession on equal terms with other health care occupational groups, as explained by Beth.

_I believed that nursing had the right to stand up as a profession, alongside other health professions. The reason it had been difficult to acknowledge it as a profession before was because of the apprenticeship role.... Clearly here was the opportunity to produce a professional image, not only in terms of being seem to be a profession, but actually behaving and acting as one, with values, skills and knowledge all being important, not one particularly overriding the other._

(Beth, 257-)

Radical feminist discourse moves beyond a desire for equality of opportunity on gender lines. Proponents of radical feminism regard liberal rhetoric to effectively serve the needs of women and girls in education as rhetoric and tokenism (Jones, et al., 1995: 133-134). A radical feminist discourse promotes the principle that women’s inequality to men is the most significant form of oppression (Pihama and Mara, 1994: 226- 227). There is a common belief that revolutionary change, rather than any gender-oriented reforms, will be effective towards liberation of women from patriarchal-dominated societies. For example, radical feminist constructions of nursing ontology pursue models of practice that are independent from the medical profession, both in terms of institutional organisation and epistemology. Cathy offered a comment in this regard.

[I wanted nurses to be] _highly independent, critical thinking decision makers who act on their decisions, [and are] accountable for them ... [In clinical areas I saw] nurses with considerable experience and good intellects being subservient to junior medical practitioners in relation to_
nursing. That didn’t make sense to me. [I wanted] people who will make responsible, accountable, informed decisions and implement them.

(Cathy, 1029-)

Radical feminism has remained a relatively impotent discourse in the Aotearoa New Zealand education sector, but liberal feminists have gained some institutional control. This said, my analysis of individual women nursing educators reveals that radical feminist forms of pedagogy have been influential in their organisation of comprehensive nursing programmes. Details of the ways participants report this are examined in Chapter Six.

**Feminism and health services**

In the health care sector, both liberal and radical feminist discourse have been a potent force for change. Coinciding with the second wave of the women’s movement, radical feminist groups have criticised the paternalism of the medical profession through the continued dominance of men as practitioners and the less serious regard for treatment of women’s health problems. This has prompted women’s groups to challenge medical sovereignty. Furthermore, the cultural authority of the medical profession was associated with the continued subordination of women as nurses in stereotyped feminine, handmaiden and adjunctive roles. Such perceived powerlessness was increasingly resented by groups of feminists inside and outside of nursing. This frustration concerned the working conditions, status and authority of the nurses themselves and was equally motivated by an awareness of nurses’ increasingly important role as patient advocates (Wiggs, 1991; Wootton, 1989). A challenge to the traditional regimes of medicine and medical paradigms also appears.

A heightened cultural awareness of medical complacency, inadequacy and even intentional malpractice has emerged over the decades under review. These include the notable examples of *The Unfortunate Experiment* on women with *in situ* cervical cancer in Auckland in the 1980s (Bunkle and Coney, 1987; Coney, 1988) and the 2000 Gisborne misread cervical screening and diagnosis enquiry (Duffy, et al., 2001). Furthermore, there has been increasing evidence that the medicalised systems of health care continue to encroach on aspects of women’s health claimed as treatable by medical services. An example is menopause and the development of hormone replacement therapy for women (see Coney, 1991). Feminists have
been active in exploring the connections between the proportions of women who suffer harmful consequences of medical care and the enduring masculine hegemony of the medical profession.

This said, the increasing numbers of women entering the medical profession over recent decades has had consequences for the ways traditional paternalist medical practices and knowledge were constructed. Women as patients were offered new opportunities to be cared for by women medical practitioners. Groups of politically-conscientised feminist nurses have joined or actively supported lay women’s reactions to the paternalised health care system in New Zealand, modelled on the consciousness-raising, self-responsibility models of health care exemplified in self-help initiatives such as Our Bodies, Ourselves (Boston Women’s Health Book Collective, 1984). Innovations in the context of Aotearoa New Zealand include the establishment of The Health Alternatives for Women in Christchurch (Bird, 1986) and a national network of Rape Crisis and Women’s Refuge Centres (Harvey and Moon, 1993; McCallum, 1993). Women health professionals also joined lay feminist action and lobbying groups in pursuit of legislative reforms that they saw as oppressive to women’s rights. These included the abortion, contraceptive and sterilisation legislation through the Women’s National Abortion Action Campaign (Hughes, 1993). Other examples include the support for independent midwifery practice by the New Zealand Home Birthing Association (Donley and Hinton, 1993; Tully and Mortlock; 1999), and homosexual law reforms (Hodge, 1985).

I have reviewed the discursive foundations of welfarism associated with the conceptualisation and provision of education and health. Now I turn to the discourse constructions which I utilise in my analysis of the discourses nursing educators have engaged with to explain the development of CNEP.

**Poststructural challenges**

**Feminist poststructuralism**

My attraction to the work of feminist poststructural theorists was based on their troubling of gendered discourses in ways that I hoped would enlighten my particular field of study. By feminist poststructuralism, I am referring to the bodies of knowledge that have emerged from questions about the relationship between
language, discourse, power and subjectivity as they are played out in gendered ways. Feminist poststructuralism has been employed as an important *episteme* across a vast range of research projects, including innovative analyses within the health and education sector over the past two decades or more. Of primary interest in the poststructuralist feminist perspective is the “…identification of] the social discourses available to women and men in a given culture at a given time” (Gavey, 1989: 466). Specifically, feminist researchers seek to gain insight into the discourses that provide subject positions which people adopt and modify over time, and the ways in which this relates to how people constitute their own subjectivities. Discourse analysts with a concern for feminist issues also seek to understand how groups of women negotiate change within gender-oppressive social contexts, and how the hegemony of gendered discourses otherwise remain unchallenged. Finally, feminist forms of discourse analysis embrace aspirations towards emancipatory change, where analysis of discourses might signal strategies through which groups of women may reinforce or undermine existing gender relations (Fraser, 1997: 152. See also Hollway, 1984; Walkerdine, 1986). In other words, feminist poststructuralists employ “…historically specific analysis to explain the workings of power on behalf of specific interests and to analyse the opportunities for resistance to it” (Weedon, 1997, 40).

**Non-unitary subjectivities**

An important principle of poststructuralist feminism is the understanding that there is no single unified humanist self which is held together by a unitary “centrifugal power” (Sidonie Smith, 1995: 155 quoted in Bloom, 1998: 3). Instead, a shared understanding of non-unitary subjectivities is employed by poststructural feminist theorists to explain the ways in which women can make sense of their lives, while embracing both the fragmented aspects of themselves and acquiescing to the contradictory aspects of self which exist in the realm of personhood.

In order to understand this concept effectively, it is important to explain what I mean by subjectivities, and the way in which I distinguish them from the notion of identity. Essentially, I employ the term identity to mean the descriptions of individuals or groups of people who experience life within the confines of the discursive contexts. In this sense, I believe that identities are socially bestowed by people, about other people, and are thus conferred rather than self-imposed (Burr, 1995: 30). I employ Chris Weedon’s explanation for understanding subjectivity,
namely that "subjectivity is used to refer to the conscious and unconscious emotions of the individual, her sense of herself and her ways of understanding her relation to the world" (1997: 32).

Extending from these concepts, the notion of non-unitary subjectivities can thus be understood as the varied and simultaneous senses of self that individual people employ in the ways they interact with different contexts. In other words, the potential for contradictions within the self is not only abided and/or tolerated, but also embraced as being components of the self. This incorporates the ways the nursing educators in my research can, for example, understand themselves to be advocates for the transfer of nursing education to a general system of education on the principle that hospital-based programmes provided poor educational standards. At the same time, the participants may understand that their confidence and skills as clinicians stem from the calibre of their own apprenticeship-style nursing training. In such ways, understandings of non-unitary subjectivities draw out the complex ways people engage with contemporary and historical discourses. Furthermore, the complex variable of memory also influences how people make sense of, and explain, the past. Some of the comments offered by the participants in the section entitled "Memory and History" in Chapter Five demonstrate these points.

Feminists have suggested that understanding the multiplicities of self has politically transformative power. Leslie Rebecca Bloom draws on Bronwyn Davies' work to propose that such understandings may provide feminist researchers and their participants with "a clearer comprehension of their own fractured and fragmented subjectivity and allows them to explore ways that patriarchal discourse is inscribed in their bodies and emotions" (1992, 55-56, in Bloom, 1998: 4). Understandings of non-unitary subjectivities are also important through the ways they provide a transparency of the context in which notions of the self are formed. In other words, the ways people make sense of themselves is interwoven with the understanding that the forms of self are constantly renegotiated within a political, cultural, social and economic context. Thus understanding people with regard to non-unitary subjectivities is to embrace the idea of agentic crafting of the self. Agency is therefore an intrinsic component of subjectivity. This thesis explores nursing educators' understandings of their work in comprehensive programmes, the complexity of the varying health and education
milieu, and the changing authority of medical and managerial discourses. While
the subjectivities that nursing educators describe about themselves can be
ambiguous, when combined they form a sense of the self for the individual women
identified as nursing educators. Such analyses also reveal much about the context
in which nursing educators themselves operated. The ways they construct a sense
of their work between the complicated context of the health and educational
environments, and the ways they have negotiated their ambitions for nursing
students, patients and the nursing profession at large, are valuable sites for
understanding the particular discourses at play here.

Clarification is necessary at this point. While I propose that understanding the
nursing educators’ senses of selves is most effective through a feminist
poststructuralist notion of non-unitary subjectivity, it is not something that is
endlessly fractured. Again, Leslie Rebecca Bloom’s discussion of this idea is
useful. She writes:

To accept that subjectivity is non-unitary and fragmented, however, is not
to ‘promote endless fragmentation and a reified multiplicity,’ for, as
Sidonie Smith argues, this would be ‘counterproductive’ to the narrative
project... (1993: 156) ... [N]on-unitary subjectivity and its fragmentation
should not signify a loss of self. Rather, it should signify an alternative
view of the self located historically in language, produced in everyday
gendered, racial and cultural/social experiences, expressed in writing and
speaking, and employed as a political feminist strategy.

(Bloom, 1998: 6)

It is this regard for non-unified subjectivities that I uphold as a meaningful strategy
employed in poststructural feminist analysis.

Nursing as performance

A second poststructural feminist theoretical tool that is useful in analysing the
discourses around CNEP draws on Judith Butler’s theory. Her work on the politics
of gender as performance offers the possibility of a form of Foucaudian genealogy
concerning clinical nursing work and femininity as performance (Butler, 1990: viii-
xi). Susan Bordo describes Butler’s thesis as proposing that:

...our identities, gendered and otherwise, do not express some authentic
inner ‘core’ self but are the dramatic effect (rather than the cause) of our
performances. These we learn to ‘fabricate’ in the same way we learn how to manipulate a language, through imitation and gradual command of public, cultural idioms (e.g. the corporeal gestures of gender).

(Bordo, 1992: 168, italics in original)

I believe that the traditional western cultural assumptions concerning nursing as women’s work reflect the hegemony of a patriarchal and medical-dominated health care sector. Butler’s strategy of proposing a way of understanding “drag” as a form of gender work that parodies, mimics but also reinforces notions of femininity, can be used to illuminate questions around the construction of nursing identities. Her hypothesis about gendered performance allows me to reflect on the extent to which gender by physical assignment – secondary sex characteristics for example – comprises natural, socially constructed and/or artificial performances of femininity, and the implications this offers to nursing as traditionally feminine work.

Also helpful is Judith Butler’s challenging theory of performance as disruption to the status quo of gendered identities. This raises questions about the particular concept of “nursing as gendered work”. In particular I consider the term “nursing work” as a “foundational category of identity” in the context of Butler’s comment.

What other foundational categories of identity – the binary of sex, gender and the body – can be shown as productions that create the effect of the natural, the original and the inevitable?

(Butler, 1990: viii)

When nursing is considered as gendered performance, “the natural” can be understood to involve constructions of women as innately caring, kindly, tender and empathetic, while “the original” associates a paternal construction of motherhood with nursing work. Furthermore, “the inevitable” can similarly be read through the power relations inherent in binarised male/female, masculine/feminine, dominant/submissive, knowing/doing, doctor/nurse dualisms. If we understand the potency of nursing as feminine gendered performance, the enduring cultural construction of a legacy of the primacy of nursing practice for a feminised profession becomes apparent. By this I am referring to the inherent value placed upon clinical nursing work that involves care of people who are sick within the secondary care sector. Such valuing also involves an internal hierarchy
where levels of patient dependence and illness and the prioritising of physical forms of ill health are criteria upon which the calibre of various forms of nursing employment are judged.

In proposing this I am suggesting that such a dualism has only developed within the past century with institutionalised systems of health care provision where paternal medicalised discourses have traditionally dominated. By viewing nursing work as a gendered performance, I am not suggesting that clinical nursing skills are innate or even culturally learned by women. The provision of nursing education is fundamental in the acquisition of nursing skills and knowledge. Instead, I believe that a cultural expectation of female inclination to such forms of work exists, and that this view continues to imbue the health services and the health education sector. As I have previously discussed, the theorising of nursing as feminine performance also connects to constructions of nursing as a form of vocational employment.

**Foucault and medicine**

As well as offering methodological theories which will be reviewed in the following chapter, Michel Foucault offered his own historical interpretations of particular topics which are pertinent to a discussion of nursing education discourses. His history of medicine, *The Birth of the Clinic* (1963) offered a deconstruction of medicalised knowledge that has inherent relevance to understanding the relative identity of nursing. The work focuses on the bureaucratic organisation of the modern state, and the ways in which historical developments in medical knowledge serve to monitor and have a controlling effect on society. As White explains, “modern social and medical sciences ... as branches of knowledge, work through professional groups of helpers and healers, and are internalised by us as subjective realities” (White, 1999: 27). In his description of systems of power/knowledge, Foucault draws on the principle of surveillance. Surveillance operates as an integral component of systems of social order and individual self-control. Foucault also explored the powerful implications that medically sanctioned “scientific” discourse has had on social understandings of the body as corporeal space, discursive constructions of disease and, as previously discussed, the authoritative gaze of the medical profession (Foucault, 1973, Chapter One).
Furthermore, Foucault reminds us that understandings of the body and of health and illness are historically, or more accurately, genealogically reconstructed within the frameworks of political, social, economic and gendered discourse. Through this range of work Foucault’s theorising offers challenging new ways of understanding medical sovereignty, notions of health and illness and the role of nursing that differ from those already discussed in this chapter. In particular, I am influenced by Foucault’s portrayal of medical authority as a fractured, continually reorganised system of power and knowledge. This provides a complex and dynamic interpretation through which the role of medicine and also nursing can usefully be reviewed (Street, 1992: 37-48 and 100-113). The consideration of issues of wellness and illness similarly illuminate the understandings of health care and health care provision.

A particularly poignant example of medical sovereignty in relation to the developing comprehensive nursing programmes has been documented by Alison Johnston, who lead the establishment of a pilot CNEP at Christchurch Polytechnic in 1973. In an unpublished Masters-level paper which reviews the image and role of nurses, she explains the animosity felt by the Canterbury Division of the Medical Association of New Zealand to the education of nurses. A meeting in April 1971 discussed the proposed transfer of nursing education to the tertiary sector. Johnston recalls that the notice of meeting stated:

... this Association... must assume a major role in planning any changes in nursing education and administration... Nursing is not and never can be an autonomous profession but it is and must remain one of the mainstays of our medical system. Doctors have let the control of this group slide away and it is high time we resumed a greater measure of responsibility in this field.

(Johnston, 1978: 56)

Foucauldian constructions of power/knowledge are useful for deconstructing the control and authority that this particular group of the medical profession evidently aspired to maintain over nursing and nursing education. Furthermore, the notion of surveillance is apparent in the paternalism evident in this quotation.

In the study of nursing education, it is important to uphold an awareness of, for example, the power that nurses wield over patients in clinical practice. Foucault’s
legacy also promotes questions about why efforts to construct unique systems of nursing knowledge and practice from medical epistemology have been pursued in recent times. Indeed, the partnership of power/knowledge can be understood as one of the basic rationales associated with the decision to transfer nursing preparation away from the health care sector to the mainstream education system. Thus the discursive statements employed by participants as components of a discourse of comprehensive nursing education can be read for their attention to the role of Foucauldian power/knowledge. Anne offers a pertinent comment in this regard.

*We [as nursing educators] can do something about social justice issues, by understanding and recognising it. Nursing education is a mechanism for that, by helping nursing to change, to stop just band-aiding and just doing bio-medical things and enlarging our world view and make us active to do something.*

(Anne, 1422-)

A major contribution to this in the context of Aotearoa New Zealand nursing education comes from the 1997 doctoral dissertation by Elaine Papps. Her work presents a Foucauldian analysis of the construction of nursing identity through curricula and power relations since the establishment of comprehensive nursing education programmes. She attends to the particularly dominant discourses of gender and medicine, and the challenges that the transfer of nursing education into the tertiary education sector posed to these regimes. This general introduction aside, the connections between Papps' thesis and my own will be explored as particular issues are discussed in subsequent chapters.

**Foucault and education**

Foucault offers ways of reconsidering traditional paradigms of pedagogy, knowledge and power as they are manifest in the education sector. According to Foucault, pedagogical events and strategies represent an important site of capillary power where professionals assert their authority over students (and clients) in subtle and explicit ways. Foucault explains this system of power.

In thinking of the mechanisms of power, I am thinking rather of its capillary form of existence, the point where power reaches into the grain of
individuals, touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives.

(Foucault, 1980: 39)

The educational institutions form part of this network of authority by regulating people through systems of surveillance (Middleton and May, 1999: 78). Again, it is not merely the force of external forms of surveillance as Foucault describes it in relation to Bentham’s panopticism, but the extension from this to the individualised systems of self-monitoring that characterises Foucault’s panoptic view of education (Foucault, 1977). Through this system of surveillance and the organisation of powerful disciplines of knowledge, Foucault’s work offers a critique to explain how the education system works in covert ways to organise and control students and their teachers alike. This raises an important point: that the teachers and students are controlling and controlled, and powerful as well as powerless across the spectrum of education. In this way, Foucault’s critiques of education transform the rhetoric of the liberal theory of education into a complex system of control, surveillance and authority that challenges the culturally potent discursive statements regarding personal freedom, citizenship rights and democracy. I believe Foucault’s analyses of education offer powerful new vistas for viewing the organisation of CNEP. In the particular contexts of the health and tertiary education sectors, the strategies nursing educators have employed to promote comprehensive nursing education as a legitimate form of pre-registration nursing education reveal much about systems of education and training as a form of power/knowledge. More specifically, I believe his work allows me new ways of regarding how nursing educators have made sense of their experiences, and their deployment of particular discursive strategies to advance CNEP within the health and education state sectors, and across civil society.

Feminist poststructural theories of nursing education

The field of nursing education spans the disciplines of health and education, so the work done by comprehensive nursing educators has always been called to account by both social institutions. International literature concerning the theorising of nursing in the field of education has centered around debates regarding the locations for nursing education, duration of programmes and the forms of assessment and credentials that accompany successful completion of nursing training (for example, Humphreys, 1999 and 2000). Questions have also been
raised about forms of pedagogy involved in nursing education, teaching innovations, and philosophies which underpin styles of nursing preparation (Harden, 1996; Peters, 1998; Wotton and Gonda, 1998).

Associated literature reviews the relationships between nurses and other members of the multiple disciplinary health team. Most commonly this involves reviews of the relationships between nurses and the medical profession (for example Mackay, 1992; Wicks, 1999). This field tends to focus on the power relationships between these gendered forms of work, and the enduring historical legacy this has on the work done by nurses, and the images they construct of themselves. Within the discourse of nursing, recent theorists have drawn on both Foucauldian and feminist poststructuralist theories to reflect upon the work nurses do, and, for instance, how they relate to their patients. Examples of literature in this field include Cheek and Rudge, 1997; Goopy, 1997; Lawler, 1991, 1997a, 1997b; Parker, 1997; Rudge, 1997; Street, 1992. Many of these reviews make explicit the connections between nursing and women's gendered identity.

Where feminist poststructural critiques of Foucauldian literature have appeared in the Aotearoa New Zealand nursing context, accounts are most likely to describe and critically evaluate innovations in nursing education programmes (for example, Hylton, 1995; Mayson and Hayward, 1997; Owen-Mills, 1994; Ramsden and Spoonley, 1994; Wood and Schwass, 1993). At the same time, theses about comprehensive nursing programmes also offer new ways of understanding the contributions of feminist and poststructural theory to this form of tertiary education (Clare, 1991; McCallin, 1993; McEldowney, 1995; Papps, 1997). It is against this significant literature that this dissertation research has been completed.

**Discussion**

This chapter has presented two interrelated topics, each of which is pertinent to the topic of comprehensive education posing as discursive challenges to the traditional apprenticeship model of nursing preparation. Discourses that concern employment identities, models of nursing ontology and institutional organisation combine with specific rights discourses to contextualise the changes that comprehensive nursing educators promoted over these decades. At the same time the ways language, meaning, identities and subjectivities are constructed by Foucauldian and feminist
poststructuralism provide potential systems for deconstructing and reconstituting the ways women can make sense of their lives as nurses and nursing educators. By theorising in feminist poststructuralist ways, there is the potential, as Judith Butler explains, that we can “... resignify the very terms that, having become unmoored from their grounds, are at once the remnants of that loss and the resources from which to articulate the future” (1990: 11). Furthermore, Butler’s comment signposts an intrinsic component of feminist theorising of poststructuralism by raising the question of the future, and the potential for possible change (also Weedon, 1997: 19). Elisabeth Adams St. Pierre explains it another way. She is worth quoting at length here, as a springboard to the following group of Chapters Six through Nine in which I examine a genealogy of women’s experiences as comprehensive nursing educators.

... we must learn to live in the middle of things, in the tension of conflict and confusion and possibility; and we must become adept at making do with the messiness of that condition and at finding agency within rather than assuming it in advance of the ambiguity of language and cultural practice. In addition, we must be on the lookout for each other as we negotiate meaning and create new descriptions of the world. We can never get off the hook by appealing to a transcendental Ethics. We are always on the hook, responsible, everywhere all of the time.

(St. Pierre, 1997: 176-177)

The goal of this dissertation is to explore the complex and sometimes ambiguous means by which comprehensive nursing educators have constructed a cogent group of statements that reflect the challenges they faced in developing comprehensive nursing education. The next chapter gives an account of the “conflict ... confusion and possibility” that I encountered in the epistemological foundations of my thesis.
Chapter Four: Theorising my Method

This chapter provides an account of the theoretical foundations of the research methods I have employed in this thesis. To this end I make transparent the explanations of what I believe is a legitimate and useful epistemological stance for exploring nursing educators' work in developing CNEP. This involves upholding a position between social constructionism and the potentially extremely subjective position of poststructuralism. These and all other ways of understanding the world have implications for what sort of research is valuable and how it can be undertaken. In this research this involves a reliance on Foucauldian poststructuralist genealogy as a theoretical perspective from which local and under-documented forms of history are read as discursively imbued text. My work draws on a particular methodology of feminist discourse analysis as advocated by Chris Weedon. Most specifically this includes an account of valid research methods, namely semi-structured interviews as a form of qualitative research method.

To describe how I theorise the methods used in the dissertation is no simple task. I have utilised the stepped model offered in Michael Crotty's (1998) The Foundations of Social Research as a formula to move between an epistemological level to theoretical and methodological levels and finally to the level of the methods enacted in the research project. Unlike Crotty's clear and logical style, my explanations are somewhat less ordered. As a unique and personalised dissertation rather than a general textbook, the theorising of what I have done has not been straightforward or evenly laid out. My work also draws on a variety of theoretical approaches rather than a single commitment to one coherent paradigm. I understand that such disclosure can be thought of as academically legitimate given the trend among feminist poststructuralist researchers to celebrate such eclecticism, for example Lather and Smithies (1997); Richardson (1997) and St. Pierre (1997). In order to account for the theories of methods that I have employed, I commence with an explanation of social constructionist and Foucauldian poststructuralist epistemology and how I have used each of these to support my methodological approach.
Epistemologies

I understand the term “epistemology” to concern theories of knowledge, and more particularly, the study of how certain forms of knowledge are deemed to be worthy of shared understandings. It is therefore fundamental that I account for the philosophical premises that have grounded my knowledge about the challenge an emergent discourse of comprehensive nursing education represented to the organisation of health and education sectors in the Aotearoa New Zealand context.

My understanding of epistemological foundations is premised on a conception of a broad but “fuzzy” spectrum which places a range of philosophical standpoints from objectivism to subjectivism at opposite extremes of a continuum. I visualise such a continuum as neither a horizontal nor vertical axis, but rather as an arc. Such a model avoids potential judgement by ranking or hierarchies of importance or value. The first of the two epistemological discourses that I am concerned with, social constructionism, represents the middle ground. The second, Foucauldian poststructuralism, would most likely be “located” between the central social constructionism and the nebulous point of extreme subjectivism. By employing this idea of an arc, I concur with Michael Crotty’s recommendation that any particular stances should “not ... be seen as watertight compartments” (1998: 9). To this end, I am reminded by theorists such as Burr (1995), Scheurich (1997) and Skrtic (1995a), about the fluidity of epistemological mapping.

To describe more precisely my groundings within such a arc, it is useful to explain why I have used particular viewpoints. Objectivist epistemologies uphold the essentialist and quantifiable nature of knowledge and have an untroubled acceptance of ontological and philosophical belief systems. My rejection of such a theoretical foundation is tied up with theorists (for example; Davies 1994; Lather 1991; Richardson 1997; Linda Smith, 1999; Weedon, 1997), who dismiss the fixed nature of such monolithic and modern regimes of truth. My wariness is also based on my personal frustration at objectivist epistemology’s failure to account for the power relations upon which such paradigms are themselves created and legitimised.

At the other end of the arc, subjectivism upholds a belief that ways of knowing are purely created by the people who claim that knowledge. People construct and
impose meaning on things which, without such interpretation, do not “really” exist in the world. Such an epistemology thus challenges the very idea of the existence of such social foundations as reality, truth, knowledge, science, fact, fiction and authorship (for example, Butler, 1990; Rich, 1986). I have found this standpoint uncomfortable, given my training as an educational sociologist for whom structural critique formed the foundations of my world view. Because of this, I find it difficult to surrender a belief that structural systems, for example capitalism and patriarchy, are only textural constructions.

Somewhere in between these esoteric extremes, the epistemologies of social constructionism and poststructuralism offer an elaborate and effective foundation to my research project. I offer a review of the social constructionist standpoint. This is based around the principle of inter-subjectivity, where proponents of social constructionism regard the development of knowledge as generated through the interaction of both the person who seeks to confer meaning, and the existence of the item or idea upon which meaning is conferred. This represents an adaptation from the subjectivist belief that meaning is purely imposed on an object or idea, and totally constituted through understandings of the world. At the same time, social constructionism is distinctly different from objectivist epistemology which assumes an object to hold meaning independently from and prior to the presence of the human being who imposes meaning on the object or idea.

To explain what social constructionism means is inherently complex, and I offer a review of both Crotty and Burr’s theories to explore such complexity. Pivotal to both is the understanding of discourse as the organisational system of knowledge and language. Crotty, (1998) proposes a specific definition, that is:

...the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world and developed and transmitted within an essentially social context.

(Crotty, 42: italics in original).

Crotty suggests that meaning is derived from the relationship between an objective reality and social thought, yet simultaneously, he affirms the principle that reality pre-exists language. He indicates that poststructuralism is purely subjectivist in that “meaning comes from anything but an interaction between the subject and the
object to which it is ascribed” (1998: 9, italics in original). Before I move on to the work of Vivienne Burr, there are two components to Crotty’s work that I remain hesitant about. Specifically, I regard his ability to provide a generalised definition for social constructionism and his review of poststructuralism to be oversimplified. It is even ironic, given the nature of social constructionists’ fluid and contextualised meaning, and the complexity of Foucauldian epistemology. This is an important point I will return to when I address Foucauldian poststructural epistemology later in this chapter.

Vivienne Burr offers a list of characteristics that are fundamental to social constructionism. These include “a critical stance towards taken-for-granted knowledge; historical and cultural specificity; [and an understanding that] knowledge is sustained by social processes; [and that] knowledge and social action go together” (1995, 2-5). As a result, Burr’s definition of social constructionism is quite broad and fluid, and more useful to my work than that offered by Michael Crotty. She suggests that such epistemologies encompass a broad range of views. These range from Parker’s (1992) thesis that there are some components of reality which manifest beyond the text. Specifically these are epistemological, ontological and moral/political object statuses. On the other hand Edwards et al. suggest that “nothing exists beyond the ‘text’” (Burr, 1995: 86 and 87; Edwards, Ashmore and Potter, 1995).

I believe that a middle ground theory of social constructionism presents a useful epistemological base to my enquiry into nursing educators’ experiences of CNEP. Like Crotty and Burr (through Parker), I believe meaning is derived from the relationship between object and subject. Specifically, “objective” includes material things like the reality of hospitals, polytechnics, nurses and departmental budgets, for example. The “subjective” involve the interpretations of people who have lived through the first two decades of comprehensive programmes. Without ways of explaining the world through language, and through discourse, knowledge cannot be developed or transmitted.

Social constructionists are also concerned with understanding the dissolution of dichotomies by understanding each component as only becoming meaningful in combination (Burr, 1995: 107-108). An important consequence of this is the illumination of the potential for human agency by unpacking the dichotomy of
structure and agency to find the space of potential in between (ibid, Chapter Six). The ways in which nursing educators have portrayed their involvement in the development of nursing education within the context of both health and education sectors will be considered through this theoretical perspective. Similarly, social constructionism upholds particular views about the individual and society, that both can only be understood in relation to the alternative aspect of the dichotomy. As they pertain to the field of nursing education, the concept of the individual is important to the ways participants employ particular discursive practices to explain themselves, and the ways they explain their experiences in nursing education within a particular social context.

The second epistemology that I draw on is a collection of the components of Michel Foucault’s work, which I believe offers a bridge linking what has been constituted as structural and the potential freedoms upheld by poststructuralism. In particular, the theories that I employ involve what I believe are his poststructural standpoints. This is his conception of discourse and how this allows the conception of discursive formations as well as a discussion of the dyad of power/knowledge. These reviews will then be followed by an explanation of genealogical theory as a foundation to the theoretical method I have employed.

The foundation of Michel Foucault’s work is concerned with the questioning of epistemology through the idea that existence of all knowledge and all that is understood to be real is instead subjectively constructed and ontologically fragile. Foucault’s deconstruction of history involves the ways systems of knowledge have been developed as driven by particular epistemes or organised practices of discourse. Consequently his work has been described as “transcendental philosophy” where discourse is the core unit of meaning from which objectivity and subjectivity are constituted, and by which fundamental assumptions about time and history must be questioned (Mohanty, 1993: 34). It is therefore important that I explain what I think he meant by the term discourse. But before I do this, I include the following three caveats. First, throughout his work Foucault was careful to avoid explanations of the issues central to his thesis on the basis that what could be interpreted as precise definitions would contradict the very foundations of uncertainty that he was proposing (Rose, 1994: 50). Second, his wariness about precise meanings of language, such as what he meant by discourse is also associated with Foucault’s constantly evolving analysis, a point which I
attend to in greater detail when discussing genealogy as a theoretical perspective. A third reason for caution in offering a recommended meaning for Foucauldian terms is Nicholas Rose's reminder about his lack of generalised reviews of institutions such as medicine. In Rose's opinion this reflects Foucault's reluctance to understate historical and cultural complexity and specificity (ibid: 49). At the same time, an understanding of the essential transience and constant renewal and negotiation that imbue discourses with meaning must be upheld.

Such cautions aside, I understand Foucault's use of the term discourse to refer to particular communities of language, values systems and practices that people engage with as expressed in language and other forms of texts. Through such engagement, discourses are continually reorganised, and by reading them, we can consider evocations of historical constructions of power and knowledge. Foucault described discourse as a "will to truth", or a particular and effective way of naming, viewing and/or being in the world (Foucault, 1984: 96). The complexity of what Foucault means by the notion of truth is a point I will return to later in this chapter.

In my opinion, Michel Foucault's coupling of pouvoir/savoir, commonly interpreted throughout Anglophone cultures as "power/knowledge", offers a concept that should duly be elevated to the status of epistemic philosophy. In relation to the particular topic I have chosen the inter-relationships between nursing educators and institutions, most notably the health and education sectors and the medical profession, are founded precisely around questions of power/knowledge dialectic. In other words, this dissertation seeks to unravel the ways in which the nursing educators' experiences have been constructed around manifestations of power/knowledge. The way these issues will be reviewed is by teasing apart the "... hyphen, or principle of coherence..." between the two concepts, by considering the way issues of education and the places of nursing within the health sector manifest between the dialectic of power and knowledge (Hoskin, 1990: 52). This serves to enlighten the senses of meaning in power/knowledge itself, as well as establishing the couplet as a heuristic strategy for the critical review of aspects of social life.

In the History of Sexuality, Volume One Foucault represents power as a complex, pervasive and elusive construction which forms the foundations and the challenges to the variety of dominant social discourses in any given society (1990:
Chapter Two). Foucauldian reviews of power regard both the historic and contemporary forms of theory as important. He warns against the over-simplicity of considering power in forms associated with sovereignty or particular institutions or groups of people, yet he views the hegemonic power of the sovereign leader in western states as of central historic importance. His pursuit of research to explore power advocates a reorganisation of history to understand power through “domination and subjugation” instead of the historically potent “sovereignty and obedience” (Foucault, 1980: 96). Of greater interest is Foucault’s concentration on the modern mechanisms of power, which are based around the constant and pervasive nature of societal and material surveillance, as an alternative to the embodied presence of a sovereign figure (ibid: 104). This system of disciplinary power is omnipresent: it involves a “closely linked grid of disciplinary coercions” alongside a legislative system of public rights, that combine to form the boundaries within which power is played out (ibid: 106). It is the combination of these two forms of power that Foucault identified as “the arena in which power is exercised”. Different disciplines uphold, in Foucauldian terms, specific discourses which promulgate unique “apparatuses of knowledge” (Foucault, 1980: 106). Such discourses therefore contain, limit, reiterate and develop systems of knowledge that are inherently interwoven with issues of power. Indeed, fundamental to his work in this field is his belief in the integration of power and knowledge:

We should not be content to say that power has a need for such-and-such a discovery, such-and-such a form of knowledge, but we should add that the exercise of power itself creates and causes to emerge new objects of knowledge and accumulates new bodies of information. One can understand nothing about economic science if one does not know how power and economic power are exercised in everyday life. The exercise of power perpetually creates knowledge and conversely, knowledge constantly induces effects of power.

(1980: 51-52)

Power is the polymorphic “substrate” upon which relations of dominance and powerlessness are played out (Foucault, 1990: 93). Given that my understanding of discourse involves the linguistic enactment of constantly shifting, unstable and culturally potent “force relations”, discourse can be understood to re/present power through forms of knowledge (ibid: 92). Therefore, the analysis of discourse can be understood as a topographical reading to explore the changing contour lines
of organisations of knowledge to reveal the constantly changing landscape of power. Power is constantly shifting and developing: it occurs at the level of global politics, between world leaders, for instance, and in person-to-person interaction such as my meetings with women involved in the development of CNEP.

Power/knowledge also represents a particular point of connection between social constructionism and Foucauldian poststructuralism, whereby the power/knowledge couplet represents the most important dichotomy to review in discourse analysis. In specific terms, the power/knowledge dyad also illuminates the ways education-as-epistemology has shaped social constructions such as the organisation of nursing education (Foucault: 1980: 51). For example, in forthcoming chapters I will discuss the complex subjectivity around the participants' construction of themselves as nurse educators from particular comments offered by the participants. This involves a reflection of the duality of the participants' subjectivity as nursing educators. The implications this has had for the constructions of nursing knowledge, and power in relation to nursing and nursing education are implicitly bound up with discourses concerning professionalism, vocationalism, and the discursive formation of social democracy and neoliberalism as contextual variables. Such constructions are necessarily reviewed in terms of a “history of the will to power”, that is, through the ways CNEP have challenged discourses around nursing and nursing education within the context of Aotearoa New Zealand (Foucault, 1984: 89).

A third epistemological approach is also relevant to this project. Feminist interpretations of poststructuralist theory are necessarily focused on systems of understanding which have much to offer those interested in women's studies. Feminist poststructuralists have explored Sausaure’s work for ways to give prominence to questions of gender. By breaking down the binary systems of gendered opposites, feminism provides new ways language can question and reveal changing ways of understanding the world (Davies, 1994: 8-10). In the context of this dissertation, feminist poststructural interpretations of the ways language has worked to influence understandings of components of language as signs in nursing and nursing education are explored in Chapters Six to Nine.
Poststructuralist feminism, founded by French women philosophers such as Cixous (1994), Irigaray (1985) and Kristeva (1986), has proposed that systems of such binary opposition are grounded in psychoanalytic thought. These systems can be understood as presenting an alternative way of considering psychoanalysis from the work of Freud and Lacan, who had based the existence or absence of phalluses as grounding individual constructions of identity (Weedon, 1997: 51-53). This literal and figurative order of phallocentrism provides the foundation upon which binary systems are established. The very essence of poststructuralism is to move beyond these opposites and look for the meanings that have been and continue to be created in the “in-between” of traditional binarised epistemologies. It is within this “in-between” that feminist poststructuralists believe there is potential for new ways of understanding and enacting gendered subjectivities (Davies, 1994: 5).

Feminist researchers who identify the usefulness of poststructuralism, and who seek answers to problems which are grounded in gender inequalities, have engaged with aspects of Foucauldian theorising for new systems of analysis. Of relevance to my work is the ways in which concepts of discourse are extended beyond a masculine construct, to place gender at the forefront of any such analysis. To elucidate this point, it is helpful to review Bronwyn Davies’ explanation of Chris Weedon’s feminist poststructural definition of discourse. In comparing it to a definition of discourse offered by a male poststructuralist, Gunther Kress, Davies suggests that Weedon’s definition:

... is much more focused on those aspects of discourse that take their effect in the lives of actual persons, and so brings the body, emotions and the unconscious mind into the definition of what discourse constitutes. Weedons writes as a feminist poststructuralist. She thus writes from the position of one who has heightened her awareness of gender, of her own genderedness and her experience of being female in a world where masculinity and power are closely linked. Power and powerlessness are central to Weedon’s definition as is her experience of being constituted through the words of others. Whereas for Kress the institution is the predominant organising concept in analysing discourse, for Weedon it is an occasional element mentioned at the end of her definition.

(Davies, 1994: 17-18; italics in original).

I identify with all that Bronwyn Davies is describing about the qualities implicit in feminist poststructuralism. However, there is an important distinction to be made
with regard to my approach to this study. In the field of nursing education, I believe that it is important to consider the institutional contexts that organise discourse at the same time as giving critical regard to gendered formations of power. Indeed, while I am drawn to prioritise feminist analysis, it can best be considered in relation to the institutional dimensions of discourse. It is my contention that only through upholding an awareness of the structural discourses that constrain women, and through a sense of the potential viability of personal agency, that we can promote feminist theorising and feminist methods. Without such rigorous aspirations, discourse analysis could be dismissed as mere "...language games" (Fraser, 1997, 153). Furthermore, without such rigorous forms of analysis, any potential vision for a future of feminist scholarship remains opaque (Fraser, 1997).

**Theoretical perspectives**

The second layer to the theoretical foundations of my thesis is attended to in the following section. I begin by examining Foucault's genealogy as a theoretical foundation to my research methods. This approach allows me to analyse the discourses surrounding the development of CNEP and the question of the constantly changing power play within this discursive field. I need to justify the research methods I employed that account for my reliance on interviews and analysing people's speech as a valid research technique. By valuing the primacy of language, both social constructionists and poststructuralists ground their research in the very words that people speak and/or write, and the meanings that can be derived from forms of language. At the same time, there is much to be understood about the ways people construct themselves through language (Weedon, 1997: 20). Each of these three concepts - that is, language, meaning and subjectivity - will be explored in turn, to review the ways I have understood poststructuralist discourse analysis in my research.

Foucauldian theory emancipates history from the rigidity and inflexibility of the past by proposing a concept of genealogy. By the term genealogy, he explained:

> Let us give the term "genealogy" to the union of erudite knowledges and local memories which allows us to establish a historical knowledge of struggles and to make use of this knowledge tactically today.

(Foucault, 1980: 83)
In reviewing the important terms in this definition I interpret “erudite” to mean not commonly held understandings of knowledge and the consideration of ideas not held in dominant social discourse. By “knowledges ... and local memories” I understand the informal, unrecognised constructions of knowing that are similarly not represented in authoritative cultural paradigms. Not only is Foucault suggesting that genealogy will assist people to know these things, but that the discipline of such a method is useful for understanding the history of power relations involved in shaping these constructs.

He acknowledges a debt owed to the German philosopher, Nietzsche, in the development of this concept; the central characteristic of both philosophers’ regard for genealogical forms of history is a recognition of the social and political agendas that shape the ways history is understood to have occurred. As such, genealogy represents a development and extension from his early work that he entitled “archaeology”. This earlier term referred to a value free, objective narrative that is claimed to represent the organisation of the past by the rigid analysis of discourse (Dreyfus and Rabinow, 1982: 104). It is important to acknowledge the role of archaeology to the potential of genealogy, given that the latter both emerged from and continues to be grounded in archaeological theory (ibid, 105). Chapter Two outlined a group of specific discursive formations that I understand to underpin the context in which nursing education has developed in Aotearoa New Zealand. “Discursive formations” is a term which is purely archaeological, yet it is on the basis of these formations that I am able to present a genealogical approach to a discourse analysis of comprehensive nursing education.

Much has been written about the way Foucault utilises genealogy, (for example, McGowen, 1994; Rose, 1994) and social commentators have offered analyses of disciplines and social groups through a genealogical method, for example, Colebrook (1997); Marshall (1990); Reekie (1997). At a superficial level I believe that my thesis could be understood as a genealogy of the experiences of comprehensive nursing educators. This is because my dissertation accounts for the history of the “will to power” of the women who were involved in establishing and developing comprehensive nursing education programmes (Foucault: 1984: 89). At the same time, the text is imbued with a study of the power play between
discourses that shape and challenge constructions of nursing preparation as an historical project.

Genealogy is useful to my study of the development of comprehensive nursing and the experiences of nursing educators as it draws on the concepts of herkunft (descent) and enstehung (emergence) (Marshall, 1990: 18). To examine what is meant by each of these terms, genealogy as herkunft refers to descent, which involves the consideration of:

... passing events in their proper dispersion; it is to identify the accidents, the minute deviations - or conversely, the complete reversals - the errors, the false appraisals, and the faulty calculations that gave birth to those things that continue to exist and have value for us; it is to discover that truth or being does not lie at the root of what we know and what we are, but in the exteriority of accidents.

(Foucault, 1984: 81)

By understanding that chaos is intrinsic to historical constructions, the diversity between viewpoints in recollections offered by the women who spoke with me about their experiences in CNEP enlighten my understanding about the field of nursing education.

Genealogy as emergence refers to historical changes as the consequence or result of power struggles between opposing discursive forms (Marshall, 1990: 18). In looking beyond the logic of chronology and cause and effect understandings of history, enstehung considers the “entry of forces” and the “non-place” where confrontation between systems of power struggle for authority (Foucault, 1984, 84-85). This serves as a reminder that the field of nursing education has been shaped by a variety of competing discourses that have been employed to develop and/or maintain the state health sector in Aotearoa New Zealand. My role in this research is to tease out the ways nursing educators have embraced particular discursive strategies and resisted others through their roles as senior comprehensive programme teaching staff.

Genealogy is employed by Foucault to refer to the study of historically subverted, repressed and under represented forms of knowledge. In his reference to such subjugated knowledge, Foucault describes two specific issues. One of these involves the awareness of erudite knowledge that has buried or concealed aspects
of history within "functionalist or systematising theory" (Foucault, 1980: 82-83). The other involves the dismissal of knowledge held by local or undervalued groups in society, for example indigenous or radical knowledge which holds potential to subvert traditional hegemonic forms of social order (ibid: 83). In the case of this latter genealogical type, Foucault identifies genealogy as concerning the re-emergence of "... low ranking knowledges, these unqualified, even directly disqualified knowledges such as that of the psychiatric patient, of the ill person, of the nurse, the doctor - parallel and marginal as they are to the knowledge of medicine - that of the delinquent" (ibid). Here I understand that Foucault is emphasising that knowledge held by groups of people is marginalised in relation to dominant discourses that pervade social life, such as those concerning the scientific legitimacy of medicine and the rationality of sanity, for example.

Nursing has been traditionally constructed around forms of work and knowledge that complement and respond to medicalised discourses of health and illness. This focuses nursing on feminine models of innate caring, paternalism, and the work that nurses enact to assist medical staff. This is explained succinctly by Kate,

*I think [early comprehensive graduates] were enormously under-utilised. It depended on the environment they found themselves in, [but] I would have to say that most of it was the obedience, subservience model of working in a medical model in a hospital.*

(Kate, 1253- )

Parallel constructions depict people seeking care through the health service as sick, devoid of agency and individuality and irrelevant to the decision-making process regarding possible treatments. This sense of patient powerlessness simultaneously yields nurses limited but significant levels of power, through their authority over patients, while continuing to orient nursing towards work in a secondary care, illness-focused ontologies of work. In the field of education, a reliance on traditional "banking model" pedagogy acts as a system of institutional control. This undervalues the potential for teachers or their students to have their own knowledge claims heard. Teachers are understood to hold power over their students, yet such authority is oppressive to the teaching staff themselves.

The purpose of genealogy is to give voice to these less valued ways of understanding the world, by placing under critical examination dominant and
authoritative forms of discourse that uphold scientific, rational and hegemonic forms of knowledge. Genealogy is thus concerned with the "historical knowledge of struggles" (Foucault, 1980: 83, italics in original) and is an important form of study to be employed by researchers who are interested in exploring under-valued forms of history. As a result of all this, I understand my research to be a text which works towards a genealogy of women who were nursing educators in the CNEP in the early years of the developing programmes. Their stories have remained unheard for two particular and interrelated reasons, both of which concern gender politics. Firstly, the stories of nurses as an example of women’s history have, until recently, been subsumed within patriarchal medical histories of the health sector. Secondly, the still-pervasive secondary care and hospital-based discourse of nursing continue to construct CNEP as new and arguably less legitimate forms of preparation for registered nursing practice.

In combination, genealogy constitutes a theory and method of (re) constituting history by considering the primacy of questions of power and knowledge. What makes Foucault’s work even more intriguing is not only how he “does” such history, but the subjects he uses as vehicles for such deconstruction, namely by theorising such phenomena as the “body” and “sexuality” and “subjectivities” (for example Butler, 1990; Richardson, 1997). All of these are intrinsic to an exploration of the field of comprehensive nursing education. Genealogy thus offers a way for me to explore the “...complex, contingent and fragile ground” of the development of comprehensive programmes through a discourse analysis of interviews with nursing educators and of primary and secondary texts which document aspects of the transfer process (Marshall, 1990: 19). Such analysis aside, I believe my work does not fully constitute a genealogical project because there are important facets of the comprehensive nursing project which are not reviewed in this particular work. For a genealogical analysis of power/knowledge, constructions of the politics of curricular and assessment management of CNEP would necessarily be reviewed, as would a more explicit attention to the relationships of power and powerlessness between nursing educators and their students.

Having dealt with genealogical theory, I return to my earlier point that alongside meaning and subjectivity, a review of language theory is a cornerstone to understanding my research processes. The study of language which is grounded in
Ferdinand de Saussure’s theorising of structuralism, includes the social, cultural and political construction of “signs”. This linguistic system identified that there are randomly assigned relationships between “signifiers” and “signified” which are the building blocks of language systems. This refers to signifiers as the noises and written markings that create a unit of meaning when they are associated with a particular thing, form or symbol. “Signifieds” include more than concrete empirical objects and can equally imply an action, a value, ideal, or a social system, while “signifiers” exist only at the level of abstractions (Burr, 1995: 36-37; Crotty, 1998: 197-198; Davies, 1994: 5).

To illustrate this point, the signifier “nurse” has been randomly assigned to mean a particular range of qualities - including skills, knowledge and values - that involve the ability to care for people in certain ways. One of the issues that develops as I move through the thesis is that participants’ promotion of CNEP offered a different model of nursing identity to that which has dominated the Aotearoa New Zealand health sector for the past century. One particular example of this is offered in Chapter One in Beth’s opening statement, where she reflects on the overused assignment of the term “nurse” from the time students moved into the Nurses’ Home to commence their training. This issue is closely examined by Elaine Papps in her 1997 doctoral dissertation, which includes an examination of the legislation which confers the legal right to use the term nurse to only those who have completed a recognised training programme as registered or enrolled nurse (Papps, 1997: 6). Drawing on Foucauldian theory, her thesis identifies the comprehensive programmes as disrupting traditional nursing identity by educating nurses away from medical-oriented nursing knowledge and towards a new model of nursing identity (Papps, 1997: 267-268). This idea, that CNEP represent a particular discursive strategy to reconstitute the “nurse” identity, remains an important theme throughout my research.

Saussure’s belief that these systems are self-referent means that systems of signing are only and always constructed in socially constituted systems of meaning. It also means that they are transient and culturally and politically asserted. This involves a questioning of the structural understandings of binary constructions as a foundation to language. Of central interest to my work are the ways that such formations of language reflect systems of power (specifically Foucault’s power/knowledge dyad) and gendered power, as it is revealed through the ways
comprehensive nursing educators draw on and negotiate particular new forms of discourse.

The second facet of poststructural foundations is a regard for meaning, which is constructed from social action and interaction. Poststructuralists uphold the view that there can be no fixed or shared sense of meaning. On the contrary, meaning is randomly assigned to the systems of signs, and through the uses of language, people construct senses of meaning which are fleeting, transforming, and individualistic. Meanings are also constructed through the discourses that are available to people, as well as through the sense of subjectivities and degrees of authority they hold. Jacques Derrida’s extension of Saussure’s thesis is important for his suggestion that the construction of language systems and meaning stems from the referential signifier/signified system: what a dog is, is other than cat, cow or fish, for example (Burr, 1995: 106). The uniqueness of any single couplet of text meanings is that it can be read for understanding of what it is and by what it is not. This further builds on the notion of meanings having been constructed through binary oppositions that concern issues of power and powerlessness. The usefulness of Derrida’s system of deconstruction lies in this extension beyond binarised forms of knowledge, and the potential for understanding people’s agency in poststructural analysis.

The importance of subjectivities is a third integral component of poststructuralist theory. As I explain the concept here, I seek to complement the review I have previously given concerning non-unified subjectivity. People adopt and have conferred upon them subjectivities (by which I mean socially assigned identities or roles) which are always multiple, transient, and potentially contradictory. The origins of poststructuralism lie in structuralism (including Marxist, radical feminist and other critical theories) that questioned whether people’s identities were imposed, enforced, and or prescribed by overarching socio-political discourses and paradigms. Extending from this, poststructuralist views uphold the potential for people to negotiate, construct, and shift between subjective forms of identity. The potential to change is confined and emancipated by processes of social interaction in any given context. Feminist poststructuralism explores how discourse functions to limit and facilitate constructions of gendered subjectivity for women such as those in my study (Alvesson and Sköldberg, 2000: 165-167).
Methodology: Discourse analysis

Esoteric theorisations aside, I am left with the central principle that language plays a primal role in constructing social life. Both social constructionism and Foucauldian poststructuralist theory conceive of discourse as the conceptual framework from which meaning and knowledge is built, and agree that the creation of discourses occurs through and from language. With these values in mind, in the previous chapter I proposed that discourse could usefully be understood as systems of language and knowledge that emerge from people’s engagement and interaction in social contexts. I also suggested that the ways discourses are constituted reflect people’s subjectivities and most often centre on important societal power relations. The symbolic coupling of power/knowledge thus forms a fundamental “signifier” of poststructuralist theory. Discourses are thus understood as the manifestations of these broad systems of power/knowledge, and it follows that as a theory of poststructuralist research method, the analysis of discourse is a fruitful field of study.

The next point in this exploration of the methodology that I employ concerns the ways in which I have regarded discourse analysis as a technique through which my data can be understood. Social theorists disagree on the intent or purpose of various forms of discourse analysis as research methods, only one of which is employed in this research project. This choice will be discussed before I review the specific style of feminist discourse analysis employed. A review of why there are no precise formulas for discourse analysis will be explored subsequently. A final aspect of Chapter Four shifts focus to the theory behind my decision to employ interviews and document analysis as the qualitative research strategies in this work.

Of the breadth of sociological research that draws on discourse analysis, there are an array of ways to understand what it means to “do” discourse analysis: specifically these are concerned with how and why discourse analysis is done. These choices concern questions about the purpose of discourse analysis, the ways such methods regard social entities and relations, and how discourses position people differently (Fairclough, 1992: 3-4). For poststructuralist discourse analysts, the questions of autonomy and power are of particular importance, through a theory which understands people as social agents who are not only
constituted through discourse, but who are also enabled and constrained through the subject positions available to them (Davies and Harré, 1990).

There is coherence between discourse analysis and the epistemology of social constructionism, which understands language as a performative form of social action (Burr, 1995: 5). Vivienne Burr (1995) describes analytic reviews of discourse in alternate ways, including a discussion of Potter, et al. (1990) distinguishing between the “analysis of discourse” and “discourse analysis” (Burr, 164; Potter, et al, 1990). She describes the systems used in the former method, based around Derridian deconstruction of seemingly homogenous texts for contradictions, while the latter examines texts for discursive constructions which underpin the relationships between the individual and the social context in which the person lives (165-167). It is this second form of discourse analysis that I am more interested in, given its connection to Foucauldian genealogy and the influence of the past on the present.

Foucault’s work was fundamentally concerned with the analysis of discourse. His genealogical approach examines the ways discursive practices are organised and looks for patterns amid the systems of power relations that oversee these discourses (Foss, Foss and Trapp, 1985: 201). He explains this in *The History of Sexuality, Volume One*, when he wrote “my main concern will be to locate the forms of power, the channels it takes and the discourses it permeates” (1990: 11; also cited in Foss, Foss and Trapp, 1985: 202). Throughout his genealogical work, Foucault was mindful to look beyond the analysis of particular historical discourses and discursive practices, for the ways historical systems of power have left legacies on the present through contemporary discourse. This quality of the genealogical project allowed Foucault to describe his work as “writing a history of the present” rather than a “…history of the past in terms of the present” (Foucault, 1977: 31; also Foss, Foss and Trapp, 1985: 203).

The legacies of the past on the present raise two final important components of Foucault’s contribution to my work. His opening statement to the essay *Neitzsche, Genealogy, History* (1980: 76) describes genealogy as:

...gray, meticulous, and patiently documentary. It operates in a field of entangled parchments, on documents that have been scratched over and recopied many times.
His description of parchment is especially important to my research methodology. As an understanding of historical knowledge that involves particular meanings that already exist, I have constructed my sense of the development of comprehensive nursing education in these terms. In this regard, my participants’ engagement with a particular group of discourses, namely the six discourses which are analysed in Chapters Six to Nine represent new ways of understanding how nursing education, and registered nursing practice could be. But my thesis proposes that these discourses are not original, and that in fact they are imbued with traditional forms of nursing knowledge and subjectivity. It is therefore a blending of old and new that constructs comprehensive nursing, and what is original about CNEP is the combination of discourses.

This strategic blending represented a common response of senior nursing educators to account for the transfer and development of comprehensive programmes from the hospital-based apprenticeship model of nursing training. At the same time as the women deployed these discourses to effect what they understood was positive change, the discourses simultaneously provided the nursing educators with particular subject positions. In effect the participants can be understood to embody the very discourses they upheld as vital characteristics of this new form of nursing preparation. Here too, nursing educators’ narratives can be read for tracings of the past: while they personally embrace rhetoric of, for instance, the values of New Nursing, such valuing is written upon the values and skills they acquired in the hospital-based training context. Aside from this Foucauldian imagery of documents Bronwyn Davies’ reflection of the contradictory location of self between different discourses, employs the same metaphor. While she explains the only partial erasing of writing on parchment as a palimpsest metaphor, her meaning is close to Foucault’s (Davies, 2000: 138). She makes the point that the indentations and markings of the not-completely-erased writing has consequences for the composition of the new. In these ways, I understand the discourses that this group of nursing educators engage with are imbued with the legacy of the past organisation of apprenticeship model nursing training.

A final issue to be reviewed is Foucault’s deployment of truth. This is equally significant to my thesis in that the discourses that the women have constituted as
integral to the development of CNEP are based on their understanding that each is true to the nursing education project. Foucault’s account of truth includes the following.

... truth isn’t outside power, or lacking in power... It is a thing of this world, it is produced only by multiple forms of constraint. ... Each society has its regime of truth, its “general politics” of truth; that is, the types of discourse which it accepts and makes function as true...

(Foucault, 1980: 131)

Quite simply, the participants in my study worked to uphold, and at the same time, embodied particular discourses which have been socially constructed as true to the realities of nursing identity and nursing work. In other words, their narratives were grounded in a range of discourses that iterate nursing to be about caring for people whose health status might become, is currently or has been compromised. Here again, the strategic deployment of the particular group of discourses was necessary to appeal to the vested interest groups who were wary of the newly formed comprehensive programmes. But they were not only aspects of a legitimization strategy for outsiders. At the same time the nursing educators themselves have retained an engagement with the truth value of these discourses to sustain their own challenging and pioneering work within the field of comprehensive nursing.

**Feminist interpretations of discourse analysis**

As I have already proposed in Chapter Three, feminist poststructuralists are centrally interested in the “identific(ation) of the social discourses available to women and men in any given culture at a given time” (Gavey, 1989: 466). Specifically, feminist researchers seek to gain insight into the discourses which provide gendered subject positions that people adopt and modify over time, and the ways in which this relates to how people constitute their own subjectivity. Discourse analysts with a concern for feminist issues also seek to understand how collective groups negotiate change within a social context where they might understand themselves to be powerless, while others are constructed as powerful, through for instance, institutional systems of gendered hegemony. Finally, feminist poststructural discourse analysis is focused towards emancipatory change, where analysis of discourses might signal strategies through which groups of
women may challenge existing power relations (Fraser, 1997: 152; Weedon, 1997: 40; also Hollway, 1984 and Walkerdine, 1986).

In terms of how such discourse analysis is enacted, feminist poststructuralists read texts for reference to gender binaries that have privileged male from female, and that have been historically employed to inform the foundations of various dominant social discourses. By troubling the very constructions of the two genders — male and female — feminist poststructuralists have advocated a particular form of discourse analysis that explores the fractured and unstable qualities of language (Alvesson and Sköldberg, 2000: 213-214)

The researchers who advocate the merits of engaging in discourse analysis are keen to remind novices to the field that there is no formula or “recipe” for such specific research methods (Burr, 1995: 163; also Gavey, 1989, 467; Potter and Wetherall, 1994). This fluidity represents the rejection of positivism that accompanies “scientific” methods utilised by quantitative researchers as well as grounded theorists in the qualitative disciplines (for example, Glaser and Strauss, 1967). In keeping with social constructionist approaches to research, and more precisely a feminist poststructural theoretical base, my approach to discourse analysis seeks to identify and deconstruct the discursive practices which have shaped the development of nursing education and imbued the nursing educators with particular subjectivities. This is drawn out through a codified review of interview transcriptions and a careful critical reading of primary and secondary document texts that I have gathered which concern the development of nursing education.

**Qualitative methods**

Qualitative forms of research are centrally interested in describing and considering the ways that social events are understood by people. Meaning is the particular focus, as it is made in relation to action and interaction; as sense-making interpretations of the past, as it reflects organised systems of language and reveals patterns of power and knowledge that are the core characteristics of qualitative research.
Just as my own identity is an amalgam between a comprehensive registered nurse and an educational sociologist, so too does the research topic that I chose to explore in my dissertation deal with these two fields of inquiry. As a student who studied what Jane Kelsey (1995) has called The New Zealand Experiment, regarding the neoliberalisation of the once welfare state, I was attracted to researching the complexities of how the uniqueness of nursing education had manifested within such a challenging cultural-political environment. My familiarity with literature that chronicles the history of the development of CNEP did not answer my questions about this. At the same time, I wanted to understand more about the contradictions between my experiences as a potential nursing education candidate and a newly registered comprehensive graduate that is described in Chapter One. My research grew out of these sorts of questions. In particular, my decision to focus on the experiences of nursing educators came from the personal and the political: I had fond memories of the dynamic group of women who had been my nursing educators. At the same time, I felt disappointed that perhaps they had not prepared me adequately for the difficult realities of my employment as a registered nurse. I was also aware of their difference from the majority of teaching staff at the polytechnic, given the shift from technical to professional programmes. I wanted to gain an understanding of how the participants had made sense of their work experiences. More specifically, as a women-dominated sector, how have gender politics impacted on their work? These sorts of questions shaped the theoretical foundations for my dissertation.

In articulating such questions, I was inevitably drawn to engage in qualitative research, in particular the strategy of interviewing because this offered me the opportunity to ask nursing educators about their experiences as staff in CNEP. Here again the choice of talking and listening as qualitative methods were common-sense strategies which reflected my background and interests. A cornerstone of nursing work is effective communication (for example Christensen 1990), so valuing "talk" came easily to me, and I felt I was a relatively effective communicator. At the same time, as a student of critical and feminist theory, I have a belief in the validity of qualitative methods as an alternative to the legitimacy traditionally bestowed upon quantitative research methods. The literature I found most valuable in the field of nursing education and sociology employed similar theories and methods, namely qualitative methods and feminist
poststructural paradigms. Such familiarity made the choice of my method and the theories behind them straightforward and logical decisions.

A final comment to this section is prompted by my reflections on the consequences of meeting and interviewing the group of nursing educators. The opportunity to meet with the participants had given me a chance to reflect on my own learning experiences as a comprehensive student and as a newly registered nurse. By listening to the women’s narratives, I was able to recognise that the problems I experienced were not simply about my personal inadequacy in practice. In the introductions to the participants it is clear that the majority had faced similar stress and anxiety in their own clinical nursing careers. I believe it is also clear that nursing educators were not responsible for the unpleasant experiences I had at Tokanui Hospital. As will be uncovered in Chapter Eight where I discuss the notion of the “ideal” type, many educators were aware that groups of graduates like me had been expected as staff to “fit in” within institutional settings for which they had not been prepared. So while it is true that talking with the women helped me reconcile my own experiences, their answers posed me new questions concerning the contradictions these women encountered between their goals and the realities of their work as comprehensive nursing educators.

Discussion

This chapter has examined a diverse range of issues that underpin the theory of my research methodology. I have sought to explain the underlying theories and methodological principles that have formed the backdrop to my research topic. The work of the particular theorists which I have drawn on (Burr, Crotty and Foucault) makes sense to me, and is useful to my analysis of how nursing educators have experienced comprehensive nursing programmes. Yet in order to be able to understand the changes in nursing education since the early 1970s, I need to embrace an epistemological standpoint which complements a form of discourse analysis and which takes heed of structural change as well as individual agency. This occurs through the processes of standing back from the discourses which explain these happenings (Burr, 1995: 153-4). Failure to attend to this would remove from the participants any sense of authority over their roles in the field of nursing education. But such a consideration of authority does not cease with the participants in this study. Rather, I propose that an extreme structural
standpoint negates any potency by which I as researcher can claim to understand what might have been happening in nursing education between 1973 and 1992. As such, this social constructionist standpoint is a pragmatic response to my desire to claim authority over this topic as well as the obligations of a doctoral dissertation to claim new knowledge from an original piece of research. At the same time, it is only through Foucauldian constructions of discourse, power/knowledge and a valuing of genealogy that I have been able to produce this historical project. Theoretical considerations aside, the mechanics of my research method are explained in the following chapter.
Chapter Five: Describing the Research Methods

This chapter describes the processes I have employed to complete my thesis. As such, it is the final component of the group of methodological chapters that broadly concern the epistemological and method-related approaches to my work. This group of five chapters is presented as a precursor to the next five chapters in which I attend to the substantive material that has emerged from my conversations with nursing educators.

This chapter is composed of six sections beginning with a description of the sources of data collection. Here I concentrate on the face-to-face meetings with the participants. I also explain the alternative sources I have used, namely archived tape-recorded interviews and the primary and secondary source documents pertaining to the field of nursing education. I move on to examine the ethical issues which have confronted my work. The third section is devoted to the processes used in the method. These are based around the interview procedures dealing with the development of questions and resources, interview style, rapport and relationships with my participants, and the methods I have used to make sense of the non-interview data. The fourth and fifth sections describe the system of data analysis I have utilised, and review the writing up processes I employed. The concluding section presents a range of particular reflections that I believe have been significant to my project.

Sources of Data

Participants

The fifteen participants in my research are women who were senior nursing educators in comprehensive nursing education programmes. I chose participants on the basis of their experience in comprehensive nursing education, and aimed to
meet people from a range of large to small residential locations where nursing programmes have been established throughout Aotearoa New Zealand. They have all had senior roles in comprehensive nursing during the earliest years of their programme’s development. Because of the gradual transfer process where CNEP were established on a fairly regular basis over fourteen years between 1973 and 1986, I was able to talk with nurse educators involved in earlier and later founded programmes. In these ways I hoped to develop a clear understanding of nursing educators’ experiences across a broad range of education and health contexts.

Aside from these shared characteristics, they remain a diverse group. Their ages, living arrangements and residential locations all vary. Some remain involved in nursing education while others have moved from the field. To disclose more than this level of description would risk identifying particular women. This is the nature of an historical study in such a small and exclusive field. As an alternative strategy to foster a sense of the particular participants’ individuality, I have sought to introduce the women throughout the thesis, by including some comments and reflections about our meetings in the Introduction and intermittently through these methodological chapters.

My contacts with the women were initiated by a number of means. I had met a few participants in a nursing or education related capacity, and I knew of others from their prominence in the nursing sector. I knew other names from reading papers, articles or other texts written by them. Most often, people involved in nursing education, or potential participants would volunteer names of women they thought I should approach, sometimes also spontaneously offering suggestions for how I might contact these people. The same names kept being repeated. This represented a modified “snowballing” process, in that I began with a few contacts, and over time built them up with prospective participants, through the recommendations of people involved in the field (Bogdan and Biklen, 1992: 70).

Similar processes of gradual development based on sound theoretical recommendations combined with pragmatism, have guided decisions concerning the size of the participant group and the extent of my dialogue with them. I embarked on my qualitative research with an unclear vision of how many women I
hoped to talk with. My list of possible participants developed over time. The final decision to interview fifteen women reflected both my list of preferred participants and the emergence of particular discourses through the initial data analysis. By the final interviews I felt I had sufficient data to present an effective dissertation. Soon after I embarked on my first interviews I realised that my initial intention to meet with the participants for “one or perhaps two approximately 90 minute interviews” was not really necessary (See Appendix One). The richness of each of the women’s narratives combined with transcripts of a group of the NERF Oral History audiotapes gave me vast amounts of text to work with.

The “snowballing” strategy had costs as well as benefits (Taylor and Bogdan, 1998: 92-94). For example, the strategy challenged my commitment to confidentiality: a participant would ask if I had interviewed certain people yet, and/or whether I was going to. I felt comfortable explaining that I could not say who the other participants were and their acceptance made me feel assured that the women understood this response. This represents an important issue which needs to be explained in greater depth. While I discuss general confidentiality and anonymity issues in the ethics section of this chapter below, it is necessary to clarify the reasons why I decided to place limitations on how I have portrayed these women. The discursive practices that unite and offer contradictions between the participants emerge in part from my commitment to confidentiality that allowed them to speak freely and frankly about their experiences as nursing educators. The “costs” associated with such a technique mean that I forsook potentially interesting nuances between the women’s experiences – for example whether women based in smaller urban locations experienced the health and education sectors in different ways from their metropolitan-based peers.

Oral histories and other sources of data

The Nursing Education Research Foundation is a charitable trust administered through the New Zealand Nurses’ Organisation which offers financial support to nurses involved in extending nursing-related research on a national level. Between 1993 and 1996, thirty-eight interviews were completed with people involved in the transfer of nursing education from hospital-based programmes to
polytechnic-based courses. Grouped around specific sites where programmes were established, several people were interviewed from each region. This usually comprised one or two senior nurses from the local hospital, a number of senior administrators based in the polytechnics who hosted the new courses, and most importantly for my research, an extensive range of nursing educators who worked to establish comprehensive programmes in the education sites. When these archives were moved from the NZNO library to the Alexander Turnbull Library in late May 1997, they were accessible for the first time to researchers who had gained consent from the Board of Trustees of the Foundation (NERF Oral History Cassettes).

My research has also drawn on documents that represent official narratives of the development and settlement of comprehensive nursing programmes. This includes a variety of official documents such as the Departments (later Ministries) of Health and Education’s written reviews of the programmes and brochures promoting the comprehensive courses to potential students. I also drew on sociological and political commentaries on the developments in these sectors by academic researchers, the nursing and nursing education professions and the education and health sector that I have discussed in previous chapters.

A second oral history project that I used as data involved accessing a series of Association of Polytechnics New Zealand (hereafter APNZ) Oral History Project: Polytechnics in New Zealand audio-recordings. This was a series of interviews between 1988 and 1990 with “...a range of people who [offered] a personal history of the changes that have affected polytechnics in New Zealand since their inception (i.e. the human interest side of polytechnic history)...” (Evans, 2001, pers. comm.).

**Ethical considerations**

Compliance with ethical guidelines which govern social science research at the University of Canterbury has been an important consideration to my thesis research. The formation of a Human Ethics’ Committee (hereafter HEC) at the
University of Canterbury coincided with my enrolment as a Ph.D. candidate. I duly completed the forms necessary to gain ethics approval, and was granted permission to proceed with my work. The committee’s approval formally sanctioned my research methods - allowing me to approach possible participants and accept a Nursing Education Research Foundation scholarship that assisted with my travel costs.

One of the key components of conforming to ethical standards is precisely the ritual of conformity. While institutions which oversee ethics are governed by “principles and values includ(ing) justice, safety, truthfulness, confidentiality and respect”, I believe the ritual of such conformity also works in other ways (University of Canterbury Human Ethics’ website). I believe that for research such as mine, approval from the HEC at the University of Canterbury serves to legitimate the calibre of my project because I was able to indicate this sanctioning on the consent sheets I ask participants to sign (See Appendix One). This approval added credence to my research and my legitimacy as a researcher. It also leaves me to ponder the subtle ways this may have influenced people’s decisions to consent to participate in the project.

On a broader level, the presence of ethics committees are vital features of health and educational institutions. In the Aotearoa New Zealand context this has been strongly influenced by two issues. Firstly, since the neoliberal reformation of such sectors, accreditation of HECs is an important consideration for institutions that might otherwise be liable for accident compensation (Grace, 1997: 19). More importantly, central government, professional bodies, consumer groups and the public have a heightened sense of the consequences of unethical research. This has been apparent since the Cervical Cancer Inquiry concluded that there had been medical exploitation of women’s health at National Women’s Hospital (Dixon, 1990; Snook, 1998; Tolich and Davidson, 1999: 80-87).

While I believe that such bodies are important watchdogs for public good, HECs can only oversee and encourage a climate of ethical responsibility among researchers. Since the HEC’s approval of my research proposal, the onus has been on me as a senior research student, carefully overseen by my supervisors, to
inform the Committee of subsequent changes in my research that could influence ethics. In this regard, I notified the Committee about any modifications to the questions I proposed to ask to participants, and the replacement of academic supervisors when this occurred.

One of the earlier nursing educators I approached strongly recommended that I apply to my local Regional Health Authority’s Ethics’ Committee for research approval. My initial reaction was not to pursue this, because my research involved no direct contact with staff or clients within the health sector. She suggested that in order to be credible, my research needed to be sanctioned by this second ethics committee (Grace, 1998). As I did not want to inhibit women from their possible participation in my work, I decided to seek this approval. My application to apply for permission to proceed with the interviews was granted by the Southern Regional Health Authority Ethics’ Committee in early May 1998. Two final sources of ethical obligation involve my membership of the New Zealand Association for Research into Education (hereafter NZARE), and my continued comprehensive nursing registration, each of which charge me with ethically responsible practice (NZARE, 1981; Nursing Council of New Zealand, 1990).

There is an irony in the need for further ethics committees’ approval. This is because of the particular status of those I wanted to interview. I know of few professional groups with a greater sense of ethical consciousness than that of nursing educators. My face-to-face interaction with the participants was governed by their assertive and forthright regard for my work. At the same time I recognise that ethical constraints need not prevent me from potentially exploiting my participants. By misrepresenting their views, or distorting or revealing identifiable aspects of their identity, this research could be considered unethical. In my opinion it is neither ethics’ committees nor the professional organisations I belong to that have been the strongest incentive for me to act ethically in this research. Instead, it has been the women themselves, their trust and expectations of me that have guided my judgement and actions as a researcher.

This particular point draws me back to Michel Foucault and the various contributions his work offers my thesis. A Foucauldian view of the value placed
upon ethical responsibility across society, or at least in academic and service-related institutions, can be understood as a dimension of what Foucault calls the disciplinary society. This in turn is associated with “economic, juridico-political and ... scientific ... historical processes” wherein power is diffused through society from an institutional to an individual personal level (Foucault, 1977: 218). His analysis of the panopticon as institutional structures of surveillance, and his ideas about the extension to a system of self-monitoring, have implications for my resolve to act honourably in my research methods. At the same time, the very presence of ethics committees can be interpreted as a direct form of surveillance. They are at once discrete and legitimate - by protecting society from dishonourable research - and act as “sentinel” by the collection of a “dossier” of information about individuals, namely researchers (Dreyfus and Rabinow, 1982: 158-159; Paterson, 1996: 40). These forms of control operate in ways that construct me as a doctoral research student while I simultaneously employ them to account for my work to participants and others such as the University administration, NERF and my supervisors.

Anonymity, confidentiality, pseudonyms

I agree to be involved in [Debra’s] Ph.D. thesis research and understand that the information I share with her will remain anonymous, with knowledge of my real identity limited only to Debra, her academic supervisors and myself. I understand that pseudonyms will be used to disguise participants’ names and our particular places of employment. I realise that my involvement in the project will also remain confidential, that it will not be accessed by other participants, and that all research data will be securely stored.

From the “Consent Form” (see Appendix One).

One of the most important issues I faced in presenting this research concerned the need to protect my participants’ identities. Given the “small town” nature of the Aotearoa New Zealand setting and the small group of women who have been involved in the development of comprehensive programmes nationally, any promise of anonymity remains ambitious (Tolich and Davidson, 1999: 77). Its effectiveness depends on the readers’ familiarity with the development of
comprehensive nursing: the very way participants speak or the anecdotes they have shared with me, risk exposing their identity to readers who might know the individual participants. In contrast to anonymity, confidentiality (where connections between what is said and the speaker’s identity are unidentifiable) was more easily promised. This meant I assigned pseudonyms to all participants, and withheld aspects of their character that might indicate their true identity. My decision to withhold, rather than potentially altering aspects of their identity was made by my mindfulness of the power that such alterations represent. By way of examples, the substitution of women’s married identity to singlehood, from rural to urban location, or from younger to older, all imply potential value judgements that as researcher I choose not to bestow.

By way of this commitment to confidentiality I have stored the audio-tapes, computer discs, and hard copies of transcripts securely, and when in transit they were always in my possession. I have only disclosed the full participants’ identities to my supervisors who, in turn, are constrained by professional confidentiality codes as members of staff in their respective institutions. Where people are mentioned in reported sections of the transcript, I have described their identity with the role they had in relation to the participant who is speaking. For example in the public sphere, the name of a specific polytechnic principal or CEO would have been replaced with the bracketing of the term “senior polytechnic administrator”. I believe that this has been a successful strategy to convey participants’ meanings while preserving my commitment to confidentiality.

While I have worked hard to preserve the ethical commitments I made to my participants, what remains beyond my control is the freedom of participants to treat their role in the research in whatever way they chose. Whether they tell people about their roles is up to them (for example, Middleton, 1993: 74). I decided not to disclose people’s identity, in spite of the offers by some of the women to let me quote them as named sources. My decision rested on the unevenness of the presentation this would create, and the ways it would jeopardize the identities of the smaller number of women who remained anonymous.
Method processes

Interviews

The central focus of my research concerned the talk that nursing educators shared with me about their experiences in comprehensive programmes. Through an epistemology of social constructionism and the methodological strategy of discourse analysis, interviews have formed the most important aspect of my method. The complexity of the processes involved in data collection and review are thus accorded detailed attention in the following pages.

Development of questions

By early 1997 I had formulated a series of questions that I hoped would offer openings for women to share with me their reflections on what it was like to be a senior nursing educator in early CNEP. While my supervisors supported my work I took heed of their suggestion that the only way the questions’ effectiveness could be proven would be to trial an interview with a nursing educator. The idea of embarking on a mock-up interview had other benefits too, the most important being the opportunity for me to experience the “reality” of an interview setting and to practice the listening, questioning and technical skills that are integral to good interview techniques. At the same time, the usefulness of the historical timeline that I had drafted out could be gauged, as could the qualities of the information and consent sheets I had drafted.

The subsequent meeting and interview with an acquaintance who had been a comprehensive educator proved as effective a strategy as I had hoped. Her responses to my questions highlighted various ways in which I needed to clarify my questions. In addition, her experience as a qualitative researcher meant she was able to offer me useful strategies for managing future interviews with more confidence and more careful organisation than I planned.

This meeting prompted me to revamp all my paper work – making the information and consent sheet clearer, arranging the formatting of the timeline to make it more
useful, and reworking the questions into a more concise format based around three key issues. On re-reading the original question sheets four years later, I can see that including the jargon “agents of the state” and “non-state agents” was unhelpful, and that the second question concerning professionalism was overly directive towards this particular issue. These criticisms aside, their open-endedness and fairly logical sequencing were useful and proved fruitful probes for nursing educators’ talk. In the interviewer comments (hereafter abbreviated to I.C.s) written up after each interview as I was transcribing the tapes, I considered ways I could make the questions clearer. Subsequent minor changes are duly noted in the question sheets used in the groups of interviews completed in December of 1997 and April 1998 (See Appendix Three).

Not only were my I.C.s useful for reflecting on the efficacy of the questions posed, the significant amount of data analysis on early interview transcripts meant that by November 1998 I had significantly remodelled the questions posed to future participants. The new questions were more specifically targeted to the personal understandings and experiences of nurse educators about aspects of CNEP, rather than the more structural focus of the first agendas. Also, by this time my confidence had increased and I began to understand that the interviews I had been completing were more conversational than straightforward question and answer schedules. In response to this I felt it was important to formally offer the participants the opportunity to raise issues they thought were important, instead of only answering questions directed by me. As I altered my questions for this third and final time, it was also necessary for me to change the information and consent sheets, to clarify details about the people they could contact about my research. Here I am referring to the departure of my supervisor Missy Morton and her replacement by Daphne Manderson.

**Style of interviews**

I followed up the leads I had about possible participants by phone calls to the women concerned - to introduce myself, to explain my broad topic of study, and to ask if they would consider being involved in my research by accepting a mailed
out information pack. These “information packs” comprised a covering letter referring to our conversation, an information sheet explaining my field of study and a copy of the consent form to view and consider (See Appendix One). After these were sent I telephoned the woman one or two weeks later, at a time agreed during our initial phone call, to inquire whether they were interested in meeting with me as a likely participant. Only one of the women I approached declined to participate and this was on the basis of extensive prior commitments. To the fifteen who consented to proceed, I sent a list of the questions I hoped to ask them, and a copy of the timeline, as previously described in Chapter Two which I had created to facilitate their reflections over the first two decades of nursing education. Copies of these can be located in Appendices Two and Three. The usefulness of this timeline is reviewed in more detail in the following section of this chapter. These were accompanied by a second covering letter confirming my understanding of the details of our meeting, and reiterated the means by which I could be contacted if they wished.

Sometimes the interview would be conducted within a few weeks of the follow-up telephone call. Sometimes it happened after a few months, and in two cases there was a lapse of nearly a year before we met. I met the first participants in April 1997 and the thirteen other women over the following two years, travelling throughout Aotearoa New Zealand. We met in three different types of locations. For four participants it was most convenient for them to meet me in their own home or hotel room. A larger number were content to receive me at their place of work. Of these, some had a suitable quiet office space in which we could talk, while others who had noisy or shared workspaces had spontaneously pre-arranged quiet rooms for us to meet in. A final group of interviews took place in educational settings that we were able to “borrow” for this purpose from contacts either she or I already had.

I have vivid memories of the rooms where these interviews were conducted. The coolness of one living room, the warmth of another, the annoying traffic noise outside an office, and the lingering cigarette odour of a past guest in a hotel room. I felt delight when women told me things that “clicked” with the hunches I had been formulating, or jolted my ideas out of their comfortable order, or made clear
an issue that I had not properly understood. Such memories remain evocative. These are perhaps the things that I will choose to remember after this dissertation has been completed. However, I think I will also remember how difficult it has been: the gnawing, nauseous fear I felt before meeting the women, the sense of tremoring panic when I (mistakenly) thought I had left the tape recorder on “pause” for ten minutes of interesting dialogue with Delia. Other vivid memories include sitting in unfamiliar cafes only a few minutes away from my meetings with Anne, Cathy and Beth where I drank bowls of latte and wrote furiously scribbled notes about what it had all been like to meet with them. I also remember my reluctant decision to interrupt conversations with Emily and Kate to close windows from outside noise, and the embarrassment I felt for letting my tiredness show to the point that Maria enquired in our late afternoon meeting whether I was feeling able to continue the interview. I need to remember that amid the happiness and the pleasure, the pride and the privilege of such work, there remains an awkwardness and weariness involved in the doctoral dissertation process. I discuss this last point more in the final section of this chapter.

The ways I managed the interviews depended very much on the conditions in which the participant and I were situated. My goal was to conduct informal semi-structured interviews, with my list of questions and with an expectation that it would take about ninety minutes to cover them. As I became a more confident interviewer, I grew more flexible about moving between topics and moving aside to issues that the participant had indicated as something they wanted to speak about more. My growing confidence also freed me to relax and enjoy the interviews. This is indicated by the occasions when the interview shifted into a conversational style in which I would offer related personal experiences as a form of dialogue with their comments. It is also reflected in the “I.C.s” that I wrote up after the interviews were completed.

At the same time, as I read back over transcripts, I recall my sense of frustration for not asking more probing questions about issues that I didn’t understand clearly. Sometimes this was because I was anxious to work through all the topics within the agreed timeframe, or because I lacked assertiveness and/or because I was reluctant to be seen to misunderstand particular points occasionally made by
the women. It is not mere coincidence that my final meeting with a participant was split over two sessions, and included approximately one more hour of recording than the earlier audiotapes. By this stage there was much that I sought to understand in greater detail and felt more comfortable asking for explanations than from earlier participants. Interruptions from, for example, support staff or outsiders, seemed to disrupt participants' reflections, while on other occasions either the participant or I would suggest a break from interviewing as a strategy to draw us back onto the topics in hand.

Finally, I became more skilled at simultaneously thinking through my interview schema while listening to what the woman was speaking about, and simultaneously monitoring the technical demands of an interview. In this regard, I am reminded of the descriptions and advice given to novice interviewers about the various simultaneous roles necessary in effective qualitative research (Ely, et al. 1991: 57-69; Glesne and Peskin, 1992: 75-87).

Employment of a timeline in interviews

I envisaged that provision of a “timeline” might assist during interviews, so I constructed an historical account from primary and secondary source data of what developments had occurred over the first two decades since comprehensive nursing education was established in Aotearoa New Zealand (see Appendix Two). Participant responses to the timeline varied. I was delighted to see that Rachel and Beth engaged with it and wrote detailed notes of their own life experiences in the yearly spaces provided. Other women simply referred to it when answering questions to help me understand clearly the context of the times they were speaking about. More commonly, however, the women did not utilise the timeline as a resource. I continued to include it with the question sheets and draft consent form that I sent out to prospective participants, and I discussed it with them if they wanted to refer to it. But my interest gradually shifted from trying to isolate specific socio-political discourses which might have informed changes in comprehensive programmes, to a quest for more subjective impressions of the era under review. This certainly seemed to be more realistic for the participants, many of whom would often speak about their reflections of what happened in
comprehensive programmes without specific reference to any particular dates or socio-political events that had taken place.

**Rapport and the processes of interviewing**

Researchers ... traditionally establish rapport to attain ends shaped primarily by their own needs. In qualitative research, rapport is a distance-reducing, anxiety-quieting, trust-building mechanism that primarily serves the interest of the researcher.

(Glesne and Peskin, 1992: 94)

With my initial phone conversations I began to establish a rapport with the women in my study. I found it difficult to “settle in” to talk with these people I had never met before. More importantly, I hoped that the women would trust me enough to talk freely about their experiences. This presumed much of the participants. I employed small talk as a deliberate strategy in the initial part of our meetings but on a couple of occasions time restrictions made mere conversation a luxury neither the nursing educator or I could afford (Merriam, 1998: 84). At times, the information that I had sent the participant served as an initial source of talk between us. As Glesne and Peskin point out above, this aspect of the interview was most important to me, providing the best possible data without really considering what the whole encounter was like for the women concerned (1992: 92). For example, I sought to convey the impression that I was a confident and well organised researcher. I felt this was almost impossible in some interview situations, for example, in people’s own homes, when I would find myself on my hands and knees under their kitchen table or groping behind office furniture to find a power point for my tape recorder. Such moments felt less than conducive to developing a relationship of rapport with the women.

On reflection, I believe the single defining perimeter that I can recall from the times I spent with the women was precisely that: the time we had available to spend together. If time was short, establishing rapport became a particular challenge because we had very little opportunity to converse before and after the interview. When the women indicated that there was no particular time by which we needed to end our meeting, we would continue talking over lunch or another
coffee for up to another hour. These occasions were much less stressful for me than the few interviews where I was aware of the constraints of the limited time we had together and I found it difficult to find a balance between the breadth of questions discussed and the depth of reflections on any given topic. Another impression is the role of humour in the establishment of rapport as an important and under-researched consideration in qualitative research methods.

With some participants, a common bond helped to acquaint us. For example we might have both worked or studied in the same institution, or they might have known someone I also knew. In the latter cases I was very mindful not to initiate, or explain how I knew these connections for fear that the circle might close the all-important gap of confidentiality between me, my participants, and the research. Rapport was perhaps made easier, too, because I am a woman engaged in a research project with only women participants. Perhaps more importantly, my identity as a comprehensive nursing graduate held some degree of commonality with the nursing educators, in that I represented one of the generations of students they had taught. Not only had I that educational experience, I was also continuing to practice part-time as a clinical nurse. To some participants, I gained the subtle impression that this made me a more legitimate researcher into nursing issues. This emerges as an important connection between my method and the conclusions I draw from my analysis, as described in more detail in the closing chapter. Finally, my role as a post-graduate student was a critical form of shared identity. All of the participants had themselves engaged in some graduate-level tertiary study. Some were interested and encouraging about the progress of my degree and I am left to wonder if part of their decision to participate in the research was from a sense of empathy for my role as a research student, as well as from an interest in the topic itself. Here again, I am left with the impression that the women’s commitment to nursing education motivated their support of my research. This suggests another evocation of their nursing educator subjectivities. At the same time, what they agreed to talk with me about also perpetuates their image for me as nursing educators, myself as a student and them as educators teaching me about nursing.
Not only were these women experienced communicators, enabling them to reflect on the richness of their lives as nursing educators in ways that I had only hoped possible, but they also understood a great deal about the processes involved in conducting qualitative research. On a couple of occasions the women had anticipated a tape recorder and found an extension power cord for me to use. As I have suggested earlier, they all understood the importance of a quiet uninterrupted space for us to talk. Some asked their support staff to hold calls, and people at home took the phone from the receiver so no incoming calls could disrupt us. Most had prepared some responses to my questions before I arrived at the interview, by jotting on the copy of the question sheet I had sent them, or by finding and copying archival material for me to see and sometimes borrow or keep. I was grateful for the thought that the women had made to assist their reflections. For instance, Jane sought to reflect on my question about professionalism prior to our meeting, by considering the dictionary definition to compare it with her own beliefs about the term. In such ways the women have truly “participated” in my research.

How we understood each other revealed some interesting differences in the ways the participants and I positioned our own and the other person’s identity. On more than one occasion, participants would check with me for feedback as to whether what they were telling me was the sort of information I was looking for. One participant asked me if I thought what she was explaining sounded “on the right track?”, while another pointed out an inaccuracy in the timeline that I had constructed. I found it hard to move beyond constructing the women in their senior nursing educator roles. Simultaneously, I understand that the women constructed me as holding a variety of identities, from expert to naïve researcher; from colleague and insider to the field of nursing education to outsider, because I was neither a comprehensive nursing educator nor a person who was known by previous research. In this multitude of ways, there were complex dynamics between myself as researcher and the nursing educators involved in my study.

In these shifting ways in which we construct ourselves and each other, it is useful to draw on Leslie Bloom’s reflections in her book *Under the Sign of Hope* (1998). She considers the complex relationships with one of her participants thus:
What happens if interview rules and roles compete with, rather than preempt the normal rules and roles of polite social communication, particularly between women? I want to suggest that ... we each struggled with multiple authoritative discourses and internally persuasive discourses of what constituted appropriate communication in our interview settings. The two operative and influential authoritative discourses of communication were the discourses of polite social communication and feminine communication.


She elaborates by writing about how such discursive habits confine and restrict the potential for feminist methodology to explore beyond the superficial representation of their lives. By being aware of such traditions and such complex demonstrations of power and knowledge dynamics, I defer further consideration of the implications of these shifting relationships to the discussion chapter at the end of my thesis.

Managing other sources of data

Of the fifteen women I had interviewed, a number had previously recorded oral history reflections as part of the NERF archive project. Having been granted access from the secretary for NERF, I was able to interloan and transcribe these interview cassettes. This archive offered valuable information to augment what I was gaining from them in my own interviews. Hereafter referred to as the NERF interviews, I have coded these texts and analyzed them in the same ways as my own field work.

The range of documents I have drawn on can be understood as primary and secondary source documents. Primary source data include original accounts

... that came into being during the period of the past that is being researched while [secondary data] is usually seen as text that is produced much later than the events being studied [and which] offers an interpretation and conversion of the primary data into an account that may be consulted by others.

Secondary source literature has been useful for gaining an understanding of the broad field of the development of comprehensive nursing education. More important to my work has been primary source data, not so much because of its "serious and scholarly" status, but because as a qualitative researcher I value the richness and originality of these sources of information (Bogdan and Biklen, 1992: 2; Purvis, 1994).

I am aware that my research processes have been pragmatic and less "pure" than advocates of qualitative research methods might recommend. My research began with document study long before I ventured to talk to any nursing educators. My training as an educational sociologist through an undergraduate and Honours degree lead me towards embarking on a course of research which would critically review the scope and impact of health and education reforms on the development of comprehensive nursing. Thus my research proper began with an analysis of texts that, for instance, critically reflected on the decision to locate CNEP in polytechnics and the implications neoliberal reforms have had for nursing students and graduates (for example, Wilson and Cadman, 1995). Only as I shifted towards the advantages of a qualitative research paradigm, Foucauldian and feminist poststructural theory, and sought new supervisors to replace my initial supervisor, Dr. Liz Gordon, did alternative ways of understanding history and the values of qualitative methodology open up to me. As these changes were made, my utilisation of documentary sources has only remained important as an archival commentary on how history has been constructed.

To further supplement this range of sources, I listened and took notes from a small number of Polytechnic Oral History audiotapes to enhance my understanding of the context and change within the polytechnics nationally over this period.

**Data analysis**

**Transcribing interviews**
The transcribing process demanded extensive time. The processes of preparing the transcripts for coding entailed listening to the tape a minimum of three times.
This was necessary to compile word-processed transcripts of the conversations, to check that the typed copy was as accurate a record of the interview as possible, and to clarify the development of my interviewer comments. I then sent a draft of the transcript of our meeting to each participant with I.C.s excluded in a double spaced, wide-margined format for them to edit as they wished. Their particular editing details were completed and the I.C.s reinserted before I began any data analysis.

My transcribing technique included the level of detail I understood to be necessary for the style of discourse analysis I planned to adopt. To this end, I decided it was unnecessary to employ either a pure Jefferson system of transcription or a modified version as used by discourse analysts Potter and Wetherall (Jefferson, 1985; Potter and Wetherall, 1994). Rather, my pragmatic decision was to include pauses, hesitations, laughter and repetition, for example, only when I understood these to reflect a significant point of meaning that could help clarify the women’s comments. I also sought to include gestures demonstrated by the women where I thought these were important to aid my understanding, although I endeavored to describe such movements on the tape. By employing this strategy, I am reminded of the comment cited in Bogdan and Biklen that, “the tape recorder should be thought of as a third party that cannot see. When subjects gesture or show size with their hands, these non-verbal cues have to be translated into verbal language so that the tape recorder can play them back for typing” (1992: 100). These aside, I transcribed the interview material essentially for the language expressed on the tape as my central field of study.

I transcribed the NERF tapes while they were on interloan from the Alexander Turnbull Library. Unlike the interviews I had participated in myself, these tapes were more complex to understand and work with. This was because of several issues. Firstly, because I was not present during the sessions, I found it difficult to understand what was being conveyed in terms other than verbally – for example, the lack of visual cues such as use of hand gestures and facial expressions made it hard at times to comprehend the speakers’ meanings. I also missed the social context of the interview, the surroundings in which they met, and the pre- and post-interview interactions between participant and interviewer.
These “unknown” elements served to remind me of the intrinsic value of face-to-face meetings and the value of developing interviewer comments (about the interview process) after the event and how much value these factors have had for my understanding of the issues under review in my research topic (Bogdan and Biklen, 1992: Chapter 4; Glesne and Peskin, 1992: Chapter 3). Furthermore, a number of the taped interviews reveal a familiarity between the participant and interviewer. At times the two would agree about shared elements of their past: a colleague, a politician and a reform, which they would not always elaborate on, but would begin to talk about, then just agree and fall silent. Sometimes they would trigger each other’s memories about an issue and/or compare recollection of aspects of the situation in which they had been working. While I found these silences or shared memories frustrating and difficult to understand, I also felt a greater sense of reassurance that my relation to the participants meant that I recorded perhaps richer and less ambiguous descriptions of the experiences of nursing educators in my own work. With me as an “onsider”, a term I discuss presently, the participants had to explain clearly what they meant.

Being able to interview some of the women after I had listened to and transcribed their earlier recorded interviews, made my encounters with them more effective. It gave me a sense of familiarity with the person concerned, and I was able to draw on their comments from the NERF tape to direct my questions into more accurate and specific issues. More generally, listening to the NERF tapes helped me “warm up” to my role as interviewer. Aside from these unique issues, my transcription processes for the NERF data remained consistent with those described in the face-to-face transcription method outlined above.

**Interview analysis**

I began the formal process of data analysis after I had transcribed only three of the interviews. This decision was made in the light of advice from textbooks, colleagues and my supervisors to begin analysis and writing to record my emerging impressions as early in my research as possible (for example, Bogdan and Biklen, 1992, Chapter Five; Merriam, 1998: 151-153; Silverman, 2000: 121-122). Over the same period, I was transcribing the NERF oral history project
tapes and began to code these at the same time. My foundational understanding of the issues surrounding nursing education, and in particular the experiences of nursing educators involved in comprehensive programmes, thus emerged from these two forms of collected data.

A colleague who had done some coding a few months earlier for her own Ph.D. helped me set up a specific space and system for coding my data. We talked about the general principles we shared about coding, then she left me alone to commence coding with a single transcript, some poster-sized blank pieces of paper, pens, pencils, erasers, the phone off the hook and coffee and chocolate at hand. After a few initial hours trying to code by myself, she joined me to talk over what I thought the participants were saying, why I had developed the codes I had, and what I meant by their names. Intermittently over the first weeks my coding companion would spend an hour or more with me, reading through the transcript and watching me assign developed or newly created codes to sections of it. Over the next few weeks, I worked through the face-to-face and NERF interviews to create over 200 codes. Each one was generated from a single issue that I understood the participants were speaking about.

There are benefits in having a coding companion, and they represent an alternative to the idea of team analysis or peer checking suggested in some qualitative method texts (Ely, et al., 1991: 161-164; Silverman, 2000: 158). Before describing such benefits, ethical concerns need to be addressed. My coding companion saw only transcripts where names had been masked so she remained unaware of the participants’ true identities. In addition, she and my supervisors were aware of her own ethical responsibilities in regard to any particular details (for example, if a particular location was mentioned) she might encounter in this role.

The advantages of working with a coding companion or having a second reader who has not been involved in the interviews and has no specialised prior knowledge of the field, is that they can read alternative meanings from a transcripts. She could therefore challenge the choices of codes I would nominate to categorise the issues participants spoke about, and in doing so encourage me to think about the possible meanings of thinking in both methodical and creative
ways about the transcript text (Ely, et al., 1991: 140-155). Secondly, by questioning why I was assigning particular codes to specific sections of text, she made me clarify in my own mind what the coding category referred to. This helped me to demarcate the differences between codes and helped to define their meanings. Such discussion also gave me the opportunity to raise ideas that might have otherwise remained as internal hunches – by explaining them, I could then write about them. Thirdly, the validation from an outsider that my interpretation seemed useful and interesting, increased my confidence to continue with the coding processes.

The transcripts were printed out on A4 paper, with wide margins down the left hand side of the page. The lines were numbered continuously throughout the whole transcript, and the I.C.s that I had begun writing up while transcribing and that had continued when I edited the copy sent off to participants for proofing, were present and denoted by an italicised font. Non-verbal data was also italicised to distinguish it from spoken text. Having read through an entire transcript, marking ideas in the margin and on a note pad alongside the transcript, I would then proceed with coding development and assignment. This involved reading through phrases and sentences of spoken text, and looking for meaning from the expressions used, which would either raise a unique idea, or echo something a previous participant had spoken about. These would be written up as new, numbered codes with a brief description included, and its number bracketed to the area of text. Alternatively, if the idea had already been written up as a code, I assigned the text its appropriate coding number. Very often the text would be multiple coded: that is, a single comment could have various meaning units associated with it.

While I was mindful of the suggested ways of categorising the sorts of issues that participants described (for example coding categories, Bogdan and Biklen, 1992: 165-182; Lofland and Lofland’s suggestion of “thinking units” in Ely, et al., 143-145), I treated such recommended lists as guidelines only. For my own work I thought them too prescriptive and instead tried to keep an open mind to simply create units of whatever sort of ideas appeared as they emerged from the data. In other ways, however, my coding method was firmly based on the systems
recommended by researchers such as those mentioned above. For example, Bogdan and Biklen’s suggestion of subcodes was useful to clarify coding for particularly substantial issues (1992: 177). This allowed the specific components to be related to each other though their foundation codes, yet retained the uniqueness of each.

In choosing to interpret the principles of coding categories in my own way, I am reminded that in qualitative research the legitimacy of one’s methodology comes through a commitment to integrity, consistency, honesty and an understanding that the work is imbued with my own subjectivities. As Taylor and Bogdan (1998: 177) explain:

Social values and ways of making sense of the world [that] can influence which processes, activities, events and perspectives researchers consider important enough to code ... Different theoretical perspectives that researchers hold shape how they approach, consider and make sense out of the data. ... So analysis is shaped both by the researcher’s perspectives and theoretical positions and by the dialogue about the subject that one can not help but enter.

I understand that all the research I have gathered comes through the filter of what Ely, et al. call the “self-as-instrument” (1991: 86). They suggest that “self-as-instrument ... connotes personal control and personal responsibility, and therefore, personal creativity” over the material I have gathered (ibid). They go on to comment that the researcher “must come to rely on his/her own talents, insights, and trustworthiness and, in the end, go public with the reasoning that engenders the results, while accepting with equanimity that other people may make different meaning from the same data” (ibid). Coming back to my earlier point about coding companions, I am not suggesting that each of these points contradicts the other, but rather the purpose of engaging a coding companion is to draw researchers to look widely and account for their line of reasoning.

While I advocate the benefits of working with someone on the initial coding of transcripts, I do not suggest that overall the dissertation is anything but my own work. Indeed, my constructions of what has emerged from the nursing educators’
talk is uniquely my own, and I am the conduit by which the dissertation appears. As Sari Biklen (1998) describes this, I “... act as the signifier of the worth of the study”, and it is through my unique and privileged positioning as woman doctoral student and comprehensive nursing graduate that I have developed this dissertation.

The conversations I had with participants produced dense and complex responses which were frequently difficult to code. This was because most frequently I interpreted what they were saying as being simultaneously about several different issues. I responded to this complexity of meaning by multiple coding, by which I would assign as many codes to any section of texts as necessary to encapsulate all the various issues that I understood were being spoken about. This required the assignment of up to seven codes to a single phrase of text. Such richness and density was unnerving at first. But as I progressed, I came to understand this richness was a positive quality of my research material.

Aside from this characteristic, which suggested my work was different from recommended formulas, another issue soon emerged to challenge my coding style. Having coded most of the NERF tapes and the first four face-to-face interviews, the fifth face-to-face interview transcript did not “fit” the codes I created. I came to understand that this participant had responded to my questions in a style of narrative that was different from some of her colleagues. Where others had spoken of personal experiences that had affected them and their work, this woman spoke on a political and sociological level about the sorts of issues that had affected the work of nursing educators such as herself. This connected with an impression I had at the time I met her, and I captured this feeling in the fieldnotes I wrote up soon after our interview ceased. I wrote “...it felt like she was telling me the ‘answers’...”. In terms of my analysis method, I was reluctant to create completely new codes or to subsume these different comments within the coding lists I had already created. In some despair, after attempting to code the first few pages, I chose to temporarily put the transcript aside and returned to code other, perhaps more straight-forward transcripts.
The process of moving from codes to the formation of sensitising concepts (hereafter abbreviated to S.C.s) was the next phase of the data analysis which began after I had coded seven of the transcripts. This process involved my careful and repeated reading of the lists of all the codes and the notes I had written about them. From this I began to group codes that concerned similar thematic issues. Sometimes it was obvious that many of the 225 codes could be understood as discourses, by the way the women had employed systems of ideas to make sense of certain issues. I created 31 S.C.s in all, and I then collated these within eight broader meaning units. Then I began to assign S.C.s instead of codes to the unprocessed transcripts. As with the codes themselves, I would assign S.C.s to both examples and negative cases of the phenomena under consideration. After this level of analysis I was able to revisit the fifth interview (as mentioned above) and discovered that this woman's reflections fitted more clearly within S.C.s than the range of coding options. I progressively worked through all the transcribed interview data I had gathered over the past two years to complete this phase of my analysis. After coding more than twenty interviews from my own and the NERF project transcripts, I felt the "weary sense of relief" that data saturation had been achieved (Ely, et al., 1991: 158). At this point almost no new codes could be developed, and all the talk "fitted" within at least one of the SCs. I completed the rest of this data analysis with further confirmation of this idea.

**Document analysis**

As I have explained, primary and secondary source documents were used to inform my understanding of the ways official and informal commentators had claimed the developmental history of CNEP. Using written texts in this way meant that I have not completed a systematic document analysis method of the style suggested by some qualitative researchers (for example, Bogdan and Biklen, 1992: 135-137; Merriam 1998, Chapter 6). Rather, I have treated such texts as archival material to be critically evaluated for their depiction of events. I also treated the Polytechnic Oral History Project tape recordings in the same way, to extend and challenge my ideas about how people have interpreted aspects of history, and to enhance my understanding of the variety of ways such happenings can be socially constructed. In this way, these texts have provided me with "both
historical and contextual dimensions” for my interviews (Glesne and Peskin, 1992: 54). In particular regard to the discourse analysis perspective, these texts have been considered for the ways they have framed discursive constructions of history around nursing education.

Writing up

Once my coding was completed, there was still a great deal of consideration and planning to be done before I could begin the “writing up” of my dissertation. This involved staying with the transcript material, and in particular sorting the units of dialogue into the sensitising concepts that I understood the women to be talking about. I continued this sorting process by cutting up and assembling piles of transcripts into particular S.C. - labelled envelopes. I found these awkward, risky (some comments were very brief, for example) and difficult to organise, so moved onto a system of recording each sensitising concepts component by computer document files. The details of each sensitising concept was accompanied by lists by participant pseudonym, transcript line number and a verbatim or brief summary of each comment as I understood it. As often as possible I worked to retain the feel of what the woman had said by quoting key phrases and words. This proved useful for developing a sense of the discourses the nursing educators engaged in both affirming and dismissive ways. I made a conscious effort to frequently take time away from this organisation strategy to write memos about what I understood was emerging from these processes, as I understood this to be an important aspect of my research method.

My hunches and memos developed into organised propositions, as I continually moved between the transcripts themselves and my memos, and between quiet periods of simply thinking about what the women had said, and the occasional opportunity to talk my ideas over with friends or colleagues. This last point is worth reiterating further from my previously acknowledged valuing of a coding companion: that my development of understanding has come with the greatest clarity as I have explained what I understand about the topic to someone who has not been associated with comprehensive nursing education. Here I demonstrate
my own belief in the principle of "ako" by the mutually educative process between teacher (my role in trying to explain an emerging theme concerning CNEP to a colleague) and learner (their role as one who listens, asks questions pertinent to my research method, and responds in insightful ways).

I understand this strategy to represent a form of reflection that is aligned to a particular nursing epistemology which is closely associated with notions of Freirian praxis and conscientisation. Reflective practice is a pedagogical tool employed by nurses to critically review aspects of their clinical nursing work (for example, Christensen, McMahon and Stevenson, 1994; Palmer, Burns and Bulman, 1994; Street, 1991). This most commonly takes the form of writing narratives through journals and the publication of exemplars and in verbal narratives and storytelling forums. The valuing of storytelling in particular has a long and rich history for nurses, and in connection to my research, the pursuit of nurses oral history projects has become increasingly valued (Langridge, 1993; McEldowney, 1995; Williams, 2000). In the context of Aotearoa New Zealand, recent literature has explored the efficacy of reflective practice for nursing educators’ work with students in clinical settings (Booth, 1997; McManus, 1994) and teaching staffs’ perception of critical thinking in nursing judgment (Walthew, 1999). By my own engagement with this method, I understand that I, like my participants, am not only employing principles of praxis, but that my subjectivity as a qualitative researcher is simultaneously being constructed by a discourse of reflective practice.

Following such discussion I returned to my writing, and by drawing on my memos and the original sensitising concepts that had emerged from the data, I formed a coherent plan of how a range of the emergent discourses could be organised into chapters. It was from this that I came to the decision to present four substantive chapters of data to review the nursing educators’ commentaries. Each chapter presents a range of comments from nursing educators, identified at the end of their quotation by their pseudonym and the line number on which the quotation begins in the corresponding coded transcript.
The shift from studying the narratives of nursing educators to composing my own text to re/present the research material has been an immense challenge. For an inordinately long time, I felt burdened by the limitations that my initial focus on professionalism seemed to have on the data I had collected. I kept thinking “why professionalism?” because it seemed to be such a redundant topic to the women in my research project. At one stage I considered turning the question around by simply shifting from considering the extent to which ideas about professionalism have shaped changes in CNEP to a conclusion that professionalism was the answer. I considered the proposition that the professional characteristics reflected a new discursive formation, and that through a poststructural gaze, these shared traits actually celebrate heterogeneity and a power partnership instead of traditional forms of authority. In this way, my Ph.D. journey would have led me back to the place where I began, at the proposal that the women I interviewed shared a group of important and unique characteristics which constructed comprehensive nursing educators as an emergent feminist profession.

My decision not to offer such a succinct conclusion reflects my commitment to a Foucauldian/feminist poststructuralist paradigm. Instead of orchestrating such a “punchline”, my work offers a discussion of the discourses that nursing educators have engaged in to account for their qualities of CNEP. While I am suggesting that the women employ particular discourses in a variety of ways, nursing educators’ subjectivities are themselves being constituted by these discourses. All I am able to present is a fairly whole, mostly coherent account of the women’s working lives as comprehensive nursing educators, as they portrayed themselves to me, and the ways I have interpreted them, and as I have been able to discuss in this dissertation format. At the same time, while I developed my ideas into appropriate form, I began to explore the literature that had some connections, whether affirming, complementary, or in resistance to my propositions. Such topics form the foundations of what has already been presented in the theory chapter, and this literature is further considered in the next four chapters. Finally, I continued to return to the transcripts and the original audio-tapes of my participants, to critically consider whether my work was immersed in their narratives. On reflection, I now believe that my depiction of their narratives are both representative and illuminating.
Reflections on the method

This section of text considers a variety of reflections on the theoretical issues that have emerged from my research processes. In attending to this as an integral aspect of my dissertation, I am acknowledging the importance of “recognising fully the notoriously ambivalent relation of a researcher’s text to the realities studied” (Alvesson and Sköldberg, 2000: 1). In other words, by not assigning this text to a secondary location (for example in a methodological appendix), the interplay between academic epistemologies and ontological realities of my experiences of doing the research become illuminated. Such interplay imbues the ways I have come to understand the experiences of women educators who worked through the emergence of comprehensive nursing in New Zealand between the 1970s and 1990s.

Memory and history

The way nursing educators have explained past events and their historical memories to me has been an important dynamic to the emergent thesis. In particular, the degree of variance between the participants’ narratives, and their and my own understanding of history raises important implications for my research methodology and what has been produced as the thesis itself. This section of work lies literally and symbolically in what Elizabeth Adams St. Pierre calls the “messiness... of the middle of things” between the dissertation’s ontology and epistemology (1997: 176). Ontologically, the components of the dissertation are formally obliged to account for what was done and why in methodological and theoretical text. At the same time, new knowledge is proffered through my dissertation by the careful and precise analysis of my “data”. Epistemologically, it celebrates what I have already explained as the “in-between” of feminist poststructuralist research. In this sequencing, it represents one of the by-products of the murkiness of constructing understandings of what has happened in nursing education, between the clarity and stability with which formal accounts of history are portrayed, and the opacity and transience within people’s personal narratives.
My experiences as a student of educational sociology drew my interest in the ways the experiences of nursing educators related to the constraints and developments posed by the health and educational institutional manifestations of the Aotearoa New Zealand paternal state. I was familiar with debates about professionalism and nursing from my studies, and chose to include this term into the equation as a conduit by which the political, cultural and social dimensions of nursing educators’ work could be usefully understood. In other words, by exploring questions of professionalism with the women, I hoped to gain an understanding of the identities, agency and authority of nursing educators that would emerge in relation to these contexts. For this purpose, I drew up a timeline collating historical material into a document that I drafted and photocopied into an A3 format. It summarised the important events I had grown to understand as forming the context for the ways nursing education had developed over the time I was studying. The way I recounted historical events was by no means to represent a definitive chronology of the events that have been important to the health, education and/or cultural dimensions of Aotearoa New Zealand’s history. Rather, my purpose was only to provide the participants with a brief account of some of the more important events that I understood to have shaped the context in which they had worked and lived over the past two decades.

I employed the timeline as a naïve “onsider” impression of what had gone on in nursing education from what I had read and even from my own experiences as a comprehensive student. In this way the timeline formed a point of discussion and a potential starting point for the development of open-ended questions about the experiences of the participants in the context of what I understood to be a socially constructed chronology of history. I thought a variety of potential “c(l)ues” would help them make connections between what was happening in Aotearoa New Zealand society at large and their professional experiences as nursing educators.

This rationale was based on my understanding of how people’s memories are often evoked when associated with a particular event, social issue or name of a protagonist using these memories as reference points to recall and reflect upon historical moments. In these ways, the timeline represented a helpful conduit for
me to relate to the participants. The specific idea of using this resource was recommended by my supervisor, Missy Morton, and while I consider it to have been a unique interviewing strategy, I am familiar with the idea of using memorabilia and other props as catalyst to qualitative interview methods (for example Bogdan and Biklen, 1992: 99).

As I refer to the timeline as a “prop” and a “clue” throughout the thesis, I will take a moment to consider the ways that playing around with these terms can reveal different meanings and associated intent. I originally associated this first term with the term “prop” as used in the dramatic arts, as an abbreviation for properties as objects used on stage to enhance the performance. On reflection through the writing process, I am intrigued by modifications that can suggest two related terms - namely “prompt” - referring to a reminder to aid an actor’s forgotten lines, and a “prop” which refers to something which offers support. As a dramatic metaphor, this continues to be employed in the thesis as discussed in Chapter Nine in regard to heroism and nursing performativity. Similarly, by fracturing the word “clue”, the word “cue” is revealed. A dramatic metaphor is played out here again, where the timeline can be interpreted as a reminder or signal to the women about specific issues they might have felt obliged to mention.

I grew to understand that the inclusion of the timeline implied my interest in the extent to which the women’s accounts of history were, or were not, similar to representations of historical discourse. I began to question whether this was a valid form of research, on the basis that it was grounded in functionalist “cause and effect” assumptions about research, oversimplifying complexities of the fractured forms of truth and knowledge. By reflecting on these differing responses, I realised that my original intention to use a timeline as a prop was not consistent with my theoretical foundations of qualitative method. Chronological historical accounts have traditionally been understood to represent a coherent and accurate representation of social history. With the emergence of poststructuralist reviews of historical epistemology, the premises of truth, identity and social practices are necessarily examined for the purposes such constructions might serve for some at the expense of others. Foucault’s work on genealogy “seeks to define specific forms of articulation” beyond the traditionally recited explanation of
historical events (Foucault, 1972, 162). This involves a quest for discursive structures and the impacts such patterns of knowledge have on - and through - language. It reveals the fractured nature of knowledge: the rough, ruptured and clumsy nature of history which demands that historical documents be understood to “memorise the monuments of the past” (ibid, 7: italics in original). So what was initially a frustration (“Should I have asked them more specific questions?”; “Why don’t they remember the particular events more clearly?”), shifted over time to something I saw as a positive quality of the work. How the women constructed memory and history reflects much about gender power, systems of discursive authority, and for me personally, the importance of being true to one’s research methodology. In this regard, the women did not tell me what I wanted to hear, but rather exactly what I needed to know. In this way alone, they have taught me a great deal.

The whole process of doing this research has prompted a significant shift in my understandings of theories of research method. One of the issues that emerged was the challenges to my fundamental assumption in “modern” forms of sociology as to the relationship between structure and agency. This had lead me to assume a cause and effect relationship between the “micro” - of individual people and the agency in their lives, and the “macro” - of the structural context in which they live and work. Gaining an understanding of feminist poststructuralism has lead me to understand that I believe constructions of knowledge to be far more complicated, disjointed, inconsistent, uneven, “messy” and ambiguous than I imagined possible. There were some occasions when the women involved in my research were able to connect explicitly between things that had changed on a structural level, and their experiences in comprehensive programmes. Equally, the absence of talk about particular issues also demanded my reflection: were these deliberate actively avoided silences, or were the women simply unable to say all that they thought was important in the time available? The richness comes from trying to understand and explain how I think these women made sense of the messiness of their working lives in nursing education. Part of what this is about, it seems to me, is that “history” itself is messy, and never as straightforward as it has historically been constructed. At the same time, memory is similarly more complicated – what was “known” is reconstructed differently over time.
Another issue that emerged through my conversations with the nursing educators involved the ways that gender identity and subjectivity intersect with history. As Joan Scott explains:

History figures ... as the record of changes in the social organisation of the sexes, and critically as a participant in the production of knowledge about sexual difference. I assume that history’s representation of the past helps construct gender for the present.

(Scott, 1988: 2).

Extending from Scott’s Foucauldian-style rhetoric, I believe that through the analysis of the interviews with nursing educators, much becomes clear about the social organisation of the social gendered regimes. But beyond this, I am overwhelmed by the creative and enlightening ways the women reflect on history to reproduce, and also to challenge the production of knowledge about gendered differences. More than this, my analysis explores beyond the regimes of understanding the unique constructions of gendered work and subjectivities about nurse educators as a group who have been situated between the health and tertiary education sectors.

Reciprocity

The concept of reciprocity is an important component to the style of feminist qualitative research I have engaged in. While Glesne and Peskin cite Glaser’s definition of reciprocity as “the exchange of favours and commitments, the building of a sense of mutual identification and feeling of community” (Glaser 1982, 50), these authors elaborate about how notions of reciprocity can be understood in more contemporary ways. They capture my feelings very effectively when they write:

As research participants willingly open up their lives to researchers ... researchers become ambivalent, alternately overjoyed with the data they are gathering, and worried by their perceived inability to reciprocate adequately... Researchers do not want to view people as means to ends of their choosing. Nonetheless, in non-collaborative qualitative work, they
invariably cultivate relationships in order to gather data to meet their own ends. In the process, researchers reciprocate in a variety of ways, but whether what they give equals what they receive is difficult, if not impossible to determine.

(Glesne and Peskin, 1992: 122)

This advice has been a consolation to me, as without it I am left with an underlying sense of guilt that sometimes felt immutable. I have come to understand that the interviews and the research project more generally might provide the participants with an affirmation that their stories are important and interesting, (ibid, 1992: 123). I am unconvinced, however, that participation in my research has, as Glesne and Peskin go on to suggest, “...assist[ed] them to understand some aspect of themselves better” (ibid).

The debt I have to my participants extends beyond the value of the time they spent with me, and in the ways they may have prepared for and reflected upon our meetings. Three participants offered me transportation when I was otherwise reliant on public transport. One bought me gifts, and some had spent time finding useful archival material from their own years as nursing educators, or that they knew would be interesting information about the period under review. At the same time, I understand that I might have reciprocated during our sessions and afterwards. I offered encouragement when four women spoke to me of their ambitions for the future, and on one occasion I was able to refer the participant on to an agency to help her attain her goals. When two participants spoke of projects that they had helped develop, and which I remembered as particularly worthwhile to my own nursing education, I was able to give them feedback about how positive the initiatives had been for me personally. On other occasions, for example, I was able to pay for food or drinks. The most significant example of reciprocity was with a participant for whom I volunteered myself as a research assistant for a few days. Upon reflection, the unevenness of my reciprocity towards participants is no more generalisable than any other aspect of meetings I had with the women. Yet to significantly help only one of the fifteen participants does not seem reasonable or equitable. Here I am left with Glesne and Peskins’ advice that “[e]quivalency
may be the wrong standard to use in judging the adequacy of your reciprocity” (1992: 122).

Rigour

Across both qualitative and quantitative fields, the necessity to have one’s research accepted by academia depends in part on the rigour of the work in the ways it has been conceived, undertaken, analysed and reflected upon. As a qualitative researcher, my work centres around the perspectives of the participants and the reflexivity of my own perspectives. While these are important goals, the methodology demands that I can substantiate the rigour of my method. Primarily, the integrity of the work must lie in its resonance with the participants themselves and what they have shared with me about their experiences in the world of nursing education. It must also reflect the systems of rigour adopted by qualitative researchers whom I aspire to emulate and only through its own rigour will it be useful to the discipline. Through such rigour, a dissertation should represent a “...substantial and systematic piece of independent research that makes an original contribution to knowledge and understanding and meets recognised international standards for such work” (University of Canterbury Education Department, 2001: 53).

According to Rice and Ezzy (1999), rigour indicates the importance of considering questions about validity and reliability in qualitative research, and that at the “heart of the problem... is the relationship between the observer and the observed ‘reality’” (30-31). My earlier precis of the epistemology of social constructionism claims the validity of rigour in that meaning is made in relation to some aspect of ontological reality. This is an important consideration, whether it be between the observer and their vision of reality, or, in my research, between the listener and the meanings I take from narratives the women have offered me and in my work as a reader and the primary and secondary texts I seek to interpret. At the same time, my review of feminist poststructuralist theory would suggest that rejections of an independent reality would seem to make any efforts towards achieving rigour redundant. Yet I believe that the pursuit of rigour to achieve excellence in
qualitative enquiry is possible through a clear and thorough account of the processes engaged in to develop the final project.

One particularly under-theorised aspect of qualitative theory has been a valuing of the emotional dimensions of the research process. As a group of student colleagues and I have argued:

... to define rigour only in [positivist approaches to exploration and inspection] terms no longer suffices because it allows a silencing of crucial aspects of the research. It fails to provide transparency of the role of the researcher throughout the process. Although it is acknowledged within a qualitative methodology that the assumptions which the researcher brings to their research need to be challenged and exposed, their feelings and reactions are not usually made explicit (Kleinman & Copp, 1993). The interactions and participation that the researcher has with their participants become secondary to the empirical data collected. The danger in this is that it fails to acknowledge that the feelings and emotional work that occur as we weave ourselves in the lives of others play an important role in how we respond, interact with our participants, and interpret our research. Furthermore, Jaggar maintains that our emotions are epistemologically indispensable and, although not indisputable, are nevertheless data to be interpreted, challenged and revisited throughout our research. Thus, not only should feelings be recognised as an important component of fieldwork, but a researcher’s experiences in the field must also have a profound influence on what and how a researcher writes (Bogdan & Biklen, 1992; Tolich & Davidson, 1999).

(Wilson, et al., 1999: 3-4).

I conclude the substantive component of this theory of method chapter by attending to this facet of my work. As my colleagues and I have argued above, it is important to consider the “out of category” material that arises from the interface between our own subjectivities and the work we do with our participants in feminist poststructuralist research. Such considerations, named “transgressive data” by St. Pierre (1997), arguably fall beyond the bounds of traditional research, yet I believe it should be taken into account and explained in order to be true to rigorous qualitative research.
At least some of the participants in this research are people whose names were familiar to me from my experiences as a comprehensive nursing student and later as a registered nurse. Collectively, they represented the educators, experts, mentors and theorists whose success and status I admired. Consequently I began thinking of these women as “goddesses” and “gurus”, and in approaching them regarding participation in my research, I felt fearful of their potential scorn or challenges to my dissertation (Davis and Gremmen, 1998). I understood this to create an extra layer of anxiety that other researchers might not have to confront. Further into the research process, their recollections of courageous strategies to overcome adversities in the fledgling programmes confirmed my construction of them in such heroic terms. Furthermore, having met with these people, and having accepted “the gift” of their time and their participation, I have found myself wanting to please them, and to pay them homage (Limerick, et al., 1996).

On further reflection, my bestowing of heroic identities related to more than my positioning. It reflected the powerful use of heroic language the women employed to account for their work in CNEP. Details of this are explained in Chapter Nine. It also reiterates the power of discourses to constitute the women in particular forms of subjectivity, and the efficacy of discourse analysis methods to illuminate the complexity of these processes. The risk of thinking of the participants exclusively in heroic terms would depict these women only as flawless, selfless and benevolent actors of whom I never truly gain an understanding beyond the metaphor of “goddess” or “guru”. My quest for academic acceptance means I have had to move beyond the metaphor, unpack it, and work to see the participants in all their complexity, in a “warts and all” sense of their real-ness. I have constantly had to remind myself to consider the shifting power dynamic that imbued my interactions with these women beyond any binarised constructions, for example between dominance and resistance, or between success and failure, receptive and disinterested, or helpful and unhelpful oppositions (Scheurich, 1997: 70-72). Here again, I sought to look for the transgressive data that emerged from my encounters with the women in my research.

Tackling the question of how we account for thinking of participants in these terms reminds me that I can and should make these preconceptions transparent. In
the end, such transparency calls on me to put aside such labels, and grapple with
the complexities behind the facades I have conjured up for my participants. The
feelings I have about my participants cannot, and should not, be ignored or erased,
but rather be understood as intrinsic elements of my aspirations to engage in
rigourous and credible research. Examples of the emotional hard work I have
experienced as a researcher because of my relationships with my participants have
implications for the research - both processes and products - and the way in which
I understand notions of excellence in qualitative research in a poststructuralist
world.

**Discussion**

In this chapter it has been my responsibility to explain the means by which I have
ventured into qualitative research methods, into discourse analysis, into coding
and sensitising concepts, and through the theoretical paradigms of feminist post-
structuralism and social constructionism. Having explained the tools and
parameters of my work, I now turn to reviewing the major issues that characterise
the nursing educators’ narratives about their experiences in CNEP.
Chapter Six: Freedom and Difference

Education as emancipation

As I recounted in the first chapter, at the interview for my local CNEP, nursing educators assured me that the world “would be my oyster” were I to qualify and seek work as a registered comprehensive nurse. In this sense alone, the idea that education could emancipate was an underlying discourse in the women’s talk by offering me opportunities to travel and work with such a qualification. I believe that the discourse of “education as emancipation” forms an important characteristic of the ways nursing educators have worked to account for the development of CNEP. The variety of ways that the women spoke about their memories of CNEP centered around the notion that education offers people freedoms and liberties they otherwise would not be able to access. The women talked about this in ways that reflect their different experiences, values and educational backgrounds. Despite such diversity, the ways women have engaged with this coherent language structure has led me to deem “education as emancipation” as a significant discourse nursing educators have engaged in to account for the development of CNEP. At the same time, I consider the ways this particular discourse serves to construct them as nursing educators.

To examine such a discourse, I need to elaborate about what is meant by the components of the phrase, “education as emancipation”. As I have indicated earlier, my focus on education is particularly on an organised, formal system of teaching and learning in the post-compulsory education sector, although the discourse is potent across all levels of education provision, from early childhood to adult education and training. By emancipation, I refer to the awarding of freedom, entitlement, and independence to members of a community from restraints that otherwise limit their possible life choices. In this context I draw on emancipation to mean the liberating of people by increasing their knowledge, understandings and/or skills which they acquire through formal and informal
learning process. Together I understand education as emancipation to refer to the liberation of people through a variety of education forms. This involves various freedoms from economic independence to the improvement, of quality of life through knowledge and skills acquisition. I understand a discourse of education as emancipation to pervade the ways people understand aspects of education as diverse as curriculum, teaching styles, the organisation of particular programmes and the status of students and teachers within the educational context. To convey the qualities associated with the ways the participants employ this discourse effectively, I present three constructions of emancipatory education. They involve traditional liberal democratic ideas including those of John Dewey, radical pedagogy theorised by Paulo Freire, and liberal feminist models of emancipatory education.

Modern schooling systems have been significantly influenced by John Dewey’s liberal democratic theory of education. He regarded democracy as having many meanings, and “... if it has a moral meaning, it is found in resolving that the supreme test of all political institutions ... shall be the contribution they make to the all-around growth of every member of society” (Dewey, 1920: 186). Deweyian philosophy has been as influential to adult and post-compulsory education as to the compulsory sector (Beeby, 1992: 50-51, 131, 290; Ewing, 1970: 153; Williams, 1978: 2-9). The extensive provision of polytechnics for post-compulsory and adult-oriented vocational programmes have been understood to serve the needs of a developing economy, by educating and training workers across a broad range of industries and trades. At the same time, the provision of such education and training has been exalted for giving citizens the opportunity for self improvement through the acquisition of skills and knowledge (Ewing, 1970: 271-272; Keys, La Trobe and Kirk, 1939; Offenberger, 1979: 13-22; Williams, 1978).

From the 1960s onwards, the radical and transformative pedagogical theory of Paulo Freire has been influential among critical educators, culminating in the publication of Pedagogy of the Oppressed (1972) which offered a treatise on radical liberatory education. This work provided both first and third world nations new ways of understanding how education might be promoted and organised, in
particular by offering emancipatory literacy programmes among adults (for example Findlay, 1993; Kirkwood and Kirkwood, 1989; Smith, G. 1999; Torres, 1993). On a visit to Aotearoa New Zealand in 1974, Freire challenged the dominance of a colonial pakeha culture by calling educationalists to reassess the systems of authority and power they continued to uphold (Armstrong, 1999; Jenkins and Martin, 1999).

In particular, groups seeking sovereignty through Maori education initiatives have been influenced by his work. For example, similarities exist between Freire’s rejection of a “banking model” of education in favour of a power sharing relationship between students and teachers and the Maori model of ako (Pere, 1982; Shor, 1993; Smith, G. 1999; Weiler, 1988: 17). The term ako refers to a traditional model of learning and development, which involves the dual principles of teaching and learning, as previously discussed (Metge, 1986). In offering such challenges, Freire questioned the assumptions about democratic and liberal educational discourse that had governed the development of Aotearoa New Zealand’s welfare state education system.

What has been called the second wave of the feminist movement was characterised by a common goal of equality for women alongside their first world male peers (Fraser, 1997: 175-176; Weedon, 1999). On an international political stage, this was evidenced by the resolution passed by the United Nations in 1967 that articulated that education access and provision should be the same for female as for male students (Byrne, 1987: 25). Women who chose to engage with liberal feminist movements sought new ways to understand their life choices and experiences and seek out new opportunities for personal and political freedom. Such developments were promoted by consciousness-raising, grass-roots and civic strategies across western societies. Although they differed in their definitions of equality from opportunity to outcome, feminists were understood to share the homogenous bond of “sisters under the skin” (Whelahan, 1995: 71-73; also for example Dann, 1985; Jones, 1991; Middleton, 1987; Weedon, 1999: 12-16). At the same time, a flourishing feminist literature, and an acceptance of gender equality at institutional level through Departments of Feminist Studies, the appointment of Women’s Rights workers and equal employment legislation all
served to articulate feminist liberation politics (Jones, et al. 1995: Chapter Three). These initiatives offered powerful forms of criticism of traditional systems, and strategies for liberation that involved educational reform. As a result, strong connections between the value of education as emancipation and early feminist campaigns became linked, and this influence had consequences for the organization of nursing preparation in Aotearoa New Zealand. As a consequence the three discourses - namely Deweyian, Freirian and liberal feminist strategies - offered radical challenges in education. The participants may have encountered these through tertiary education, during the years when they were involved in the vision and reality of planning an alternative organisation of nursing education in Aotearoa New Zealand.

**Emancipation for students**

I believe that Tracy, Emily and Beth articulated an explicit commitment to a liberal democratic model of education, while many of the other women suggest an implicit belief in liberal education as a strategy towards emancipation for comprehensive nursing students. Emily and Beth offered personal reflections while Tracy recalled the philosophy of the programme she worked in.

*I have a strong commitment to the idea that nursing education is a socialisation process. And so you have to give as much attention to what is going on in the learner as to the organisation of the content.*

(Emily, 224-)

*The great highlight was seeing what good nurses you were turning out. ...To see these students grow, because they were given the freedom to fly with a bit of support.*

(Beth, 933-)

*...opportunities to be really innovative and to encompass that feeling. That this is a comprehensive programme and these people are going to be*

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1 For example, Whelehan describes the protagonist in Betty Freidan's "The Feminine Mystique" (1963) as a woman who surrendered the opportunity of higher education for marriage and domesticity. One of the most important solutions to women's oppression posed by Freidan included educational reform to ensure equal access by merit and access to higher education for women (1995: 35).
generalists. Because underpinning the whole philosophy was the idea of a generalist education. And that education was for the whole person. It wasn’t necessarily for employment.

(Tracy, 276-)

The argument I am presenting here is that the combination of components form the discourse that together represents a democratic and liberatory valuing of education. This leads me into an examination of other comments offered by participants that represent their dialogue with this aspect of a liberal democratic educational discourse. The provision of a supportive learning environment, where students feel safe and supported to learn, is another important quality of the education as emancipation discourse. The opportunity to acquire clinical nursing skills in a classroom setting represents an important contrast to the potentially unsupported and dangerous hospital context in which the participants themselves trained for registration. This idea has already been introduced in the opening chapter, where Helen, Gwyneth, Olivia and Jane have spoken about their experience as student nurses in clinical settings as incentives for the reorganisation of nursing education. Similarly, Emily and Maria offer the following comments:

*I always believed in setting up a framework that allowed people to maximise their roles, their imagination and their creativity. Which means kind of a loose reign. Being there to step in and support people when things go wrong, but also being very strong about reviewing what it is and making sure that the same thing doesn’t happen again.*

(Emily, 239-)

[One of the most important things I believed about nursing education] was that there should always be the opportunity for the person to be supported in such a way that they did not have to be totally perfect in what they did. That there had to be an opportunity for them to fail, if you like, so that however you were organising it, it needed to be safe for the people concerned... Because there is nothing more damaging than to have made a mistake that is harmful to others.

(Maria, 170-)

The comments offered above also connect with a rights discourse that I will be looking at in greater detail later in this chapter, specifically concerning student
rights to learn nursing skills in a safe and supportive environment. A liberatory education philosophy is also articulated by Tracy and Anne, each of them reflecting on the consequences of neo-liberal reforms for an emancipatory philosophy of nursing education.

*That whole management model has detracted from what we saw as enlightenment in the progress of women. I don’t think women being managers is really the answer, because it’s the model they operate from, you don’t take your liberation with you. I mean, Paulo Freire was great. I would explain [the philosophy of CNEP] to people in pure Paulo Freire. ‘This is what we believe in, this is what we do, this is what we are trying to do’. That whole model of education was what I saw we were doing for women in nursing.*

(Tracy, 520-)

*The political climate and the movement to the [political] right has been very hurtful to the development of [a comprehensive model of] nursing practice. In terms of enabling nurses to be powerful through information, powerful through knowledge, powerful through liberal education and excellence in practice.*

(Anne, 1162-)

In a second comment, Anne explains a related articulation of Freirian education:

*It’s sort of loving the students though their education. Bringing each student through it carefully, and validating their experience, however limited it might be.*

(Anne, 1267-)

Both of these women are relying on Freire’s construction of praxis and dialogue

... involving communication between leaders and people, teachers and students, a communion that is only possible when there is love, hope, faith, trust and humility. ‘Love is at the same time the foundation of dialogue and dialogue itself’ (Freire, 1972: 62) cited in Coben, 1998: 77.

While Anne and Tracy are the only two participants to talk explicitly in these terms, I believe it is an influential component of the education as emancipation discourse.
Freirian educational theory has been widely used to deconstruct systems of nursing education. Annette Street proposes a reason for the continuing attention nurses give to Freire’s work:

For nurses, the instigation of a modern understanding of a relationship between pedagogy, language, culture and liberatory politics can perhaps be traced back to the seminal work of Paulo Freire in *Pedagogy of the Oppressed* (1972). Freire’s interest in articulating and changing the experiences of oppressed people resonates with many nurses who have experienced the double oppression of medical domination and patriarchy.

(Street, 1992: 86-87)

In Aotearoa New Zealand, literature has reviewed facets of comprehensive nursing education by drawing on Paulo Freire’s work. For example, Judith Perry recommends that students be encouraged to develop a Freirian critical consciousness to prepare them for the potentially difficult transition to registered practitioner (1985: 82), while Antoinette McCallin explores connections between the development of nursing educators’ subjectivity and Freirian transformative pedagogy (1993). Other commentators have examined the particular Freirian notion of “praxis” associated with nursing education, and have successfully advocated that this term be used to represent reflective practice as a learning tool for clinical nursing practice (for example Booth, 1997; McManus, 1994; Perry, et al., 1988)

Of particular relevance to my work, Heather Forbes advocates a dialogue in educational processes where power relations are minimised between teacher and student, and critical dialogue serves to educate, conscientize and empower all those involved in the education process (1990: 40-41). The power relations that Forbes discusses concern Freire’s critique of the modern liberal model of education, where knowledge is deposited by teachers to students who act as depositories and remain powerless and silenced (Bowles and Gintis, 1976: 40). Instead, Freire advocates a dialogical relationship, where:

The teacher-of-the-students and the students-of-the-teacher cease to exist and a new term emerges: teacher-students with students-teacher. The teacher is no longer merely the-one-who-teaches, but one who is himself
[sic] taught in dialogue with the students, who in their turn while being taught also teach. They become jointly responsible for a process in which they all grow.

(Freire, 1972: 53)

The goal of this reorganisation of pedagogy is emancipation, where the “student” and “teacher” are both freed to understand and potentially transform the power relations that constrain their worlds.

I believe that there is an implicit Freirian theory apparent from the participants’ reference to power relations as they traditionally exist in teacher-student relationships, and their efforts to minimise these in their own work as nursing educators. Tracy and Anne, joined by Liz, Jane and Fiona, offer very similar explanations of their dialogical philosophy of the relationships between teacher and learner in their efforts to achieve an emancipatory model of education. For instance, Tracy and Fiona offered the following descriptions of the underlying theory that characterised the programme they worked in.

_It was the idea that all students and all teachers were in an environment of learning. And that the teachers were learners and learners were teachers. Underpinning the whole philosophy of nursing [was the idea] that the relationship was important._

(Tracy, 467- )

_The traditional didactic, ‘We are the experts and we stand up the front and impart our knowledge’, was not the approach we took right from the outset._

(Fiona, 152- )

_At the beginning we spent a lot of time using the person as the fundamental tool and an ingredient for effective practice ... We relied upon each other, including students, as powerful teachers._

(Fiona, 597- )

Jane, Anne and Liz claimed this philosophy from a personal perspective rather than as a shared institutional value.

... _my primary value about education is the sharing of knowledge aspect. ... I always like to think of it as a sharing process because you always learn something from the students, so it’s a two way process. I’ve always taken_
education to be a sharing thing. You try and convey that to your students to build that up.

(Jane, 107-)

I think I got as much from students and I think any reasonable teacher sees teaching as interactive.

(Anne 322-)

... [in] a classroom of students, I always knew that there were things that they knew heaps better than I did, and that never bothered me.

(Liz, 1429-)

The comments made by these women reflect issues beyond the nursing educator's personal values. The importance of modeling such emancipatory values serve to heighten the nursing student's awareness of the power relations implicit throughout the health and education sectors. In particular, students would gain a consciousness of the responsibilities that are associated with their future power held as registered nurses in relation to their patients. Having nursing educators model and mentor a dialogical relationship with students works to facilitate a partnership approach between comprehensive nursing graduates and the people they care for throughout the health sector (Christensen, 1990). This issue is discussed in greater detail in chapter eight where the participants describe their ideal/ised type of comprehensive graduate.

Staying with the consideration of power relations between student and teachers, Delia offers a different but related explanation of her work as a comprehensive educator. She described the strategy she used to minimise the hierarchy between herself as senior nursing educator, and the comprehensive students.

I tried very hard to visit all the student groups at least twice a semester. I didn't want the [teachers] there. I talked to the students and tried to create an open door. ... If somebody wanted to come and say something, they could. I'm wouldn't agree that I would agree with them. But they could come and say it. And I think I got quite a good rapport with them. That was important for me.

(Delia, 851- )
This approach can be understood to serve the immediate situation in the education context to enable students to communicate freely with their senior teaching staff. Her actions can also be seen as a mentoring strategy through which the students might understand power relations differently. Specifically, the relationships between “practitioner” and “client”, whether the former refers to nurse educator or students, and the latter to nursing student or patients, can be viewed in a similar way. As a nursing education leader, Delia is therefore modeling a form of idealised professional practice by demonstrating accountability, accessibility and a willingness to engage in dialogue as an engagement with a discourse of education as emancipation.

The liberal democratic and emancipatory principles espoused by Anne, Beth, Maria, Delia, Jane, Tracy, Emily and Liz can be contrasted with an instrumental approach to nursing education as explained in comments from Olivia and Liz. While these comments demonstrate the desire to provide comprehensive graduates with a generalist education which would perhaps equip them with life skills beyond merely those directly relevant to nursing work, Olivia and Liz suggested a more pragmatic approach.

_There were certain key things we went through and labelled that to nurse in a general ward or a medical surgical ward you had to be au fait with, this, this and this, and we noted those key behaviours. And then we worked out... what they had to do, the tasks or the behavioural changes they had to demonstrate to show that they had got to that key part of whatever it was, general nursing or obstetric nursing or whatever else. We went through all those areas and identified what we thought were key components for safety._

( Olivia, 492-)

Regarding the preparation towards State final examinations Liz echoes the emphasis on outcomes in the following comments:

_They've got to find ways to learn, anyway. You're hoping that you teach them how to learn. And at the end of the day you look at what the requirements are. They had to sit State exams that require a particular_
sort of frame of mind, and an ability to do what the environment wants. We rehearsed them and rehearsed them and they hated it, but I think they saw the point.

(Liz, 1372-)

My presentation of Liz’s contradictory engagement in this discourse serves to demonstrate precisely the non-unitary subjectivities of nursing educators who worked to balance the requirements of both the health sector and the education system. By reading Liz’s later comment in a particular way, it can be understood as a pragmatic response to a view that State nursing registration examinations are more of an initiation ritual than an accurate reflection of students’ preparedness for registration. Such contradictions also emerge in this analysis when Liz’s previously cited comment concerning students’ knowledge (1429-) is reviewed. Her comments suggest a type of pragmatism that she and her colleagues faced: by comparing this liberal education value with the instrumentalism of her most recently cited “test-prompting” practices, a picture of the conflicts inherent in her role as an educator emerges.

It is precisely the notion of ambiguity and contradiction within women’s individual narratives that is central to the analysis of discourses employed by comprehensive nursing educators. Consequently Liz’s comments reflect the complexity of trying to persuade students to take responsibility for their own learning and the contradictory messages nursing educators were faced with offering their students. These include the importance of conformity (to learn the knowledge specifically necessary to succeed in examinations) with the possibility that “teaching to the test” strategies compromise the integrity implicit in liberal constructions of nursing education. Such a reading can encourage an alternative review of Liz and Olivia’s statements: namely that they are both being pragmatic about the nature of students’ educational experiences.

Heather Forbes explores nursing students’ sense of the “anti-dialogue” power relations held over them by their teachers (1990: 40). Forbes’ suggestion is based on a banking model of pedagogy, whereby students “receive, file and store” pieces of information deposited by their teaching staff (ibid). Similarly, Clare (1991)
considers the discrete and harmful effects of the anti-dialogue style of pedagogy practised in comprehensive nursing programmes. Forbes' work analyses comments from comprehensive nursing students which suggest that their nursing educators wield power and status in relation to students, and that, unless checked, a powerful hidden curriculum will be perpetuated. In relation to this, she recommends that harmful contradictions between the rhetoric and the realities of comprehensive programmes for registered practice need to be confronted by comprehensive nursing educators and their students.

Delia's reflection of her role as a democratic and consultative programme coordinator is evident in her comment about her emancipatory and dialogic relationship with students. Heather Forbes suggests a significant contrast to this through the undemocratic qualities comprehensive students reported experiencing in CNEP. One notable facet of this is the lack of dialogue students could engage in with their teachers about curricular, pedagogical, evaluative and teacher-learner relationships (Forbes, 1990, 47-62). A reiteration of the rhetoric of a democratic and emancipatory educational discourse in comprehensive programmes concerns the RePIENs recommendation (1986: 21) that students be actively consulted about the content of their nursing curriculum, which Forbes cites as further evidence of such a potential contradiction. Although a discourse of education as emancipation is employed by nursing educators, it is important to remember that they too are enmeshed in similar contradictions. Here I am referring to the obligations and constraints placed upon nursing educators at the same time as they understood themselves to be self-governing, independent and emancipated professionals. Judith Perry has described such obligations as "...hegemonic control of nursing education and practice [that] provides the coercive conditions which prevent successful challenges to the dominant ideology." (Perry, 1985: 64) I examine examples of such dichotomies of power in the following section.

**Emancipation for nursing educators**

The participants spoke about their work in CNEP in ways that conveyed a complicated power play between freedom and constraint and between the education and the health care sectors. On one hand, the women certainly
experienced enormous freedom in their decisions about how their particular comprehensive programmes should be organised. On the other hand, the women explained the varied ways in which they felt immensely constrained by the expectations and actual obligations they were required to conform to, in order to be accepted as legitimate polytechnic courses and nursing education programmes.

The Nursing Council of New Zealand formally oversees the comprehensive programmes to ensure that students have gained the necessary clinical experience and curriculum components that are the prerequisites to nursing registration. As participants indicate throughout this chapter, the Nursing Council offered few precise guidelines for developing comprehensive nursing staff to assist them in the organisation of the three-year programmes. This is constructed by the participants as a freedom from the traditional regulation and prescription of hospital-based training curricula. But the lack of guidance is alternatively portrayed as leaving some of the participants feeling rather isolated, frustrated and even vulnerable. Essentially, the Nursing Council is represented as being concerned with measuring outcomes, while not being supportive about how such goals could be achieved.

Concurrent with the Nursing Council’s monitoring, the Department (and later Ministry) of Education also oversaw standards of nursing education programmes, as part of its management of the tertiary education sector. Since the establishment of the New Zealand Qualifications Authority in 1991 as part of the neoliberal educational market reforms, the accountability that comprehensive nursing educators have had to the Nursing Council is now shared with responsibilities to NZQA. The two organisations have worked in close alliance to ensure standards of education are maintained in CNEP. This has not only meant that comprehensive students are assessed by two bodies, but also that nursing educators work has been closely monitored by a variety of governing agencies (Clare, 1991: 5). Aside from accountability to these state-sanctioned monitoring agencies, nursing educators were constantly accountable to “two highly structured institutions”, namely the health and education sectors in which they worked (ibid: 7). This has been a significant constraint on participants autonomy and freedom to organise nursing education, and it contradicted the rhetoric of a discourse of education as emancipation for nursing educators.
The participants draw on language based in a discourse concerning “education as emancipation” across a breadth of discursive formations, from the “macro” level of social structure, to the “micro” subjective construction of themselves as nursing educators. By examining a selection of comments by particular participants, much is revealed about the ways nursing educators have utilised a discourse of education as emancipation to evoke particular understandings of their work in CNEP. Comprehensive nursing programmes offered the participants new forms of freedom and autonomy. For example, they had independence to organise nursing programmes according to their personal and shared visions for nursing. Beth reported this as something she had not experienced before, while Olivia and Jane offered related comments about the freedoms that CNEP offered them as nursing educators.

There were basic guidelines from Nursing Council. That was just a framework so you had the professional freedom to put together whatever package you liked in whatever form you liked, as long as it met that outcome. ... You certainly had to submit the curriculum to the Nursing Council and they go through a lot of scrutiny. But you did have that freedom, which I think was quite important. Because until then, nursing had been so prescriptive. It had been a bit like schools. You were just treated like children really. ... So it was a huge leap for nursing. And I think quite peculiar to nursing. I think most other professions were still very prescriptive.

(Beth, 643-)

We had very few constraints on us at all in those [early] days.

(Olivia, 1302-)

The way each individual education institution worked was very different.

(Jane, 598-)

These comments represent a stark contrast between the women’s perception of the previous hospital-based schools of nursing, and the freedoms associated with the comprehensive programmes. As such it represents the series of comparisons between the traditional and the new comprehensive education that participants utilised to explain the qualities of the new programmes. CNEP are therefore
represented as emancipatory, while hospital-based nursing training is portrayed as constraining and oppressive to students and their teachers alike. I believe such contrasts are strategic tools employed by participants to emphasise the logic and efficiency of transfer of nursing preparation into the tertiary sector. Their explanations are also important for the professional identity of nursing educators, which relates to the Foucauldian power/knowledge dyad and the gendered liberation accorded to the women who lead nursing programmes in polytechnics.

"Education as emancipation" is employed as a discourse by participants to suggest that their appointments in polytechnics gave them significant degrees of power, authority and status. But at the same time, being employed in the mainstream tertiary sector presented problems and constraints to the participants that perhaps they do not believe they would have experienced had they remained within the culturally sanctioned, nursing-specific and women-dominated hospital schools of nursing. The multiplicity of freedoms and constraints, which promoted the development of a sense of comprehensive nursing programmes as a legitimate form of education and preparation for registration, are indicated in the following comments.

*I do find sometimes a similarity of thinking in [nursing educators]. Now I am not actually saying that in a derogatory comment about the [particular education provider] but I think that very often [nursing educators] who have completed the same course of study tend to view things in a similar way.*

(Rachel, 723-)

**DW:** Are there things that have changed in the education system which have affected what has happened in comprehensive programmes?

**Delia:** Well putting us into it, number one. Where you actually got into an educational mode, and you did link theory to practice, you did have people not only with a focus in nursing, but with education skills, and adult learning and teaching skills, and so we created another profession for us. ... The polytech system ... was heavily male dominated, heavily vocational, and this whole influx of women came in and altered the dynamics. But it was very positive as well, for teachers, for female teachers to begin working with male teachers and to work with other vocations. I mean I think that really helped nursing. I mean, we ended up knowing we were good, because we had a reference point, which we had not had before, and
I think that always enthuses people. I think we came in and took polytechs over by storm. I know that in this school when you used to have institute-wide promotion rounds, we would be more successful than any other area. And with ease. We had never had a reference point to reinforce ourselves like that, and I think it was very positive.

(Delia, 1447-)

My reading of the first comment suggests that Rachel viewed a particular form of further education that nursing educators have engaged in might serve to limit rather than broaden their knowledge base. She simultaneously acknowledges the value of tertiary education for nursing educators, while offering a criticism of the uniformity of knowledge shared by members of the profession.

Delia’s comment also alludes to a complex interplay of identities between professionalism and vocationalism. She explains that the polytechnics had been vocationally orientated even though they were sited in the education sector, yet there is also an implication that nursing had been vocationally based while in the health sector. Once it transferred into polytechnics, nursing’s vocational identity became unclear. In one way, for example, nursing educators have been understood to have attained a professional status by working alongside - but also by being perceived as potentially more sophisticated than - their vocationally oriented teaching colleagues. But in another way, nursing vocational status was confirmed by the appointment of CNEP in the polytechnics, as opposed to the universities or even teachers’ training colleges. This ambiguity reveals the complexity of shifting meanings and semantics about the use of terms such as “profession” and “vocation” within the post-compulsory education sector. This aside, to return to the discourse under review, I believe that Delia’s comment refers to the ways that education has posed opportunities for emancipation to comprehensive nursing educators, students and graduates of CNEP. By these comments I am drawn to consider the ways in which education can operate as a constraint and a harness to people’s potential emancipation.

We wrote to Nursing Council, and asked for some guidelines. [They] wrote back and said ‘Just make sure you have got the 1500 hours
clinical.... And that's all we got”.

(Helen, 425-)

The criteria that was set down was quite specific. Three thousand hours spread over three academic years, and it was suggested that the curriculum should comprise about 50% theory and 50% practical/clinical work. There were designated responsibilities for clinical teaching and assessment and so on. People also had to meet conditions set out in legislation in regard to the registration of nurses in this country. Now that was quite interesting, I think the Nursing Council wasn’t really sure how to proceed... In reality the Council didn’t want to be too prescriptive. But on the other hand it saw itself as having a statutory obligation to ensure that people were safe to practice. I think they went light on telling us exactly what we ought to do, apart from being comprehensive and some general things that were set down. But they would catch us out or check us while making sure our students sit the examination. .... They were pretty reasonable, they didn’t interfere grossly, but we had to report to them [in great detail].

(Cathy, 812-)

The above comments by Helen and Cathy capture the complex nature of freedom and autonomy that was faced by the senior nursing educators of early comprehensive nursing programmes. While their freedom could be empowering, the lack of direction also challenged nursing educators to set up programmes. The potential for failure or rejection by the Nursing Council reconstructs this educational freedom into a constraint.

Nursing educators’ talk can be read for the discourses they employ to make sense of their experiences, but at the same time, the discourses should also be understood as constructing the nursing educators themselves. In terms of discourse analysis, this is an important consideration: discourse remains a constantly renewing and renegotiating process. One way of exploring this is to consider the ways the women have reflected upon their career in the nursing education sector. Most of the women I spoke to expressed the opinion that their involvement in CNEP had afforded them opportunities and freedom to develop careers within and/or beyond nursing education. This ranged from comments about the better pay and conditions for nurse educators in the polytechnic system compared to salaries offered to hospital clinical or teaching nursing staff, to the
potential for advancement into senior positions of responsibility and authority in or outside the health or education infrastructure. The comments made by a number of participants who had advanced through administrative and/or academic ranks in the education sector is a significant indication of how education represented an opportunity for nursing educators to assume positions of power and authority.

*When I [was a hospital nursing educator] there were only two steps for a nursing educator's salary. When I moved [to Polytechnic] ... there was a career structure and the salary was higher.*

(Rachel, 759-)

*Nurses... were taking a leadership role, not only in leading the nursing but in the polytechnic activities. And it's fascinating how many nurses have moved on through to very senior positions.*

(Liz, 775-)

*[I took on a new role because] I had been [a senior] nursing educator in the Department for [so long] I was actually [preventing] my staff [potential promotion]. ... It was a huge step, but I could see things that needed doing. If you've got a bit of ambition, I think you do a wee bit of climbing.*

(Helen, 2056-)

A group of participants offered accounts of how their employment as nursing educators facilitated their promotion into roles where they continued to influence comprehensive programmes in various ways. In other words, they sought to attain increasing positions of status and power to potentially advantage the development of CNEP while advancing their own careers and personal development. The participants who remain silent on this issue were perhaps more content to seek positive changes in nursing education at a site-based level, and through face-to-face interactions with their nursing students.

The decision to site comprehensive programmes in the tertiary sector provided expectations as well as opportunities for the participants and their colleagues to pursue educational qualifications. Although the extent and ease of access and support differed between locations and the particular administrative regimes in each setting, the women most commonly depicted their ongoing tertiary study as being both professionally and personally rewarding. Support from the then
Department of Education and/or the polytechnics for the participants' continuing tertiary education represents an indirect but equally important example of the ways participants employ discursive assumptions about how education emancipated the women themselves.

_The department has always had a very strong programme of supporting colleagues to do post-graduate nursing._

(Kate, 427-)

_The Department of Education supported nursing educators to do the Advanced Diploma of Nursing (hereafter ADN)… If they could do the ADN it was often the first step to further education because you got a thirst for education._

(Jane, 813-)

What Jane describes as “a thirst for education” encapsulates an aspect of the discourse of education as emancipation by regarding it as a positive, affirming strategy towards self-development. But they also employ it to mentor students about professional nursing characteristics. By modeling a continued commitment and openness to learning, the educators were mentoring their students to understand that they have a professional obligation to continue education at post-registration level in their chosen discipline. In this way the women draw on education as emancipation to construct themselves as nursing educators. It also reveals much about the common values upheld by nursing educators about their unifying sense of identity within the education sector. According to Cathy:

_I think you wanted people who wanted to go on learning themselves, who were interested in that, who valued and had a commitment also to trying to translate that commitment across to students._

(Cathy, 540-)

Maria and Helen reflect on the same issue in other ways:

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2 The Advanced Diploma of Nursing was a one year course established to replace the national-focused Victoria University-based SANS from 1979. These diploma-based programmes were originally offered at Auckland, Wellington and Christchurch Polytechnics and developed through other locations at later dates (New Zealand Department of Health, 1988: 28).
I think that as a group, we in the school of nursing did see ourselves as educators. We saw ourselves as nurse educators, and that our purpose for education was nursing and nurses, but that was our job. And that wasn't a universal perception of people who ran or taught in the polytechnics as far as I could see.

(Maria, 1146-)

We could all see the writing on the wall, and so when we employed people, I used to say to them, "there will be an expectation" [of pursuing further study]. ... Only one refused to do any, and she didn't actually last terribly long, because she got left behind, to be honest. Because you can't teach in a comprehensive programme unless you broaden your own horizons.

(Helen, 2040-)

While broadening horizons may have been a particular motivation for an emphasis on credentialism under a liberal model of education, more pragmatic incentives also existed. A fundamental assumption throughout the tertiary sector relies on educators having qualifications in their chosen field of at least one level higher than the students they teach. Quite simply, nursing educators needed to have more extensive credentials than their students, comprehensive graduates and the majority of clinical nursing staff. So for example, when the CNEP shifted to a degree level course, nursing educators were expected to have Masters level credentials.

A more utilitarian motivation for the pursuit of credentials is also possible. This credentialism among nursing educators represents a legitimation strategy to justify the continued presence of nursing education, and more specifically nursing educators' advancement within the tertiary sector. This can be read though Helen's comment about "the writing on the wall". By legitimation, I am adapting the term from its usual meaning to that proposed by critical theorist, Jürgen Habermas. He defined legitimation as a "political order's worthiness to be recognised" (Habermas, 1976 in Habermas and Outhwaite, 1996: 248-250). I employ it to refer to an engagement in a particular course of action to demonstrate a commitment, and thus to justify personal and/or political advantage. In this particular case, I am suggesting that nursing educators might not have had a personal desire or interest in courses of advanced study, but would participate to secure their future employment in the field.
This reworking of the meaning of legitimacy contradicts the liberal discourse's construction of education as pursuit of interest and desire for knowledge to a more instrumental "means to ends" motivation for people to study. Yet this is precisely the reason I believe discourse analysis has been an illuminating method to explore the views of this group of women: Foucauldian and feminist analysis of discourse illuminates the connections but also the contradictions, ambiguities and alternative readings of particular discursive forms revealed through people's language. In what way and how they use language reveals much about the underlying discursive constructions of particular discourses in the context of Aotearoa New Zealand.

Helen's comment about the "writing on the wall" therefore suggests the resistance of some nursing educators to the need for ongoing qualifications. I understand the women's engagement with education as emancipation to portray their colleagues who were unable or resistant to continue formal learning as those who inevitably did not remain comprehensive educators for extended periods of time. These ideas reiterate the notion that education relates to emancipation for those, including the participants, who remain in nursing education, but I am left to ponder the attitudes of the educators I did not interview. I think it likely that some would query such expectations as associated with the assumption they considered dubious that extensive credentials correlated with excellence among nursing educators.

This viewpoint turns the discourse of education as emancipation on its head, by portraying successful nursing educators such as the women in my study as trapped into a pattern of constant educational pursuits by the pressures of credentialism in order to maintain employment security. It would also signify an alternative way of viewing the women who have left CNEP employment as emancipated, precisely because they abandoned the continuing cycle of credential inflation by their decisions or circumstantial reasons not to continue such educational pursuits. This issue of credential inflation and the pressure and expectations of nursing educators to engage in ongoing education as well as their educator roles is one I will return to in chapter nine where the discursive metaphor of heroism is reviewed.
Alternative research projects might explore the usefulness of nursing educator work for women who exited CNEP and moved into different fields of employment, or examine the level of pressure on nursing educators to engage in academic research in the current tertiary sector climate. But as a circumscribed qualitative research project I must limit my work to an exploration of the material I collected which is centrally concerned with an examination of the narratives and the silences of the fifteen women who participated in this research.

The strength of character necessary to advocate the merits of the comprehensive programmes amid the apprenticeship focused and medically dominated health sector, demanded that nursing educators be assertive and act in an empowered and confident manner. The self confidence necessary to support comprehensive staff and students constructed nursing educators as emancipated and potentially heroic. Here is yet another way in which participants draw on the discourse of education as emancipation. Cathy, Gwyneth and Helen offer comments about the need for strong-willed nursing educators who would be committed to the philosophy of comprehensive programmes.

[Nursing educators needed to] be strongly supportive of what we were trying to do, often in the face of criticism. You didn't want someone who was going to say 'Yes, yes, I'll do this' and then go into the wards and the ward sister said something, they'd go and do it, 'Yes, yes, yes'. I mean, fine, you wanted them to practice reliably and accountability and so on, but those people had to be committed to explaining the objectives of what we were trying to do. And how it was different. And not being apologetic for it... you were looking for people who were internally fairly strong.
(Cathy, 544-)

If I could identify one [quality] for those initial people, there was one above everything else, [it was] zealousness. Absolute commitment to what they were about. ... They really had to know why they were wanting to change. [They] had to believe passionately in what they were doing.
(Gwyneth, 1570-)

The participants are implicitly making connections between the development of comprehensive nursing and the presence of articulate, committed nursing educators who would advocate for the burgeoning programmes.
The effect on the education system was extreme, as far as that polytech went, because of the huge influx [with nursing programmes] and the women, women everywhere. ... There had been nothing in the polytechnic in the way of women, except for a few hairdressing and secretarial tutors who were very, very compliant women. And then we came in. I remember the [senior polytechnic administrator went] to a meeting in Wellington, and he had met [two nursing educators]. And he came back and I remember him saying to me so mildly, 'Are all nurses aggressive?' Because he'd met these strong women, who were telling him what he ought to do.

(Helen, 1304-)

The principal's image of nurses is implicitly grounded in a sense of tradition and passivity associated with a historical discourse of nursing as a feminine vocation. His question to Helen indicates that the principal interpreted the assertive demeanor of these nursing educators as "aggression". Underpinning such comments are the gender-related constructions of nurses as a women-dominated occupation which is out of place in the male-dominated polytechnic sector. Here too, the transfer of nursing preparation to the tertiary sector represents constructions of emancipation. Such generalisations represent examples of the complex ways in which nursing educators have sought, and been understood to assert power in the education sector. I see this as connecting a discourse of education as emancipation with a liberal feminist project. Here I refer to an aspiration to have women represented across the breadth of social, political and cultural institutions to allow women to compete on a par with men.

The ways nursing educators worked as a group in the context of the health and education sectors also helps construct nursing as a more emancipated, more respected and more empowered occupation in regard to social status. The comment by Rachel offered below, suggests one of the specific ways in which nursing educators worked for nursing, by making the connection between professional and industrial, and education and health sectors, explicit.

**DW:** Has there been a time in your career in nursing education where professionalism has been important? Where the notion of nursing as a profession has come to the fore?

**Rachel:** *The time when I can remember our talking about it a lot was actually to do with the 'Nurses are Worth More' campaign. There was a lot of debate about salary negotiations and the local action committee was*
primarily nursing educators. And it was interesting because as a group we weren't going to benefit from the wage negotiations. But we thought of it very much as a professional issue, that it was to do with the value accorded to nursing as a profession and to the status, the recognition of the professional. So it's ironic that it was an industrial issue that brought that to the fore.

(Rachel, 577-)

By indicating that nursing educators were not benefiting from the campaign directly, Rachel is proposing that she and her colleagues are exhibiting the characteristics of benevolence and collegiality towards their associates who worked directly in the health sector. It also reinforces the complex interrelationships between nursing educators’ identities as educators, and clinical nurses. This latter topic is discussed in greater detail in the next chapter in the section that examines the primacy of clinical identity. Industrial action also provoked Kate to re-evaluate her own perceptions of nurses.

We went through the first strike action in the region. [It] was quite hard, moving from what I had in my head, the ‘twin-set and pearls’ brigade, to take the strike action. ‘Because nurses are nice’. They are not meant to do those sorts of things.

(Kate, 639-)

The strike action represented a challenge to the underlying gendered discourse of “nursing as a feminine vocation” that has traditionally underpinned constructions of nurses and nursing work (Garmanikow, 1978; Wootton, 1989). But here too it is apparent that Kate’s reflection about nurses’ social status reveals her own changing values about how nurses should be understood as an occupational group. Through such learning, Kate recalls her own reflection on the discourse of education as emancipation, and reasserts the complex interrelationship between education and the emergence of professional identity amid nursing educators. The complex ways the participants interpret and deploy the particular discourse of education as emancipation sets up the circumstances under which a second discourse, legitimacy of difference, has also been articulated.
A legitimacy of difference

In a similar way to the valuing of education as emancipation, the construction of a discourse of “legitimacy of difference” underpins the ways in which participants have made sense of their work in CNEP, and their understandings of themselves as nursing educators. The specific articulation of this discourse comes from a comment offered by Anne.

**DW:** What were the values that you wanted to instill in nursing students? What did you take [from previous nursing work] and wanted to convey to students?

**Anne:** The ones that I came in with were all still intact. But now my analysis of them is much more sophisticated. Instead of being life styles, they became very closely associated with life choices. I [gained a] much more in-depth theoretical understanding of the relationship between identity, poverty and health. So what I wanted ... to teach [was] the legitimacy of difference. And nurses' roles in relation to that. And the role of the nurse as the power holder.

(Anne, 475- )

I believe that Anne is discussing her own enlightened understanding of the political context of nursing work through ongoing education, and her ambition to teach nursing students about the power relations that privilege nurses in relation to their patients. Anne is talking about teaching her students the importance of valuing and not placing judgements on issues of difference among the people nurses work with across the health sector. What I take her phrase “legitimacy of difference” to mean is that nurses need to uphold the principles of respect and equal rights to service and care regardless of potential individual difference — for example by age, ethnicity, gender, dis/ability, sexual orientation or socio-economic status. This discourse is relevant to both the health or education sectors, and is tied up with an awareness of power that, unless challenged, inevitably benefits the dominant members of society while disadvantaging minority groups. Important values that may emerge in regard to a discourse of legitimacy of difference might include the belief that nurses should be respected equally with members of the medical profession. Through a variety of strategies, a discourse of legitimacy of difference can be understood to support the legitimacy
of comprehensive education as a rational and effective alternative to traditional hospital-based nursing training.

This discourse emerges in a variety of ways through the participants' talk. While some nursing educators explain the importance of critical and empowered forms of nursing practice, others demonstrate the ways they have worked to maintain respectful relationships with health sector colleagues who showed hostility to representatives of the CNEP. So while it manifests in different ways, I believe comprehensive nursing educators share an engagement with the discourse of legitimacy of difference. The nursing educators' talk attends to the ways implications of legitimacy of difference have been employed to challenge traditions upheld in the compulsory education sector and society generally, and how the discourse intersects with poststructuralist theory to pose new questions for educational values.

Challenges to the authority of Dewey and Freire have been based around the failure of such education programmes to value heterogeneity between students' identities and their differing learning needs and interests. Of particular interest to my research are feminist critiques of Deweyian and Freirian educational theses for their inadequate representations of gendered power and inequalities (for example Boler, 1999; Coben, 1998; Maher, 1999; Weiler, 1991). Feminist criticism has highlighted the importance of issues of legitimacy of difference making it an important consideration of the liberal education discourse, and a potential challenge to the valuing of education as emancipation. By appreciating and even celebrating difference, the traditions of a meritocratic philosophy of educational performance and of separate education for people with physical and/or intellectual disabilities within the compulsory sector are critically reevaluated (Slee, 1998).

An important development in liberal feminist thought has been the challenges made to the presumption that women can be understood as a homogenous group. Feminists with minority group identities - whether by ethnic, racial, (dis)abilities, class and sexual orientation – have demanded that feminist theories take into account the heterogeneity, and lack of generalisability between women. Such challenges within feminism have emerged since the mid-1980s throughout the
west, and in the New Zealand setting in particular (Fraser, 1997: 177-179; Jones, 1991: 91-92).

In the context of this country, a renaissance of Maoritanga and increased evidence of the educational and health inequalities between pakeha and Maori students over these years, further raised the awareness of the need for institutional reform. In combination, these social movements have elevated the valuing of legitimacy of difference and in the next section of this chapter, I will demonstrate this idea through a variety of comments by nursing educators.

A final issue concerning a discourse of a legitimacy of difference concerns its origins in poststructural education theory. Through a questioning of meta-narratives, the legitimacy of any coherent form of theory, including various feminisms, are questioned, as are the understandings of a unified subjectivity. Instead, post-structuralism challenges the fracturing of such wholes and the challenges to knowledge based upon traditional organisation of language have offered new ways of understanding the world and the place of people within it (Weedon, 1999: Chapter 1). An example to illustrate this point is the relative importance of multiculturalism and biculturalism as educational paradigms. A modernist sense of legitimacy of difference would regard multiculturalism as an unproblematic valuing of various cultural groups and identities as equally worthy of consideration. Within the particular context of Aotearoa New Zealand, understandings of multiculturalism might be considered of less value than bicultural models of education. But fundamental questions of power distributions between Maori and pakeha, and a recognition of the Treaty of Waitangi as our country’s unique founding document, make an orientation to a bicultural educational paradigm more appropriate in this context. What I am suggesting is that legitimacy of difference does not uncritically value all issues equally, but takes issues of power and other contextual variables into account in valuing judgements. I believe that the nursing educators’ upholding of a discourse of a legitimacy of difference has prompted unique forms of teaching practice and interesting characteristics across the CNEP.
The network of comprehensive nursing programmes throughout Aotearoa New Zealand has been characterised by the ways in which they differ from each other, as much as the ways in which they share the common goal of working to prepare students for comprehensive nursing practice. By the organisation of curriculum delivery, by teaching styles and even by theoretical foundations, the programmes are valued by the participants for their alternative interpretations of preparation for comprehensive registration. The following section examines the legitimacy of difference discourse as it imbues the organisation of CNEP and as it is engaged by participants in regard to the identities and subjectivities of nursing educators and their students.

**Differences between nursing education programmes**

The ways the women talk about pedagogical practices share a similar valuing of difference and a questioning of traditional models of education. For example, Beth explained that she felt that ways of teaching in comprehensive nursing education should be different from those strategies employed in university settings.

**Beth:** ...*I could also see that around me at the university some of those learning environments weren't too good, and that there must be a better way of doing that.*

**DW:** Can you give me some examples of what you saw at university and how that affected what you wanted to do in comprehensive programmes?

**Beth:** Well, a lot of teaching at university is still a lecture type thing, with not a lot of lateral thinking in terms of how to lighten it up and to make it interesting. Which is OK for adults, but if you are dealing with adolescents and teenagers, you have to hold their attention and you really need to make it interesting for them. Anybody could go and read a book. If you don't use your own communication skills and dynamism as an individual person to get the information across, I mean even someone doing a straight lecture can either be boring or very good. It doesn't mean to say that it is good or bad, it just means that you have got to keep the focus on that communication.

(Beth, 691-)

The emphasis Beth gives to communication represents another form of innovation and reflexivity that the nursing educators interviewed employed in these
programmes. Such initiatives can be understood to provide comprehensive students with positive professional examples to emulate. At the same time, the way Beth portrays her efforts to change systems of pedagogy constructs her in an heroic and pioneering role, which I explore in greater detail in Chapter Nine.

In the clinical sphere too, the participants can be understood to value the legitimacy of difference in relation to comprehensive nursing knowledge. Comprehensive nursing educators taught students how to understand and “perform” nursing work in differing ways. Participants prioritised being able to teach students the principles of nursing over the routines and procedures that had been relied upon, and even celebrated, in hospital-based nursing training. An interesting example of this is the task of bed-making, which two participants explained in the following ways:

*The [group] of us who set [the programme] up had all been trained in different places. And it just so happened that the first thing we taught the students was how to make a bed ... And we all taught them a different way... When we hit the hospital, one of the supervisors who was a bit of a tartar anyway just hit the roof to all of those students. She just tore strips off them, because they were to make beds [the specific] hospital way. ... We saw it as a principle, and we wouldn’t give in ... because those things are not important.*

(Helen, 451-)

*The thing I wanted for them more than anything else, because I knew you could teach a monkey to make a bed, was that they would break out of the mould... They would break out of the narrowness of it all.*

(Helen, 741-)

*[Moving between hospitals] ... brought home to me very quickly what were the underlying principles, because every place makes beds slightly differently, ... So I internalised that very fast, that it’s about principles that transfer and what you internalise, not a right way of doing something.*

(Kate, 1174-)

These examples suggest that the women used a discourse of legitimacy of difference to construct this as a value within their subjectivities as comprehensive nursing educators. Such a sense of self clearly originates in perceiving themselves to be different from teachers in the single registration nursing programmes. By
this I mean that traditional hospital schools of nursing would have been expected to teach specific nursing routines and practices because of their obligations as paid hospital employees. Without any direct affiliation to any particular health care providers, nursing educators in the comprehensive programmes had the freedom to teach principles and concepts, rather than specific nursing routines or procedures. Such comments also reflect the prioritising of knowledge as the foundation for nursing subjectivity and from which particular nursing skills can be acquired. This freedom reflects the orientation in the comprehensive programmes to equip students for flexibility of nursing practice across an international range of health care settings.

On further consideration, there is much irony in the example that Helen recalls concerning teaching students how to make beds. In the holistic and health-focused orientation of comprehensive nursing, the patient-centered rather than task-focused approach to nursing work and the importance of knowledge over skills are contradicted by the valuing of bedmaking as an initial aspect of student learning. Indeed, the women’s comments open up an enormously complex field of ambiguity in the development of CNEP, namely the enduring historic discourse of nursing as secondary sector clinical work. This will be discussed in more detail in the next chapter as “primacy of practice”. It also suggests that nursing educators were keen to demonstrate that they were teaching their students differently from those taught in hospital schools, but only to a limited degree. If the students had entered the clinical arena without knowing how to make a bed, the negative reaction from staff to their teachers and themselves could have been even more hostile than has already been indicated by the women. The ways that participants negotiated the complex relationship between the rhetoric of comprehensive nursing philosophy and clinical access to the health sector becomes evident.

Annette Street offers a brilliant analysis of the symbolic and literal meaning of bedmaking in clinical nursing work. She employs a Foucauldian analysis of disciplinary power to deconstruct bed-making as a site where nurses are subject to surveillance, control and physical discipline. From this critique she suggests that bed-making is an important component of nursing practice that nurses should critically reflect upon (1991: 14-15).
In the context of Aotearoa New Zealand, respect for alternative approaches to comprehensive nursing education is an important way in which the participants demonstrate their engagement with the discourse of legitimacy of difference. The comment below exemplifies the ways power relations can reveal assumptions about the legitimacy of difference amid comprehensive programmes:

*I think that the flavour of each polytechnic very much came out of the beliefs of those initial nurse educators. Particularly the most senior staff. But that first group of nurse educators influenced the way the curriculum was developed [and] influenced the values that underpinned it.*

(Gwyneth, 943-)

Here Gwyneth reflects on the uniqueness of the programmes offered nationally. The participants most frequently attributed these differences to the senior polytechnic nursing educators' interpretation of what nursing programmes should comprise. Such autonomy reflects the relative power and autonomy senior educators were given over some of the characteristics of programmes developed. She went on to explain:

*The fifteen programmes were very different. They have all got their unique flavour. [They] are all autonomous, producing people that can work together in the workforce and [they] are doing it all differently, [they] all have slightly different emphasis. [Some] are very strong culturally, others have developed really unique ways of being, and it's terrific... that's really exciting. Whereas with the old schools of nursing we came out very much the same. Very much more, 'This is the prescription, thou will teach this' and the textbooks we used. And the innovation and the different practice models, the different ways people are. It goes back to that professionalism, doesn't it? Recognising the knowledge base, recognising research as a component, all of those things. And encouraging practitioners in the workforce to think a bit differently.*

(Gwyneth, 1004-)

The second form of difference that Gwyneth describes is the varying ways in which students were prepared for registered practice. There is a sense of celebration in her comment, where she suggests that graduates who have been
trained under differing philosophical paradigms can be equally effective nursing colleagues across a range of employment settings. This reaffirms the assumption of legitimacy of difference as a positive characteristic of comprehensive nursing. Not only does she then relate this to ideas of professionalism through excellence in critical nursing knowledge and practice, but she further explains the value of difference by reference to the traditional hospital-based nursing. My reading of Gwyneth’s comment suggests that in her opinion, hospital schools of nursing programmes were less effective sites for nursing education, and that in part this was because of their perceived “same-ness”. She further alludes to a juxtaposition between comprehensive nursing, which she deems professional, and hospital programmes that by implication were not. Finally, her desire for nurses to think differently also reasserts this underlying discourse, by constructing nurses as professional by questioning traditions and reflecting on nursing knowledge in different ways.

Engaging a discourse of legitimacy of difference can be understood to have prompted the following comments about how outsiders responded to the establishment of CNEP. An analysis of the women’s talk reveals their expectation that outsiders would uphold a similar value and give respect and acceptance to developing CNEP and the people working in them. Nursing educators who chose to enter the comprehensive nursing workforce most commonly portrayed their shared sense of legitimacy and respect for alternative forms of work and education. In contrast, their recollection of responses from colleagues who remained in the clinical sphere suggests a construction of disloyalty towards those who embraced the changes in nursing education. This was particularly apparent in the years prior to the 1980 decision to permanently establish polytechnic-based programmes (New Zealand Department of Health, 1988: 17).

You were caught in this dilemma. ‘You are one of us. What are you letting us down for? You shouldn’t be involved in this’. Because I trained there and I had been a nursing educator there and I knew my way around the place. You had the feeling that you were a bit of a traitor. But then other people would say, ‘Oh yeah, but you know, she’s always been different anyway’.

(Cathy, 549-)
This accusation shifts between her colleagues dismissing Cathy as disloyal to her former employer and *alma mater* (and her concurring with this idea, by feeling like a traitor) and the idea that she had never been a legitimate member of the hospital based programmes. By embracing the new form of nursing preparation the sense of Cathy’s disloyalty is dismissed as a manifestation of her “difference” as understood by her peers.

While Tracy has previously commented about her aspirations to a Freirian liberatory model of education for women, she commented on her reaction to women who regarded comprehensive nursing education with hostility.

*What I found was that for many feminists, nursing was not even in the running. ... I was absolutely shocked. There was a woman who was the only senior staff member who was known to be a feminist and leading this whole thing but she was the person who gave us the hardest time. ... I don’t think those women at that time really saw in a feminist context what the position of nursing is, or was. ... There’s still this invisibility of nursing to everyone.*

(Tracy, 536- )

This demonstrates the complexity of feminist history in the Aotearoa New Zealand context. While nursing educators such as Tracy, who upheld liberal feminist values, were working to attain greater access and power through the field of nursing work, more radical feminists dismissed all forms of nursing as a feminine and submissive occupation that should not be supported as a feminist project. Such clashing values represent one of the forms of horizontal violence that has characterised the efforts of participants to establish comprehensive programmes as a legitimate and liberatory form of education.

*We had made such a feature of the failings of the current system that many people took it as a personal criticism of them, because they were products of that system. And as often as you said ‘the system was a good system for the time... but the context has changed so much that it is no longer adequate’ ... So there were many people that were hurt, defensive threatened. ... And there were many people who truly... wanted it to fail and expected it to fail.*

(Maria, 725- )
With this comment, Maria is reviewing the consequences of nursing educators who failed to employ a discourse of legitimacy of difference to respect hospital board training programmes, and suggests that this dismissal prompted negative responses from health sector staff. I want to signpost this as one of the most important ways power was played out between comprehensive and hospital-based nursing training as they continued to run concurrently for sixteen years after comprehensive programmes were piloted. The women’s comments about the traditional model of nursing preparation are imbued with a respect for the difference and students’ free choice for one form of education or the other. While they would explain to me the reasons why nursing preparation needed to transfer, most often their criticisms were leveled at the conditions under which hospital teaching and student staff had to work. Yet many health sector staff interpreted judgements about their colleagues or their own hospital-based preparation as personal and professional slurs, and consequently resistance to CNEP staff and students continue.

It is important to reflect on the language the women employ to construct a sense of their subjectivities as nurse educators and in regard to the programmes more generally. My analysis indicates that in efforts to legitimate the qualities inherent in their own educator practices and in the comprehensive programme of nursing preparation, the women inevitably rely on dichotomies of positive and negative qualities in CNEP and hospital-based preparation. In particular, there is a characterisation of hospital-based programmes as developing a constrained and uniform construction of nursing epistemology. At the same time, CNEP are depicted as unique, independent, and offering students and staff an emancipatory educational experience. But as Helen and Cathy have explained, CNEP were similarly constrained by Nursing Council monitoring, and the hospital schools of nursing had significant independence and autonomy attributable to the supportiveness of their employing hospitals. Clearly, any comparison between the traditional and new forms of nursing education are more complex than any general negative or positive comment could illustrate. But my point is that the nursing educators employed such a binarised model to successfully account for the relative qualities and calibre of the programmes they were employed to develop.
Diversity among nursing educators

Whether valuing difference among nurse teaching staff or seeking to develop a cohesive and like-minded staff, the participants demonstrate an engagement with a discourse of the legitimacy of difference. Cathy offers the following comment:

\[\text{While you're wanting people with expertise in particular areas, you also tried to get people who had innovation. Who maybe were known to be a bit rebellious, a little bit different... you don't want clones of yourself..., you really want to build a mosaic. You want to get a variety of strengths that together contribute, rather than the strength of any one being outstanding.}\]

(Cathy, 513-)

\[\text{You had to know what you were looking for [when employing nurse educators]. ... They might be highly skilled clinicians but not terribly good innovators and educators because of their fear of change. And that's OK, but you have got to balance the positives and negatives of staff so at the end of the day you will have every one of those potential attributes and skills somewhere in the mixture.}\]

(Beth, 1263-)

\[\text{... [we] wanted to achieve a reasonably harmonious group of people, because they were going to have to spend a lot of time debating and arguing. Not necessarily from the same philosophical base, but [if there was] one nurse educator that was going to be way off base, that was going to be really hard for the department.}\]

(Gwyneth, 1597-)

This sense of difference as something actively sought among staff are in marked contrast to the view held by Olivia and Tracy. For example:

\[\text{In looking for staff we looked for people with the same philosophy for the comprehensive programmes, even though [some] came from the hospital-based programme. ... I used to send out our philosophy, and our objectives to [employment candidates] so that they knew what we were about, before they even applied. And if they couldn't come to terms with that, then they didn't apply.}\]

(Olivia, 725-)
Everybody that was there in that polytechnic in those first two years had some kind of vision of what nursing education was about, and it was fairly consistent.

(Tracy, 259-)

The differences between the comments above suggest that both the relations of power and the personal subjectivity of the nursing educators themselves have been informed by a consideration of diversity. The range of qualities of the people appointed to the initial nursing programmes in polytechnics varied between leaders of programmes. Gwyneth, Beth and Cathy sought to employ a group of teachers who would give strength to their programmes through their unique and diverse qualities and skills. For Olivia and Tracy the antithesis was true: the greater the cohesion between departmental staff, the more effective the programmes could become.

Diversity among students

The belief in a discourse of legitimacy of difference has also been employed by nursing educators to discuss their views about selection of CNEP student candidates. Undoubtedly this discourse also reflects the educators' awareness of the importance of having nurses from across the diversity of Aotearoa New Zealand society to match the universal impact of health and illness issues across the nation's population. At the same time, there is a reiteration of the liberal model of education associated with this, namely that potential nursing candidates are entitled to an equality of opportunity to achieve the status of registered nurse. Such priorities are underpinned by a vocational discourse, whereby those who have an ambition to nurse should be free to embark on such a career. The women's talk suggests an implicit understanding of the educational processes, such as the hidden curriculum and hegemonic strategies that can make it difficult to attract and support students who are different from the mainly young, middle-class, pakeha women who traditionally dominate nursing in New Zealand (Clare, 1991: 10).

[At one period] ...positive discrimination was practised in selecting nursing candidates. My experience of that [was] being 'in the middle'. On
one side were parents who were still more comfortable with nursing as a career for their daughters, and on the other education administrators wanting to improve statistics about the socio-economic status of students.  
(Rachel, 1114- )

One of our students was pregnant and [a fellow nurse educator] was looking for me to give her the walking ticket. I looked at [my colleague] and said, 'Well, why should she lose her place in the course? The father of the baby hasn't lost his'.

( Olivia, 2245- )

We didn't have many Maori or men in our courses so [we developed] strategies to attract and give them a head start in nursing.  
(Liz, 906- )

These examples demonstrate the variety of ways in which nursing educators have sought to support the diversifying of nursing student populations. In the example given by Rachel, I take her comment about the administrator's wish to "improve" statistics by gathering a range of socio-economic status (and ages and ethnicity, and male) students to demonstrate the institution's valuing of diversity. This might also be behind the motivation of the initiatives mentioned by Liz. Olivia's comment offers another example of her engagement with a liberal rights discourse by valuing the equal entitlement of a woman to continue her course of study regardless of her pregnancy and impending motherhood.

Very few of the participants offered comments concerning the recruitment and identity politics of their groups of nursing students. I do not consider this to be a significant issue, for example that it suggests a narrow expectation about the identities of nursing candidates. Rather, I believe the women's lack of discussion reflects the challenging conditions in which they worked to develop CNEP. For example, the lack of public awareness and support for the programmes, the concurrent offering of apprenticeship programmes for many years, and the strength of suspicion about the ability of CNEP to prepare nurses for practice, meant that over the first decade or more, recruitment was centrally concerned with obtaining adequate numbers of appropriately prepared applicants. Only when programmes were more established, accepted, and had a monopoly on the education of
Discussion

Having reviewed the deployment of these discourses, I am suggesting that the women I interviewed have explained their work in nursing education by drawing on the discursive constructions of “education as emancipation” and “legitimacy of difference”. As I have shown, the two systems are interrelated, in that they are both core components of a liberal democratic educational discourse. These values can be understood as a legacy from the popular educational and feminist movements of the 1960s and 1970s, precisely the years when the transfer of nursing education was first proposed and developed. The complex and sometimes contradictory ways that the participants have drawn on each discursive form are a reminder that discourse analysis illuminates the unstable and changing ways people construct meaning through discourses. In developing this thesis, I will explain not only the positive reasons why they sought change, but also how they explained flaws in education for nurses prior to the introduction of CNEP. The following chapter examines these issues in detail.
Chapter Seven: The Primacy of Practice and Experiential Reasons for Change

This chapter considers two further characteristics that frame the work of professional comprehensive nursing educators. The first of these deals with the importance of clinically-based “hands-on” nursing work in the women’s narratives, “the primacy of practice”. This discourse values the acquisition and demonstration of clinical nursing skills in the secondary health care setting. The second discourse examines the participants’ accounts of the logic and necessity for a transfer of nursing preparation into comprehensive programmes from the traditional hospital-based model of nursing training. It draws on the women’s experiential knowledge, dominated by experiences of their own studentship as well as their registered nursing experiences. I have chosen to refer to this discourse as “experiential reasons for change”. These two discourses are presented together because they each focus on the performative qualities of nursing work and their implications for the organisation of, and approach to, pre-registration nursing education.

The Primacy of Practice

A sense of the primacy of practice is a strong value I hold. It is that the whole educational process is there to support the staff nurse. So everything we do in a nursing programme should be relevant to facilitating the work of the person who is going through the socialisation process to become a nurse. And unless it is relevant to their practice, it is not worth doing.

(Emily, 210-)

In utilising Emily’s comment as a participant-generated discourse, I understand that she is speaking about the breadth of nursing practice - from primary to secondary care - and across the range of sites where nurses work with patients. My focus is on the more specific range of nursing practice which is concerned with nurses’ work with people who are unable to care for themselves due to ill-
health. This is because I believe that the health sector remains dominated by an implicit valuing of forms of secondary clinical nursing care involving physical performative forms of work (Lawler, 1991, Chapter 3). This clinical practice is most commonly situated in the secondary care context, in publicly funded hospitals and other institutional settings, including private hospitals and clinical suites where acute nursing interventions make immediate benefits to patients’ health. It also covers the range of secondary care settings, from medical-surgical fields to nursing people with psychiatric or intellectual disabilities. Such a discourse places lesser status on the forms of nursing work that are rehabilitaton and/or wellness focused. Examples of such nursing work include primary and preventative health care, wellness-based education, research, management, administration and classroom-based delivery of nursing education.

Of central importance here is the women’s utilisation of a discourse of primacy of practice to account for, justify, and legitimate the alternative CNEP model of education. The discourse itself has its origins in historic constructions of nurses as feminine carers of the physically ill that date from the time of Florence Nightingale’s establishment of formal nurses training (Baly, 1986). A primacy of practice is a logical and rational response for educators to use to explain the efficacy of comprehensive students to become excellent clinical practitioners. This is because practice remains the primary role of nurses. The irrefutability of nursing as a practice profession and the need for skilled and knowledgable nursing practice represents a Foucauldian “regime of truth” (Foucault, 1980: 131). The women’s employment of this discourse can therefore be understood as politically strategic by appealing to stake holder groups that CNEP were fundamentally concerned with the same qualities - specifically hands-on nursing skills - as those associated with the traditional hospital-based programmes. My analysis also suggests that a primacy of practice discourse simultaneously constructed the subjectivities of the participants themselves, in differing ways.

In searching for the origins of primary valuing of clinical skills, it is important to tease out historical connections between nursing and medicine. Since the formation of organised training of nursing in Anglophone countries and the formal registration of qualified nurses, there has been an implicit coupling of nurses’
work with those of the medical profession. Each promulgated the importance of the other, with nurses duty bound to carry out medical orders and the doctors responsible for the diagnosis and treatment of patients’ care which is monitored and maintained by nursing staff. As such, the perception that nurses’ work was contingent upon the directions of the medical staff has continually held cultural credence. This continues as the single dominant discursive construction in the understanding of what counts as nursing, just as our dominant discourses about health and illness generally are framed by a westernised system of medicine. In other words, the forms of nursing work which remain the most highly valued are centered around those where the medical profession continues to dominate the understanding of illness and health. I am suggesting that the authority of this discourse continues to imbue the ways the participants in my study made sense of their work in nursing education.

The convergence of a number of social, cultural and political factors precipitated the development of reforms in nursing education and work, most notably during the 1960s and 1970s. As I have mentioned in Chapter Two, the shift from illness to wellness-focused models of health care had become dominant in the post-World War Two period. At the same time, an increasing awareness of the potential flaws and failings of the medical system, and a concurrent discourse about patients’ rights began to be expressed. The second wave of the women’s liberation movement drew many women to reflect upon the variety of ways patriarchal relationships dominated their lives in the public and private sphere. Such consciousness raising encouraged nurses to challenge the assumed authority of medical staff over themselves and their patients, by obliging women to consider the power and authority in their work relationships.

As a result of these changes, there was a rejection of the narrow roles prescribed for nurses through their relationships with medical professions. Nurses began to theorise about the relationships they could develop with their patients in ways that could be independent of the medical epistemologies. The development of new systems of nursing emerged from the North American and British contexts, variously constructed through theoretical and institutional models of “the nursing process” as well as “primary nursing”, “patient centred care”, “patient
assignment”, “total patient care”, “progressive patient care” and the utilisation of “nursing diagnoses” (Allen, 2001: 11). The conception of nursing as a process rather than distinct tasks, the articulation of nursing epistemologies and an explicit patient-centred focus have served to legitimate nursing as a profession and as a fledgling academic discipline (ibid). In the British context, a generalised model premised on the nursing process has been named “New Nursing” (Salvage, 1992). The emergence of New Nursing co-incided with the reform of nursing structure, practice and education through an initiative entitled “Project 2000” (Allen, 2001: 10; Salvage, 1992, Witz, 1994). The “Project 2000” reforms were formulated in 1987, and involved the establishment of pre-entry nursing programmes in the tertiary education sector, in a similar way to the transfer that had been almost completed here. For simplicity, I conflate these theories under the umbrella title of New Nursing from this point on, unless specified otherwise.

Various styles of New Nursing centered upon the unique contribution of nursing work to the care of patients across the breadth of the health care sector. All rely on a fundamental partnership between nurses and their patients. In the Aotearoa New Zealand context, Judith Christensen’s “nursing partnership” model has offered a significant and culturally specific articulation of such a philosophy for the clinical setting (1990). More recently, Merian Litchfield’s exploration of the relationships between nurses and families who have chronically hospitalised children has developed a new and poststructuralist construction of nursing partnership, grounded in what she refers to as “practice wisdom” (1997, 1999). Such systems redefined the roles of both patient and qualified nurse, where the patients were expected to take an active part in working towards their own optimum health. At the same time, the nurse needed to plan patients’ care around their unique needs and strive to minimise the power differential between patient and nurse through a partnership model. New Nursing also sought to conceptualise a completeness of nursing where nurses would support patients by assisting them with their fundamental physical care such as hygiene and elimination needs, and to regard this as of equal importance to other forms of registered nursing work.

This paradigm challenged the hierarchical system of nursing where the most junior members of staff had traditionally been ordered to do the most fundamental
“dirty” forms of nursing work for all the patients in a unit (Allen, 2001; Mackay, 1992: 12; Wilson, 1998). Student nursing staff would gradually be promoted to “cleaner” work and leadership roles, where as senior students they would oversee the work of those less experienced than themselves. The qualified nurse’s role was focused around the management of the unit and the overseeing of the nurses’ work. By rejecting such hierarchies, individual nurses were accountable to their patients for all their care. These models also expected that nurses would work to meet the patients’ physical, emotional, cultural and psychological needs from a sound nursing knowledge base.

A major focus of this new construction of nursing has been the emphasis placed on patient advocacy. This not only included nurses working to educate and support patients in their own self care, but also concerned the promotion of the unique position of nurses to advocate for patients on the basis of the long term and intimate relationships developed from their caring work. The importance of the shift to patient advocacy models of nursing also lies in the repositioning of nurses in relation to members of the medical profession – instead of being duty bound to serve the needs of the medical staff, now nurses were aligning themselves to support their patients. This was interpreted by groups of medical staff as a threat to the dominance of doctors throughout the health care sector, as well as being constructed as promoting the negative assumption that patients required an advocate in their relations with them (Wootton, 1989: 9).

Since the 1970s when New Nursing began to gain cultural currency in the health sector, nursing has further developed by its articulation of nursing epistemologies through its emergence as an academic discipline and by the development of forms of independent nursing practice. Again, this development can be understood to threaten the sovereignty of the medical profession across the health care sector. This change in nursing culture, represents a paradigmatic shift, where nurses have increasingly drawn on health rather than illness-dominated understandings of their work. By staking the claim to a unique occupational and epistemological identity, I suggest that nurses have developed professional characteristics equivalent to their medically-qualified colleagues.
Before I review the construction of the nursing educators' sense of personal affiliation with nursing as a clinical skill, I will briefly examine the impact of locating CNEP within the tertiary sector. This is necessary because this, too, has influenced the participants' engagement with a discourse of the primacy of practice. Professional education programmes have traditionally been sited in universities, where a broad foundation of knowledge is acquired as a precursor to the acquisition of skills. Such is the case in the medical profession. On the other hand, polytechnics have been historically associated with the preparation of students for employment in skilled trades. The decision to exit hospital-sited schools of nursing and to assign comprehensive nursing programmes to polytechnics, destined the burgeoning comprehensive nursing development to an ambiguous institutional identity. By their siting in polytechnics, there was an implicit valuing of clinical expertise over academic knowledge. Yet by being part of the tertiary education sector, there was a concurrent elevation of nursing to the status of a legitimate field of study. The lack of clinical sites on campus obliged nursing students to travel back and forth between the polytechnic and local health care providers - where they were not as of right considered to belong - to gain nursing experience. The alternative in the education sector involved the provision of pseudo-clinical demonstration rooms on campus\(^1\). I believe that this lack of affiliation and belonging to sites of clinical learning and nursing work is an important component in the development of CNEP. The utilisation of the discourse of primacy of practice draws these issues together by considering how the participants reflect upon the complex interrelationships between "self as nurse", and "self as educator".

**Developing students' clinical skills**

Two of the most important pre-requisite qualities for the development of comprehensive programmes centre around the valuing of knowledge acquisition as the catalyst for emancipatory nursing practice. One of these is the notion that students should be equipped with a general and specialised knowledge base about

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\(^1\) The participants have used a variety of their local polytechnics terms for these spaces. In my efforts to maintain the women's anonymity I have chosen to reassign these areas the generic title of "clinical rooms".
a field of nursing prior to experience in any specific field of clinical practice (Department of Education, 1972: 7-8). The other concerns the valuing of a comprehensive knowledge base (and a formally sanctioned comprehensive nursing registration system) to promote holistic nursing care across the fields of medical-surgical, obstetric, psychiatric and psychopaedic nursing (ibid). Being equipped with such a knowledge base is generally assumed to optimise the potential for safe and excellent nursing care given by comprehensive nurses. These foundations integrate a health focus with traditional illness-based paradigms of nursing knowledge. As such, they demarcate the distinctions between hospital-based forms of nursing training and comprehensive programmes. The comprehensive nursing discourse of primacy of practice represents a potential for independent nursing practice that is complementary and of equal status to medicalised approaches to health care.

Comprehensive programmes have always been reliant on access to clinical health care sites in order for students to gain “real” nursing practice. This serves two interrelated purposes - to complement their increasing nursing knowledge, and to fulfil the requisite number of hours in health settings to be eligible for comprehensive registration. In this regard, there is a relationship of dependence between comprehensive programme staff and health sector authorities for student access to clinical sites. The participants reveal this in the ways they talk about the people who controlled this access and the related experiences of nursing educators and their students. Demonstrations of hostility, resentment and resistance towards the presence of comprehensive staff and students were explained by many of the participants. Foucauldian power/knowledge implications of these relations are considered in greater detail in Chapter Nine where I look at the employment of a heroic discourse in CNEP.

In the present context I examine the participants’ talk about the challenge they confronted in accessing pertinent clinical experience for students. This includes accounts of the context of the changing health care sector. Expressions of concern about the lack of opportunities for students to acquire confidence in clinical nursing skills have been shared by a significant number of the educators. Consequently, the women’s talk employs a discourse of the primacy of practice
but does so by explaining the extent to which the conditions demanded various compromises to this goal. In reflecting on the fledgling CNEP Cathy was working in, she recalled the following situation:

_The polytechnic facilities weren't designed for clinical rooms, [so] equipment-wise we had to beg, borrow and steal... My personal view was that when staff said, "Oh but we don't have this or that", I said "OK, but we've got the students out in clinical environments early, so let's use those clinical environments for teaching them". Now I have a different philosophy, in saying that there's certain basic skills training that I think ought to be performed: actual skills development._

(Cathy, 2230-)

In a similar way, Rachel offers the following memory:

_We had to organise our curriculum around resource requirements. In the first years we had one classroom, and the class was divided into two, half of them were in clinical and half were in class, partly because there was only one classroom. Half the class were out in clinical with no theory classes beforehand. And yet the principle was that people would not be in areas or required to do anything that they hadn't learnt about. [At that time] it was very much applying theory to practice, but it all got undermined because of resources._

(Rachel, 1032-)

These comments suggest an early compromise on the founding principle that comprehensive students would not enter "real" clinical settings until they had the appropriate knowledge and basic skills. As such, these comments contest the discourse of a primacy of nursing skills. I interpret both Cathy and Rachel's explanation of the use of clinical sites for teaching as a pragmatic response to the poor facilities provided for the first generation of comprehensive nursing students and educators. Yet it also contradicts the central premise that students would have learned nursing knowledge prior to their entry into clinical sites. Before I leave Rachel's narrative, it is important to explain the comment that immediately followed the above. She went on to say:

_I mean, the [theory into practice model] has changed, now we talk about generating theory from practice._

(Rachel, 1051-)
This signposts a significant shift in the pedagogical connections between theory and practice by understanding both to be interrelated and developing simultaneously. Further examination of these changing epistemologies is beyond the scope of this study, but I acknowledge the continuing critical review of teaching and learning strategies which characterise nursing education in the work of people like my participants. This field of research has been extensively utilised in Aotearoa New Zealand to construct new epistemologies of nursing practice (Litchfield, 1997; Papps, 1997) and nursing education (Booth, 1997; Clare, 1991; McEldowney, 1995).

The idea that participants necessarily compromised the rhetoric of a comprehensive model of primacy of practice in nursing education appears to have extended to issues around the duration and locations of clinical experience.

[The obligation to provide students with 1500 hours of clinical experience] turned us into liars [to allow a disabled nursing student to meet prerequisite standards in order to sit her final examinations]. Our biggest headache was spending too much time digging up clinical experience. It meant sending them away without nursing educators to supervise them. ... So we organised our courses around the clinical hours, instead of the clinical hours being secondary to the students' needs.

(Helen, 1620–)

The changing pattern of medical care, the technology, the science, the drugs, ... have changed ... the predictability of what you might find in the clinical setting .... And all of a sudden you could not necessarily guarantee that if you taught students something in the classroom they could necessarily go out and see it. So nursing education programmes had to structure it in a way that allowed students to take every possibility of learning in the clinical area, but not necessarily have a direct link between theory and practice, except in a very general way.

(Emily, 1083–)

Here Helen and Emily explain the compromises they felt forced to make in relation to their aspiration of a primacy of practice discourse. Polytechnic staff encountered problems of how to gain access to clinical sites when hospital-based programmes remained concurrent with comprehensive programmes, for example
in competing for student access to specialist sites such as an operating theatre. In
the Auckland region the establishment of three comprehensive programmes placed
increasing pressure for clinical experience, particularly in specialised clinical
fields. A further challenge to clinical access has arisen nationwide as a variety of
specialist health care professions based in the tertiary education sector also sought
to gain clinical experience for their students. Delia and Kate comment on this
issue.

The impact of direct entry midwifery programmes has meant nurses having
the traditional obstetric experience is pretty well non-existent. ... At the
same time the health delivery service for maternity care... changed
dramatically. So availability of clinical [experiences] became totally
restricted.

(Delia, 1289-)

Kate offered a similar comment:

In the early years, there was a big psychiatric hospital nearby, so getting
experience for our students was not an issue. The big institution is gone
now, [and] the number of in-beds is going down. So how do you provide
high quality mental health experience for these students if you practice
what you preach about practice in nursing? ... And with the Midwives’ Act,
what obstetric care is appropriate for comprehensive graduates to have
these days? ... The expectation that student nurses will be exposed to the
birth of a baby isn’t actually appropriate. You can teach them that on a
film or a video the key things that they have to know to be safe in an
emergency situation.

(Kate, 1718-)

Picking up on Cathy’s earlier comment about clinical resources within the
polytechnic, CNEP have traditionally included areas on the education campus,
which could be set up to mimic a hospital’s clinical area. The rationale for this
was to allow students to practise nursing skills in a simulated and safe context.
Clinical rooms have not been exclusive to comprehensive programmes as hospital
schools of nursing also provided “mock” clinical environments for their students.
But what makes CNEP clinical rooms particularly important is the reliance on
these spaces as the only place students could practice nursing skills in their “own”
space. Students could take turns at acting as patients to allow their peers to
practise safe patient lifting methods, and pieces of foam rubber or oranges could
be used for practising intra-muscular injection techniques. Classes would spend time practising procedures in these safe conditions under the supervision of nursing education staff. Some of the participants brought up the importance of these clinical rooms to students’ experiences, but they represented the usefulness of this in divergent ways.

Gwyneth and Liz employ similar values to Cathy’s earlier comment about the desirability of clinical rooms for facilitating student practice and ensuring patient safety. On the other hand, Emily expressed concern at the over-reliance on pseudo-nursing experiences.

*I think we should be recognising the clinical rooms more, and doing a lot more simulated practice where that is recognised as legitimate clinical practice... I think that [clinical rooms] have a role to play in demystifying things.*

(Gwyneth, 1085-)

*I think it is quite unethical that students learn on patients, particularly with technical skills, you have to get a level of expertise first. If you are in there trying to learn a technical skill, you can’t be addressing the personal things as well. So we had a very strong [clinical rooms] culture.*

(Liz, 449-)

Emily stated her concerns:

*I have seen students in clinical care settings do nothing but observing for weeks at a time, really not getting a chance to do clinical themselves, but those weeks counting as their clinical hours. Much less predictability in terms of application of theory into practice, and still making these amazing claims about this person that was going to come out of these programmes [because of their extensive clinical hours]. There is a lot more observation, and a lot more unsupervised practice in the [clinical rooms].*

(Emily, 411-)

Aside from their personal valuing of a primacy of nursing practice, it is clear that Emily’s utilisation of this discourse is embedded in the real context of a health care setting. Maria and Rachel explain that their emphasis on students engaging in the reality of hospital-based clinical contexts was a strategic response to
demonstrate to outside vested interest groups that CNEP students were focused on practice as well as theory.

_I personally didn't think our students had to be out in the clinical area in the first year, six months, three months. But I knew that it was absolutely imperative that they be seen out there._

(Maria, 1763-)

In an earlier comment, she had explained that there was a system of surveillance that effected the nursing educators' regard for clinical practice:

_We were very conscious every time the students went into a place where they were under the view of other nurses or other health professionals and patients, that if they appeared to be inept that was another marker against the programme and the whole concept, [as well as] the individual. So you were tempted to prepare them as much as possible for every eventuality._

(Maria, 625-)

A similar comment is offered by Rachel:

_It was so uncomfortable, I have to say my first years as a tutor were spent helping students fit in and not stand out. Which I don't like to say, but I think your values got watered down a bit in order to make life easier for yourself and the students._

(Rachel, 357-)

These comments represent a significant point of compromise between the rhetoric of a comprehensive educational model that valued knowledge before practice and the discourse of primacy of practice. The organisation of the programmes was, in reality for some nursing educators, partly a pragmatic response to the judgementalism of health sector professions and even the public at large. As such, these comments connect with literature offered by nursing education analysts. Antoinette McCallin, for example, develops a grounded theory of nursing educators' work which is premised on an awareness that comprehensive graduates are deficient in clinical nursing skills (1993: 5). Elaine Papps's doctoral dissertation offers a similarly illuminating review of the social resistance to cultural safety as a component of the nursing curriculum on the basis that this
curricular innovation resisted the dominant discourse which continued to value the primacy of clinical practice (Papps, 1997).

A final consideration of the primacy of practice emerges from the physical challenges for CNEP staff and students by being located in an education, rather than a health sector context. Jane, Cathy and Helen offer quite different but related comments which indicate that geography played an important symbolic and literal challenge to the programme’s legitimacy and success.

[A doctor who was very supportive of comprehensive nursing] was very hot on the idea that polytechnics should have a tutors’ office at the hospital and that it should be labelled. I used to think it’s not really necessary, but now I see the wisdom of what he was saying. It’s making an identity for yourself as a profession. It is important that nurses identity themselves as part of the health sector in a very physical way.

(Jane, 181-)

**DW:** How did the medical profession perceive the transfer process?

**Cathy:** ... *There were misperceptions, anxieties and tensions.* [That were influenced by] the fact that Polytech was down [the end of the city], it was a trade school where the not-too-bright people went at night, to night school. They didn’t understand that it had undergone change. And the majority of medical people had never been near a place like that. So taking nursing out of the inner sanctum of the Hospital and putting nursing activities down in that horrible old place ... added to the perception of [CNEP] being entirely inappropriate.

(Cathy, 257-)

[The lack of] tradition [in the CNEP] was very interesting. *In the hospital programme there was this incredible tradition.* You did things for the class that was coming on behind and the class that was graduating. ... These students had no tradition, they were new to the system and they had nothing to go on ... It was really about belonging. They were like fish out of water, they didn’t know where they belonged, whether they were nurses that belonged to the local hospital, whether they were nurses that belonged to the community, or what.

(Helen, 851-)
For Jane, the lack of physical space in the health sector was a significant cause of the struggles CNEP staff and students experienced, while for Cathy, the poor geographical and social perception of the regional polytechnic was particularly symbolic. In Cathy’s view this physical location was detrimental to the medical profession’s acceptance of the transfer of nursing education away from the health sector. Helen’s comment is different, given her reflection about the powerful connections between nursing students’ self image and the lack of iconographic traditions in the new programmes. In these comments, the discourse of primacy of practice is configured in ways that demonstrate the powerful influence of physicality on nurses’ subjectivity and identity.

My analysis reveals that a significant group of the women in my study have been explicit about their need to mediate their goal of primacy of practice for comprehensive nursing because of the lack of opportunities for practical experience. The reasons for their responses differ as do the responses themselves. They construct their actions as a compromise, as a positive achievement or a defeat. From a Foucauldian analysis, an overwhelming sense of surveillance pervading the health sector becomes apparent as an incentive for the work of nursing educators. What is of most interest is that all these educators employ the same discourse as an integral focus of their philosophy of comprehensive nursing. Clearly the issues around access to clinical experience are viewed differently by the participants, yet generally all are united in valuing this discourse of primacy of practice as central to the development of CNEP in Aotearoa New Zealand.

**The clinical skills of nursing educators**

I now turn to the construction of nursing educators’ subjectivities in relation to the primacy of practice. Here again, the participants’ narratives are analysed to demonstrate ambiguity and alternative interpretations of this discourse which reflect the constraining and liberating contexts the women worked within.

Maria, Olivia, Liz and Beth spoke about the importance of having strong senior nursing educators with a primary orientation to clinical nursing as integral to the success of the programme.
I had been in the region for quite some time, so I wasn’t an academic from outside either. Most people wouldn’t have seen me as somebody that knew much anyway. I mean I had been around, and so I wasn’t scary. I think people thought that I knew which way was up. Really what nursing was about and really what those students had to be able to do. A common, garden-variety nurse.

(Maria, 1564-)  

I had a long time working in clinical areas which people tended to forget when I went to polytech. They thought I was just a theoretical person and had all these highfalutin’ ideas

(Olivia, 480-)  

**DW**: How did you see your role as a senior member of a group of nursing educators?  
**Liz**: I had to be a nurse. I had to be able to value and articulate a vision of nursing. I did very little actual teaching or clinical practice. But if I couldn’t stand with that group of people and have them recognise that they were being led by someone who was committed to what they were there for, then I couldn’t do the job.

(Liz, 1470-)  

*In a leadership position [you have] to take on all of that accountability that goes with that. But at the same time, because you are developing something new which is hands-on and requires total input from you, both in the clinical and the theory component of the programme, that you are also there as a teacher/educator as well as a leader. You need to be able to bridge that gap ... It’s management skills as well as leadership skills as well as professional skills in going out there and doing your hands-on nursing and participating, and sorting out the clinical as well as the academic. So it was a major challenge.*

(Beth, 442-)  

The complex power play between the identities of nursing educators as clinicians and educators recur in these comments. The ways the participants make sense of their fractured forms of identity and who they directed their work towards are important to the thesis as a whole. A key to understanding the complex subjectivity of comprehensive nursing educators, is to understand that the participants had to balance the ambiguities between their senses of selves as expert nursing clinicians on one hand, and educators employed in the tertiary sector on
the other. The breadth of the participants' responses to this question is worthy of extensive discussion.

Most commonly, participants expressed the attitude that they and their colleagues in comprehensive programmes needed to have a primary identity as a clinical expert. This can then be sub-grouped by those participants who suggested that nurses are innately skilled as teachers, that is, if they are good nurses, they can teach well. The idea is reflected in the following comment:

*People who were nursing students in the 1950s and 1960s* [believed] *that education and nursing went hand in hand. You couldn't be a nurse without being an educator. ... What we meant by “educator” was somewhat vague.*

*(Tracy, 392-)*

Alternatively, others understand teaching as an innate skill. Gwyneth comments:

*I had always had a natural bent. My family history was very much teaching, and I think I did it automatically. I didn’t really think about it. It was just part of the role and part of what I believed.*

*(Gwyneth, 339-)*

Tracy and Gwyneth's comments imply some inconsistency between understandings about innate and acquired or learned skills and forms of subjectivity. These women are suggesting that candidates to become nursing educators could be made to be (good) teachers, yet at the same time people could not be made to be good nurses. Herein lies a valuing of nursing skills over a preparation to teach. In other words, nursing educators' identity as educators continues to be designated as secondary to their nursing status. The ways the women have engaged with this discourse can be used to raise interesting questions about the purpose of the participants' roles as nursing educators. If good nurses are born and not made, then what is the nature of nursing education, specifically the development of comprehensive programmes? Also, what role do nursing educators play in the maturation of students into registered practitioners? Such issues are both interesting and profoundly difficult to try to answer: as such they are precisely the type of question that future research should pursue in order to
extend the academic discipline of nursing and to advance the profession's efficacy in preparing nursing candidates for registered practice.

My research indicates that there was a generalised directive for comprehensive and hospital-based nursing educators to engage in teacher training. The Nursing Council of New Zealand document *The Approval of Schools of Nursing* (1977) refers to a "...requirement for approval of nurse tutors was completion of a course for teachers or steps taken towards meeting this requirement within one year of appointment". The later *Standards for Registration of Nurses from Technical Institute Courses Assessment Guide* (1990), also from the Nursing Council, states "... nurse teachers [should] have completed a course in teaching and learning". The Central Institute of Technology in Petone offered a centrally located National Tutor Training Unit (TTU) from 1972-1985, which was later replaced with regionalised programmes (Dougherty, 1999: 172). The TTU offered three month long courses for tutors (including comprehensive nursing educators) from polytechnics throughout Aotearoa New Zealand. This said, the participants rarely mentioned issues of their own or their colleagues' preparation for nursing educator roles through a formal teacher education programme.

The women's subjective understanding of themselves as educators was further complicated by the ways in which nursing educators were sometimes judged by their polytechnic colleagues as ineffective teachers, because of their lack of apparent teaching-specific credentials.

... *The need to prepare nurses to be teachers ... was never really picked up seriously on a national basis. ... The consequences were initially that nurses were not taken seriously in the tertiary sector. ... The staff didn't take you seriously. The Colleges of Education assisted in a small way to develop the skills to be a good teacher. But what it meant was that most people went into nursing education by default, with little preparation.*

(Beth, 1216-)

*I think there are some really good teachers. But because they didn't have their teaching diploma they were often belittled.*

(Rachel, 295-)
These comments represent part of the discourse that values nursing as clinical performance. On one level, such quotations raise suggestions of an essentialised discourse concerning women's innately feminine ability to impart knowledge (Grumet, 1988). At the same time, the comments evoke some of the different interpretations of credential-oriented "education as emancipation" as discussed in the previous chapter. Rachel's comment also evokes the idea of resistance by other non-nursing polytechnic-based educators who were reluctant to support development of comprehensive programmes on their campuses.

The second group of participants suggest that as clinical experts, their ability to teach students is non-problematic, because they could be taught to teach, or that teaching skills are of only secondary importance to their interaction with nursing students.

_We had a good band of clinical tutors, most of them were clinical experts because that's how I employed people. I employed people as clinical experts, because you can teach people to teach. They were highly respected people in the hospital. But that helped because we had been tutors. Now there's always the thought that tutors don't know what they're doing anyway. And those who can't, teach. But by [appointing ex-] ward charges and people like that, there was a higher respect, I think._

(Helen, 564-)

_I think that in most places those people who went into the polytech comprehensive programmes saw themselves as educators. And they had, in their various ways, attempted to prepare themselves as educators. And because they believed that, you did have to have preparation. Whereas most of the teachers in the 'techs at the time were highly competent at whatever their occupation was. And they saw themselves as that first, and as a teacher or a trainer second. Now I made quite a feature of recruiting most staff from practitioners, rather than people who had been tutoring for many years. Because I believe you could teach people to teach, but you couldn't teach them to be good practitioners if they were not. And I really wanted students to be exposed to expert practitioners._

(Maria, 1106-)

_This polytech would have liked me to employ all Masters or Ph.D.s, ... but I am not interested if I couldn't see a clinical base there as well. ... [To teach] undergraduate[s], they've got to show that strong clinical and_
sense of nursing.

(Delia, 867-)

Analysis of these comments by Helen, Maria and Delia reveal an assumption that nursing skills and experience are the primary quality of nurse educators. Their comments can also be understood to marginalise or to dismiss the skills and qualities involved in being a teacher. This echoes vocational and professional discourses which underpin the development of nursing education and which have already been reviewed in previous chapters. Such comments evoke ideas of vocationalism where one’s innate ability to perform particular types of skilled inter-personal work such as nursing, implicitly prepares the person for alternative work - in this case teaching. An early citing of this belief comes from Bea Salmon, a founding nursing educator of the SANS post-registration courses at Victoria, who, in reflecting on the usefulness of the nursing process explained: “We begin to recognise the nursing process as an educative process. In this sense, nursing is education”. (Salmon, 1970: 3, underlined in original.) Simultaneously, professional discourses associate models of teaching that involve the expert scholar imparting knowledge to students by merit of their specialised wisdom and skills. I believe this to be a particular point of irony, given the rhetoric of nursing educators’ earlier comments concerning their models of a dialogical pedagogy. It is also ironic given the emphasis on clinical nursing when it is precisely the sound knowledge base that has always been promoted as a foundation to comprehensive nursing practice.

An alternative engagement with the discourse of a primacy of practice is utilised by Fiona, Kate, Helen and Jane. This involves their proposal that it is not necessary or even realistic to expect all nursing educators to be clinical experts. Some suggest that a balance between clinical experts and pedagogically-skilled nursing educators is desirable. Others go on to explain that in their view, it is unrealistic to expect that individual people be expected to acquire such an extensive and diverse range of skills and knowledge as clinical nursing expertise and post-graduate level qualifications in order to gain employment as a comprehensive educator.
I don't believe nursing educators need to be up to absolutely up-to-speed in all clinical matters. I think it's unrealistic that nurse educators have to be at least Master's prepared - that they be expert educators and expert clinicians.

(Fiona, 1073-)

Qualifications increase nurse educators' professional standing. It makes it harder for doctors to ignore us, but then the goal posts just keep moving. They will just shift them.

(Kate, 839-)

I missed clinical quite badly when I went to 'tech. And I think the philosophical shift is, you can't be an expert at both, and that I wanted myself and my colleagues to become expert educators. And that meant you can't be expert practitioners any more. And I think that's a very real conflict.

(Kate, 892)

All the nursing educators were working extremely hard at their degrees... And once they got their basic degrees, they thought 'Oh good, that's it' ... My colleagues were all on to their doctorates and masters but the ground kept shifting. So for them it was very hard. The same thing was happening in clinical. ... Women were coming back into the workforce, and they were trying to run their homes, have their families, do the nursing and do some university work. It was a big ask.

(Helen, 1124-)

[My involvement with a professional nursing group ceased] because I found that I had too much else to deal with. ... People are studying, you have got people with families where both parents have to go to work, and they don't actually have the energy to fit everything in their lives, so you just have to make choices... I think that's actually what happened to me.

(Jane, 354-)

These comments offer alternative understandings of the subjectivities for nursing educators involved in comprehensive nursing programmes, in relation to the discourse of clinical performance as primary identity. Such comments open up questions concerning the extent to which formal training programmes to prepare nursing educators for teaching roles have been available, and the level of expectation for the women to engage in these courses of study. This pattern in the women's narratives potentially connects with a suggestion that a proportion of
nursing educators were academically under-prepared for their appointed roles to the standards recommended by the Nursing Council (Walton, 1990: 3; also cited in McCallin, 1993: 6). Here again, the pervasiveness of a primacy of practice discourse is apparent in the qualities valued among comprehensive nursing educators.

The foundational assumption that nursing educators should be clinical experts has not been universally employed throughout CNEP. Rather, two of the women I interviewed suggested that they were obliged to teach aspects of the comprehensive curriculum they were personally and professionally under-prepared for.

_Clinically, I did whatever no one else could do. There were only [a few nurse educators] to begin with, and we had students going out to all kinds of environments. So I spent my time [in a specialist hospital] and I learnt quite a lot more than I had ever known before, because the others didn’t want to go there. It was a matter of do what needed to be done, to be with the students._

(Cathy, 513–)

_Going to work ...with the students [when] ... I had never really had any experience in that area, and finding out more about nursing in the process. Those wider experiences helped to ... educate you as a nursing educator._

(Jane, 79–)

She went on to explain:

_Students changed so often, it helped to make them adaptable. I don’t think some of the nursing educators would adapt as well as some of the students, if they were going into different places all of the time, which in most cases they weren’t. They were sort of staying in a small group of areas._

(Jane, 501–)

It is important to acknowledge that such comments were rarely made, and even then were reported in relation to the initial years of programme development when staffing numbers were very low. But it is interesting to ponder the ways this contradicts the central ethos of comprehensive programmes in general, that is, the principle that knowledge was a prerequisite to safe clinical experience. Furthermore, it raises new questions. To what extent did the unfamiliarity of
tutors in clinical fields exacerbate the clinical staff’s resistance and hostility to the presence of students and their tutors, especially in regard to their implementation of clinical cares? What effect did the presence of inexperienced tutors have on their students? Were the nursing educators honest and pro-active in declaring their unfamiliarity to clinical staff, or did they stay silent, and on what basis did they act in these ways? Answers to such questions are beyond the scope of my dissertation, but some nursing academics have made significant contributions to the critical review of the relationships between nursing students and their clinical teachers (Bride, 1998; Clare, 1991; Lathlean, 1997).

By way of a final comment, a few of the participants suggested that the development of a sense of oneself as a nursing educator involve an essential shift in the individual’s sense of self as nurse. Delia relates the need to shift from nurse first to teacher first, based on the need to be an effective teacher. This involves the development of a dominant subjectivity by nurse educator as “educator” and the dilemmas this can pose regarding their potential construction of students as people in need of pastoral care from teaching staff.

_The hardest transition [is] to get the nurse educators to stop thinking ‘nurse first’, and get them to think ‘teacher first’, or somehow blend it. And it’s the hardest thing in the world. Because you can’t be both. With 18 year old students, stuff will be going on for some of them, somewhere, that’s going to come to the surface. You can not take the counselling role with the student. You have to be teacher. Both parties are totally compromised if you don’t learn how to do that. You can’t have a student tell you something in confidence and then you have got to go and evaluate their level of competencies. You can’t confuse those issues._

(Delia, 1801-)

Alternatively, Beth explained:

_Developing nursing educators meant encouraging them to take on the sort of roles and behaviours that they needed as managers and leaders. Assisting them to change - many had come from the original apprentice-type training where a nurse was a nurse was a nurse, and they still thought like a nurse. They had to change their focus to becoming an educator, a manager, a highly skilled professional as well as a nurse._

(Beth, 546-)
By foregoing a singular nursing subjectivity, the participants are putting aside their own sense of self as clinical practitioner for a much more complex and fractured group of subjectivities identified as necessary to success in nursing education. One of the most interesting issues to emerge from such comments is the idea of service orientation of nursing educators. By turning away from a direct orientation towards patient needs, did the participants construct their nursing students as their client base instead? Does this necessarily mean that they surrendered their nursing subjectivities, when, in fact, through preparing students for excellent clinical practice, the educators are continuing to indirectly advance patient care? I understand that such questions raise new inquiries about the emotional work of educators and nurses and the nature of the unique relationships that emerge between educators and their students. Such questions can not begin to be answered in the scope of this thesis, but I would suggest that there is much work to be done across these topics to promote excellence in nursing education in the new century.

**Experiential reasons for change**

As I have previously discussed, it is the cultural legacy of nursing as clinical work that the women draw on to make sense of why the preparation of nurses needed to change. In the introductions to the women in the first chapter, I have highlighted talk about the trauma of engaging in nursing work without the appropriate level of knowledge to support their patient care. Many of the women offered comments recorded in the “education as emancipation” text about the frustration of wanting to act in new ways once they had acquired new knowledge, and the constraint they felt within a dominant nursing culture which sanctioned only certain constructions of nursing identity. Some of the participants have explained the ways historical power imposed on nursing staff by doctors was reproduced by nurses in their relationships with patients, to continually construct patients as powerless. Concurrently, a number of the women have spoken about their belief in the inefficiency of compartmentalised forms of medical knowledge and the limitations such notions imposed on the ways nurses might work with their patients.
Nursing educators all reflected on their own experiences as nursing students and registered nurses as reasons for their involvement in the development of an alternative form of nursing preparation. In seeking to theorise these patterns of talk, it is appropriate to examine the dominant models of adult learning from the 1960s and 1970s, when the participants were making decisions to move into comprehensive nursing programmes. The women all spoke of their understanding and the commitment to engage with various forms of critical education. In particular, the critical cultural discourse of adult learning values that is acquired by developing an awareness of the context in which the learner exists by considering the power play between groups within the community. Such learning also demands that individuals reflect on the contradictions implicit in their own roles and actions in society within particular historical and cultural contexts (Fenwick, 2000: 258). A significant aspect of this discourse is the importance placed on acting against such anomalies. In Freirian terms:

The term conscientizaçao (conscientisation) refers to the learning to perceive social, political and economic contradictions, and to take action against the oppressive elements of reality.

(Freire, 1972: 15)

This emancipatory model of learning is useful for understanding how nursing educators have drawn on their personal experiences to prompt change for their own students in tertiary-based programmes. In the last part of this section, I will consider the major criticism of Freirian theory, and how this connects with the problems that emerge from the women’s employment of an experiential model of learning.

Freire’s work is influential to the construction of a discourse of “experiential reasons for change” that my analysis indicates as having pervaded the participants’ narratives. This discourse concerns the reflective and critical knowledge that is yielded from a feminist consciousness-raising. The emergence of a unique feminist pedagogy developed from grassroots political action is concerned with encouraging groups of women to engage in consciousness-raising dialogue about the gendered contexts that have framed and potentially restricted their lives. The
emphasis on political action as a core value of consciousness-raising feminist learning can be demonstrated by some of the participants’ involvement in the “Operation Nurse Education” lobbying campaign, prior to the Government decision to trial nursing programmes in the tertiary sector. At the same time, proponents of a liberal feminist movement were questioning the status of women throughout society. Liberal feminist models of education were promoted, based on collective group action with an even distribution of power and a valuing of personal experiences (Dann, 1985: 97; Weiler, 1991: 456). This, too, can be understood to complement the values of education as emancipation as valued by nursing educators in their goals for CNEP.

My use of the term “experiential” originates in the work of the feminist social scientist Shulamit Reinharz. The term involves “...a spiral process of interactivity involving continual reflection, analysis and synthesis individually and collaboratively” (Lumby, 1998: 95). I have chosen to employ this term, rather than, for example, naming this discourse “reflective reasons for change”, because I wanted to make a clear distinction between the discourse that had generated the women’s personal incentives to participate in a new style of nursing education and the more contemporary discourse of reflective practice I have discussed earlier. My decision was also influenced by the fact that Reinharz developed her work (published in 1979) at a similar time to the women’s participation in the development of CNEP. My somewhat pragmatic distinction between the nursing educators’ experiential reasons for change and the concept of reflective practice are not entirely separate. As with all discursive constructions, the women’s deployment of an experiential discourse can also be read as part of the subjective formation of them as comprehensive nursing educators.

The participants reflect on their own experiences as nursing students and registered nurses by way of their explanations for the need for a transfer of nursing education away from the hospital schools of nursing. Their comments suggest they believe that there had been serious flaws in the traditional subjectivities of nurses in the context of a medically dominated and paternal health sector. Associated with this has been the belief that nursing could and should move beyond the shadow of the medical profession and work to proclaim a particular niche of health care skills and knowledge within the health sector. The narrative
forms offered by participants about their involvement in nursing as students and qualified nurses, and as nursing tutors in the hospital-based schools of nursing also provides a rich source of information about how the women have made sense of their experiences as educators.

Experiences as nursing students

The narratives of the participants reflect their experiences of hospital-based nursing training. As well as describing clinical learning opportunities as harmful, the women reflect on their classroom experiences and the threats posed to patients under the care of under-informed and inexperienced nursing students. This connects with the aforementioned review of rights discourses as reasons for the development of a tertiary education-based system of nursing preparation.

The women talk about the hospital schools' system providing inadequate opportunities for students to develop sound understandings of nursing-specific knowledge, such as models of New Nursing and wellness-focused nursing practice and theory. The demands of their clinical nursing obligations deprived the students of the optimum conditions under which they approach their studies. As Olivia explained it:

*The hospital where I was training was generous in that we had a study day... But we still had a lot of lectures in our free time, and you know, had to dress up in full uniform for them, and get up for them if we were on night duty and all that business.*

(Olivia, 84-)

The requirements to work as hospital employees also necessitated that study days be kept to a bare minimum, and the participants cited their sense of frustration at inadequate time devoted to teaching and learning opportunities as well as to the limitations on what they were taught. Of the fifteen women I met, Helen, Maria and Liz explained their dissatisfaction with the narrowness of nursing curricula in their training:

*We didn't have anything in the social sciences in our training, so we didn't know how people ticked, so we treated them all the same.*
When I trained, patients came in, and you focused on what bought them here, and then away they went, and what they had come from, well it wasn’t possible to know, and they fitted in to you. You did not adapt whatever care you were offering them.

(Maria, 237-)

In terms of the technical knowledge, I found the classes boring, utterly boring, because I would’ve read that and knew it before we got into a class. What I was wanting to learn was that art of nursing.

(Liz, 347-)

The lack of any nursing-specific epistemology offered during their nursing programmes was clearly a deficiency in the opinion of this group of women. Other women focused on the implications for the young women who dropped out from their training programmes as part of the typically high attrition rates in hospital nursing. Aside from Anne’s comment in the Introduction concerning the attrition rates among her student colleagues, Delia and Gwyneth discussed the same issue as an incentive for their involvement in CNEP. This is not merely a personal concern. Explaining the historical attrition rates and associated inefficiency of the apprenticeship training system enhances the understanding that CNEP were both effective and fiscally efficient.

[In the] hospital-based system you were clearly an apprentice, clearly your learning never connected with the clinical area, and you saw people fall by the wayside. We’d be in situations that were incredible, a second or third year nurse in charge of the medical ward that is linked to coronary care... Unless you were pretty on the ball, people got damaged. It didn’t really matter because you were a pair of hands. Some people couldn’t stand or take the pressure. The attrition rate was extraordinary.

(Delia, 130-)

I was committed to getting students out of the apprenticeship system because I had seen the damage that it did to really excellent people.

(Gwyneth, 361-)
More generally, the breadth of inherent problems with the then current methods of nursing training and the need for a new style of education were, for at least some, obvious from their earliest days as a nursing student.

Well, there was always change in the air right from [the year I started training], and we talked about changes then, because we knew the system was not working as it should. We were thrown into patient responsibility long before we were prepared academically for it. And we talked about nursing education with clinical and theoretical components corresponding, instead of miles apart as they were in the hospital-based programme.

(Olivia, 76-)

These statements make it abundantly clear that the women have reflected on their own entry to practice training to inform their goals for a new organisation of nursing education. Another motivation for transforming nursing education were the depictions of hospital nursing tutors as ineffective teachers. Kate’s comment in the introductory chapter about her teaching experience as a student nurse, is echoed by Cathy’s, while Beth and Liz also offer their assessment of their school of nursing teachers.

Sometimes we had idiots teaching us things that they really shouldn’t have been. And sometimes students got called out to teach something because the tutor couldn’t understand them.

(Cathy, 776-)

Most people went into nursing education by default, with little preparation.

(Beth, 1230-)

There were two groups. Too often the teachers were those who weren’t able to be placed elsewhere. The others were the really expert teachers, they were really expert clinicians.

(Liz, 330-)

Liz’s comment equally serves as a reminder that by no means were the participants suggesting that their teachers all had been ineffective or ignorant. Indeed, the role of inspirational nursing tutors provided the motivation for a number of the participants to consider a career as a nursing educator. The women
suggested that it was not only the nursing teaching staff who contributed to
dissatisfaction of hospital-based preparation. At least two of the participants join
with Cathy’s comment recounted in Chapter One in recalling the frustration and
dissatisfaction that came from the employment of the medical profession as
teachers for nursing students. For example:

One morning [a consultant] walked in and said, ‘Well I got a bit drunk last
night, so I’ll talk to you about [a different disease than had been planned]
instead’. And I thought, ‘That’s the quality of the stuff we had’.

(Helen, 1778-)

I suppose you would say [hospital programmes] were medically oriented
and dependent. I mean, the lectures that were being given... were, ‘This is
what the doctor needs’, [and] ‘This is what we want the nurse to do’. And
it was usually to prepare the trolley and keep the patient calm.

(Tracy: 172-)

Recognition of the pervasive nature of medical knowledge and privilege in the
health sector is explained as a point of frustration by this group of nursing
educators who strove to attain an independent nursing discourse and a more
equitable relationship between nurses and other groups of health care workers. A
quite different criticism is offered by Kate:

We were educated to graduate, and we were given messages that
[registration] was the end and we expected to leave, have babies, all those
things.

(Kate, 1164-)

This reiterates a portrayal of nursing as an unquestioning and limited feminised
form of work. The lack of a career pathway can therefore be understood to
represent an important stimulus for Kate to pursue an alternative approach to
nursing through comprehensive programmes. Her comment reflects the enduring
association between nursing, femininity and maternalism. Such assumptions are
implicitly heterosexist, middle class and pakeha, as well as revealing an historical
presumption that employment as a nurse has been merely “a short adventure
between school and marriage” (Middleton, 1998). The historical roots of the
conflation of nursing with femininity and motherhood are attributed to Florence Nightingale (Dolan, 1969).

Commonly, the participants’ experiences working as student nurses in clinical settings provoked a desire that nursing education should be reorganised. Their discomfort centred around the mismatch of knowledge which was needed to work effectively in assigned patient care situations. But as paid workers, they understood that they were present in the clinical sphere to fulfil the staffing needs of their hospital employer. Jane’s comment in Chapter One concerning being assigned to an “emergency” nursing role and the stress it induced is echoed by Maria who simply described the pool of student nurses in the health sector as:

... a highly flexible, biddable, malleable work force.  
(Maria, 914-)

Gwyneth and Tracy offer the following memories.

I can remember learning about maternal-child health when I was working in the geriatric ward. And I never, I don’t think I ever had a block of study that coincided with where I happened to be working clinically. And we had to make huge gap transfers really... It was up to us to find the linkages and to find the commonalities.  
(Gwyneth, 377-)

They might have said you’re there for the patient, but you were there to get the work done.  
(Tracy, 968-)

Underpinning these is the sense that the institutional base of hospital systems of nursing education relied on the regularity and routine of students’ work experience on specific wards as a strategy to aide their learning. In regard to Anne’s introductory chapter comment, to be assigned to work on “emergency” reflects the cultural expectation of nurses’ adaptability to cope in any clinical context. This contradicts the pedagogical reliance on rote learning and repetition as learning strategies for nursing students in clinical situations. It also illuminates the participants’ view that this form of nursing preparation was becoming increasingly outdated and ineffective. Furthermore, it dovetails with another comment recalled by Emily concerning her employment as a senior nursing student.
When I was a fourth year student, waiting for results of State finals to come, I ended up staffing a busy medical ward with three other students who were all the same level as me. We actually didn’t know what to do because there was a junior nurse’s role, and a middle nurse’s role, and a senior nurse’s role... And so we sat around and instead of saying, ‘Well you take this part of the ward and you take this bit’, it didn’t actually come into our thinking. So we took the job descriptions: I took the junior nurse’s job description, so I actually went into the sluice room for the day. And I got told off by the nurse who was taking the senior nurse’s role, and I had my work checked by her. And I remember thinking how absolutely stupid it was. And for me that’s kind of a characteristic of the whole culture: that you had to be supervised by somebody at every level. We couldn’t function, even when there was no one to be supervised, we still couldn’t function because the insight into the nature of the work was not there.

(Emily: 688-)

Emily’s anecdote underpins a number of very important assumptions about flaws in the system of training offered to hospital-based nursing students. The reliance on hierarchies for the organisation of nursing work is apparent through her description of the roles of being supervised and supervising other nursing students. Implicit in her comment, too, is the emphasis on the status of this group of students as the defining factor in organising their work: Emily’s silence about any consideration of actually nursing patients is telling in this regard. Here, too, the participant reflected on the ineffectiveness of hierarchical models of nursing work, and the “boxed” thinking of graduates of the single registration apprenticeship system of nursing. Such experiences have clearly prompted nursing educators to seek more independent and reflexive forms of nursing practice, and form at least part of their incentive to become staff of the alternative system of education through the comprehensive programmes.

Experiences as registered nurses

As registered nurses the participants had a wealth of opportunities and experience upon which they shaped a sense of why and how nursing education should be different from their own. The tradition of Aotearoa New Zealanders seeking a
working holiday and “Overseas Experience” remains part of our national cultural ethos. In their interviews with me, a number of the participants reflected upon their encounters with alternative health care cultures around the world. Experiencing differently organised medical and nursing work prompted a small group of participants to reflect on the narrowness of the values that their nursing experiences had offered them.

_I taught nursing [in a third world country] for some time... Working there inspired me to study education on my own... So when I came back to New Zealand I went to teach at [a particular hospital school of nursing, that] was purely medically oriented. ... It was quite clear to me from my reading that this wasn’t the way to go._

(Tracy, 148-)

_[In Britain] it was interesting to go from a state-funded system of nursing service (where there were poor people with their plastic wash bowls and Nightingale wards) to a privately funded system with extraordinary wealth. I realised people with a lot of money could have twenty-four hour care which they didn’t really need. Seeing those differences helped form a lot of my thinking._

(Anne, 166-)

Such comments indicate that the women have understood that their overseas experiences prompted them to critically reflect on nursing practice and the ways nursing could be taught which represented emancipation for nurses and their patients.

As graduates of the hospital-based programmes, the participants recalled the challenges offered in working in new areas as registered nurses, as stimulus for wanting to work towards a new approach to nursing education. Anne is joined by Liz in reflecting on their shift away from the general system of nursing in which they had been trained, to different forms of clinical practice from those they had been prepared for:

_I learned more working in a psychiatric unit that has been useful to me in my career since. All I had there were my people skills, I learnt more about_
myself and extended my capabilities and they were pivotal to the way I wanted to develop nursing.

(Liz, 394-)

Seeing the poverty and the ineptitude of the health service to be able to actually do anything permanently effective was a very good learning experience for me.

(Anne, 216-)

The confronting of difference and the challenges of working in new ways as a nurse are provocative forms of experiential knowledge for the participants in my study. Their critical consciousness of the need to change and learn from these experiences works as direct motivation for their later roles in the development of CNEP.

For several, it was their entry to the style and content of university study which inspired the ways they investigated how nursing education might be different. In a positive light, some spoke of the conscientisation process of understanding issues in disciplines associated with nursing, which drew them into reflections about nursing and nursing education. For Gwyneth, studying at SANS at Victoria University was a significant challenge, while Kate reflected on her overall university experience.

It transformed my life. There is no question that it was the most significant piece of education I ever did. Because not only did it open the way into sort of looking at nursing education differently, but my own education.

(Gwyneth, 237-)

University education helped me be a better nurse.

(Kate, 140-)

Kate explained that it had also inspired her to work for change in nurse education through the establishment of the comprehensive programmes. As a contrast, Tracy explained her encounters in the realm of academia in an alternative way:

I know that when I went to the university, it became very clear that I wasn’t going to fit in there. Because I hadn’t started at eighteen years of age and I hadn’t been mentored through by the professor and done the
Masters and the whole bit... I think it’s sad, what’s happened at university ‘cos I really did believe in that academic education model.

(Tracy, 675- )

Her comment is reminiscent of Beth’s critical response to the forms of pedagogy she experienced as a university student which I recounted in the previous chapter. Others used tertiary education in different ways, helping them to clarify the vision of a different education for nurses influenced by what they had studied at tertiary level. For example, as a result of their personal experiences in tertiary institutions, some applied particular models of pedagogy, new curricular components and new assessment procedures to their work in nursing education.

The participants who had been employed as nursing educators in the hospital programmes reflected on their experiences in these roles, and the ways this prompted them to consider the need for change. For a few, hospital nursing training proved to be an unsatisfactory experience in a variety of ways. For Olivia, the knowledge she had acquired while studying at SANS prompted her to overhaul the hospital-based programme she had previously been teaching.

_We knew [a change in nursing education] was coming. ... So I went back, after that year in Wellington, and really tore my parts of the curriculum for student nurses apart. [Laughs] Shattered all sorts of traditions in the place. But it was good fun, it was great._

(Olivia, 166- )

In contrast Gwyneth’s enthusiasm for reorganising the hospital-based nursing programme after her study at SANS was prohibited by her senior colleagues.

_So I went back [from SANS] so charged up, so enthused... about what I had learned, in terms of how to teach and how to develop sort of adult learning techniques... And my principal tutor said to me, ‘Now you don’t need to think you are going to come back here and implement all of this nonsense that you have learnt [at SANS]’... And I thought, ‘Why did you send me there?’._

(Gwyneth, 601- )

I find it interesting to reflect on the ways in which this issue symbolises the structures of hierarchical power in the health sector, that were seemingly not
transferred to CNEP. I believe that Gwyneth’s reflections of her lack of independence as a hospital-based nursing tutor are in line with the comments previously quoted. It also suggests that there had been little reorganisation of the style of hospital pre-registration programmes over the years between the participants’ own apprenticeship-style training and their employment as hospital tutors. The participants’ perception that hospital schools’ organisation of nursing training were entrenched with ineffective teaching approaches and standards are apparent from comments such as these,

*I taught microbiology for goodness sake. I taught anatomy and physiology. I was about a chapter ahead of the students. And if they asked any complex questions, ‘I don’t know’, I used to say to them, ‘Let’s find out together’. I had no idea. And that’s not good.*

(Gwyneth, 791-)

While this connects with the educational value I have already suggested pervades CNEP, the quotation serves as further evidence of the poor preparation of hospital tutors for their teaching roles. Such a belief is substantiated by Helen Carpenter’s report into the status of hospital-based nursing programmes which was pivotal to the decision to transfer nursing from the health to the education sector (1971: 12). In a similar way, Emily “… was very uneasy about the lack of commitment to quality teaching” (183-).

*I remember sitting around a table at the hospital [before] we had a group of third year students come in…. [The nursing educators] sat ‘round the week before the students arrived. And I remember one of them, a much loved colleague saying, ‘Oh well, I’ve never done orthopaedics, so I’ll do it’. Thinking that she could just kind of go away and then teach a whole week, well it was really like a Monday to Friday on each of those… body systems… I just think, I used to think to myself, ‘How could you possibly see that you could teach something that you had had no experience of yourself and that you have never taught before, and it’s such a short period of time?’.*

(Emily, 142-)

The stresses placed upon hospital nursing tutors manifested in their awareness and frustration with the organisation and content of their teaching programmes:
We had this continuous roll over of classes of thirty or forty people,... so we were packaging stuff, to stuff into them in that four weeks... [Whereas in the comprehensive programmes] ... you didn’t have the problem of, “In another week they go out that door and that’s all they get of this”.

(Maria, 572-)

With such a comment Maria illustrates that the ineffectiveness of hospital-based nursing training was experienced and understood by my participants. From their roles as students through to practitioners and teachers, these women became motivated to engage in an alternative form of nursing education that offered potential solutions to the flaws they perceive to have been in their nursing preparation.

Discussion

It is the tension between the traditional constructions of nursing work and the emerging challenges offered by critical discourses of education and New Nursing as an epistemology that I propose form the basis of both the discourses discussed in this chapter. In the valuing of nursing practice, the participants are drawing on the deeply culturally-embedded understandings of nursing as “hands-on” physical work sited in the secondary clinical institution. The women employ this discourse in a variety of ways, each of which is centered around the accessing of clinical experience for students and the importance of practical nursing skills among their educators. In relation to their own nursing education and practice, a similar connection emerges between the traditional models of nursing work and their perception that their studentship had been significantly flawed.

I suggest that the comments I have included provide a sense of coherence among the women’s narratives. Yet it is interesting to stand back from the breadth of their comments about the primacy of clinical skills in relation to the first two characteristics of professional nursing educators as I have discussed in Chapter Six. My analysis suggests that there are significant contradictions between the discourse of “primacy of practice”, with discursive practices concerning “education as emancipation”, and “legitimacy of difference”. Such tensions concern the legacy of a theory/practice split that I suggest has always pervaded
debates about nursing education. Valuing hands-on nursing work challenges the emancipatory value of theoretical knowledge in nursing education. It also implies judgements about the relative value and kudos associated with different forms of nursing: that is, in the valuing of clinical expertise, there is an implicit devaluing of different forms of nursing work. I propose that the participants are implying that constructions of nursing graduates concerned with communication and education skills (particularly those employed in the fields of psychiatric, community-based nursing and preventative and health-oriented forms of nursing work) are less important than nursing employment which involve care of the sick and the dependent. Here too, the contradictions with health-focused and partnership models of nursing discourse become apparent in the implicit power and authority maintained by nurses working in the clinical sphere. I also signpost the problems which have emerged for nurse educators as they try to make sense of their fractured subjectivities between the demands of "nurse" and "educator" subject positions.

Less conflict and ambiguity exists in the material presented regarding the women's personal experiences in nursing education and employment and how they connect in complementary ways with the previously discussed emancipatory and egalitarian values about nursing education. I have offered a detailed examination of the participants' memories of why they were drawn into the field of nursing education, and in particular why they wanted the preparation of nurses to be different from the ways they had been educated. I have explored the ways participants represent these issues on the basis of their experiences as hospital-based students as well as employees who continue to engage in learning. This reiterates the foundation of the education as emancipation principle that characterises this emergent professional group. In Chapter Nine, I come back to these issues when I present an analysis of the women's utilisation of a discourse of heroism. The exploration of this metaphor represents the follow-up to the discourse of experiential reasons for change.

In combination, Chapters Six and Seven represent the epistemological basis upon which the group of nursing educators involved in my study have made sense of their work in comprehensive programmes. The four components that I have
discussed, namely education as emancipation, a legitimacy of difference, a primary valuing of practice, and experiential reasons for change, have been very significant to the participants. It is my belief that each can be usefully understood as discourses, as indicated by the complex ways the women employ them, through language constructions as well as by their descriptions of their actions and desires for the development of an alternative to traditional hospital-based nursing preparation. It is with these four epistemological discourses as foundations, that I turn to the next chapter where I explore the idealised qualities the participants sought for their comprehensive nursing graduates.
Chapter Eight: Comprehensive Graduates: The Construction of an Ideal Type

This chapter examines the discourse of an idealised type of nursing graduate. I begin by defining the terms I use to explain my analysis. I then examine the variety of ways in which the participants utilise the particular discourse concerning ideal comprehensive graduates to explain their work as nursing educators. The chapter’s third component details a variety of qualifying and contradictory statements which illustrate that the nurse educators’ hopes for idealised practitioners were underpinned by an awareness of the compromises nursing graduates would be likely to make in the context of the Aotearoa New Zealand health sector.

An Ideal Type

Three theories are fundamental to this chapter. The first involves my employment of the term “ideal type” which I have adopted as a heuristic device to make sense of the range of attributes the participants commonly talked about as being those they sought in the graduates of comprehensive programmes. “Ideal type” became firmly stuck in my mind as a way of describing graduate qualities during my analysis of transcripts of interviews with nursing educators. My background as a sociology student meant that the phrase sounded familiar and reassuringly academic, in contrast to the relatively clumsy names such as “experiential reasons for change” and “heroic metaphors in comprehensive nursing” that I was assigning to other discourses which emerged from the transcripts. During my initial writing-up phase I decided that, provided I made transparent what I meant by “ideal type”, and how my meaning differed from the original term, I could legitimately employ the phrase for this important discourse.
The term "ideal type" has its origins in the German sociologist, Max Weber's theory of sociological method. His deployment of ideal types involved the understanding of generalised constructions of, "certain elements of reality into a logically precise conception", against which particular historical events or social ideas that occurred in "the real world" could then be critically assessed (Gerth and C. Wright Mills, 1991). Weberian ideal types have been most commonly used to explain aspects of bureaucracy. An example is the desired qualities sought in a particular employee or system of production assembly (ibid: 61-62). In a Weberian sense "ideal" is constructed to mean abstract or pure. The term has been used to conceptualise nursing identity in previous research, namely in Mackay's 1992 analysis of medical-nursing relationships, but use of the term is neither defined nor critically appraised in this context.

In my research I have developed an understanding of ideal types concerning comprehensive nursing graduates to imply the value-laden meaning of "ideal" to mean highly desirable or sought after. The ways that the participants talk about how students would "be" as qualified nurses were discussed through both ideal and idealised understandings of nursing embodiment. From the nurse educators' transcripts, ideal type comprehensive graduates would understand nursing theory and practice, relate with patients and staff, and engage in forms of nursing work that were markedly different from nurses prepared under traditional hospital programmes. At the same time, the participants upheld particular nursing practices and values that remain historically sanctioned through the hospital-based model of nursing.

The women's descriptions of registered comprehensive nurses are essentially homogenous because of the similar values, practices and qualities the graduates are depicted to uphold. This conception of shared identity links ideal types to the discursive formation of professionalism as previously reviewed in Chapter Three. My commitment to poststructuralism demands that in choosing to deploy the theory of an ideal type, I give critical regard to the limitations and constraints imposed by this structural and positivist model. As a researcher who identifies
with social constructionism, I am using an ideal type to explore the discursive repertoire around nursing work which has provided nursing educators and their students with a narrow range of subject positions in which to operate (Burr, 1995: 145-146). By employing the ideal type as a heuristic device, I believe a complex "discursively produced, contingent and strategic" political construction of comprehensive graduates' identity has been played out in nursing education since the 1970s in Aotearoa New Zealand.

**Nursing as performance**

My analysis suggests that nursing educators in my study continue to value the performance of clinical nursing work as a legacy of their own subjectivities as nursing workers. They are aware of the implicit contradiction between the valuing of theorised and health-focused nursing paradigms and the lure of enacting (and teaching their students to enact) the cultural power and pleasure of nursing as clinical performance. Judith Butler reminds me of this when she writes "Part[ly] the pleasure, the giddiness of the performance is in the recognition..." of the ambiguities between the autonomous, emancipated, empowered, independent feminist subjectivities of self [as nursing educator] with the femininity and drama of enacting clinical nursing work (Butler, 1990: 137). To value nursing as performance is to value the idealised rituals of nursing work as skills without explicitly acknowledging a prerequisite nursing knowledge base to understand and account for this work. Such performance comprises the range of nursing work including the dramatic, the glamorous and the hard physical and "dirty" aspects of the role, yet in this theorising, I am focusing solely on the idealised performance of nursing rather than any prosaic reality. I am left to ponder whether the participants' valuing of clinical work is pleasurable because of its parodic sense (or pastiche), and/or because of the comfort of the familiar from women's own nursing education, memory and performance (Butler, 1990: 138). Perhaps it is from both. I am sure that such paradoxical messages about the nature of nursing values in CNEP reflect the poststructural idealised, fractured and ambiguous constructions of nursing educators' subjectivities.
New Nursing

The theoretical model of New Nursing is useful to this discussion of an ideal type. As explained in Chapter Three, I have chosen to use the term New Nursing to encapsulate a range of theories of nursing knowledge and practice which are centrally concerned with understanding power relations inherent throughout the health care sector. Key components of New Nursing are the use of partnership model for relationships between nurses and their individual patients and the emphasis that is placed on moving away from a biomedical model and focusing on an holistic whole-person approach to nursing care (Salvage, 1992). Nursing educators in Aotearoa New Zealand who have embraced this model have not merely uplifted a foreign model and imposed it in this country, but have instead explored ways to ensure that new forms of nursing epistemology are closely connected with the bicultural roots and culturally-specific context of Aotearoa New Zealand. The work of Judith Christensen, Irihapeti Ramsden and Merian Litchfield offer particularly important contributions in this field, and will be discussed in greater detail throughout this chapter.

The women in this study who were involved for significant periods of time as educators in the comprehensive nursing programmes are united by their highly developed view that the new graduates were significantly and qualitatively different from the nurses who had completed the hospital-based training programmes. As such, this chapter proposes that new epistemological and ontological constructions of comprehensive graduates can be usefully understood as important discourses to the nursing educators’ explanations of the qualities associated with CNEP. The discourse of comprehensive graduates as an ideal type has been a useful and strategic construction for making sense of and accounting for the development of CNEP in the Aotearoa New Zealand health sector. This chapter is centrally concerned with the idea that nursing educators constructed the ideal type and employed it in common discourse to optimise the acceptance of comprehensive nursing - the programmes, the staff, the students and the graduates - by health care workers and other vested interest groups. In this regard, I will
examine the rhetoric of change and innovation in nursing epistemology, but I will also explore the extent to which the participants continued to embrace a range of traditional medicalised-model discursive nursing practices. This discourse consequently represents a significant aspect of the nursing educators’ subjectivities.

In proceeding to examine nursing educators’ constructions of ideal/ised types of comprehensive graduates’ characteristics, the substantive component of this chapter employs comments offered by nursing educators about the rhetoric of how comprehensive nurses would work differently from the medicalised model of nursing work in the secondary health care context. It deals with the embodiment of nursing educator goals, and idealised graduates can be understood as the culmination of the participants’ efforts to develop comprehensive programmes. This text can therefore be read as constructing an idealised graduate image from the discourses that have been explained in Chapters Six and Seven, namely, how the qualities of education as emancipation, a legitimacy of difference, the primacy of practice and experiential rationales for change.

In the final section of this chapter I argue that the exploration of the complexity of such models reveals much about the way educators sought to develop nursing education and their relative power to prepare comprehensive graduates for registration. While holding on to a range of traditional nursing values and practices, my analysis of the participants’ talk reveals that new conceptions of nursing epistemology and ontology were embraced. This blending of innovation and tradition represents the nursing educators’ strategic construction of CNEP as a legitimate alternative to the hospital apprenticeship model of nursing preparation.

**New knowledge and new ways of working: The Ideal Type**

Many of the women I interviewed spoke at length about the ways in which the graduates of comprehensive programmes would work as nurses. There are five
qualities detailed by participants that characterise the “ideal/ised type” of nursing practitioner. These qualities emerged from the participants’ assumptions of the need for graduates to work differently in a changing health care sector. At the same time, this discourse involved the construction of comprehensive graduates as different from hospital-trained registered nurses. The nursing educators constructed a new discourse of comprehensive nursing practice as an ontological challenge to the traditional discursive constructions concerning “nurse” as a clinical practitioner. The first of these characteristics centres around a shift to a wellness model of nursing epistemology. The second deals with the qualities associated with graduates’ comprehensive registration as an important component of their identity. The third discusses knowledge, theorising, reflexivity of practice and a continuing commitment to education as foundations to graduates’ work. In the fourth section I examine the awareness of graduates to the power relations that are implicit throughout the health care sector at large, and in the relationships nurses have with patients. This section also involves an awareness of the ethical responsibilities and advocacy roles facing nursing graduates. The fifth characteristic is shaped by all of the above, incorporated into a partnership model between nurses and their patients, and with their colleagues throughout the multiple disciplinary health team. I will detail a range of narrative comments offered by the nursing educators which I believe can be usefully understood as key qualities for the idealised vision of comprehensive nursing practitioners.

**Health, and a wellness orientation**

The transfer of nursing preparation from hospital schools of nursing to the tertiary education sector foreshadowed an important discursive shift in the ways nursing education, and nursing work was to be oriented. By being identified with the polytechnic and holding a fulltime student status rather than holding a “nursing student” and “employee” status within the health sector, comprehensive graduates were directed to focus on a wellness or health-focused paradigm for their graduate practice. Instead of studying sickness and forms of treatment towards optimum health as provided in the secondary care hospital sector, the educational focus was to be on wellness and optimum health, and the study of disease would emerge as deficits or challenges to a state of wellness. In such an orientation, I am reminded
of the complementary developments in preventative and educational models of health that have dominated the organisation of international health care initiatives since the late 1960s (Hyde, 1999). Such a changing paradigm was thus in line with world trends in health provision as well as with a radical overhaul of the medicalised secondary focus of health care that had dominated Aotearoa New Zealand for the previous two decades. The ways nursing educators describe the wellness orientation of comprehensive graduates is demonstrated in the following comments from Liz, Cathy and Maria:

...the hospital focus meant that the focus was entirely on sickness. Whereas the comprehensive programmes were trying to say, 'Look, the whole point of nursing is towards health. We need an understanding of health first'.

(Liz, 483-)

And as Cathy explained it:

While New Zealand has historically had an excellent public health nursing sector, its community nursing sector was quite under-developed. ... There wasn't a sense that somehow lots of the people in there could be cared for outside [hospitals]. There was still that sense that the hospital was where you went when you were sick.

(Cathy, 1007-)

It is important to remember that in sharing a wellness orientation at a national level the participants were being supported by the groups of powerful bureaucrats who oversee the state health services. When I asked Maria about the relationship between the health care sector and the developing comprehensive programmes, she offered the following comment:

[Senior Department of Health staff] saw that it was very important to promote health and prevent disease, rather than concentrate entirely on the care of those who had succumbed. And that people who were trained entirely in sick-care institutions were not well equipped to carry a health care system that was really going to expand on a wellness model. ... So in one sense we were preparing graduates for the direction which was being articulated as the health policy for the future...

We hadn't quite got to the 'Health for all by the year 2000' concept, but there was a growing sense that we should be driving for health, and not
reacting to non-health. So that was a very important reason for the comprehensive programmes, an approach that wasn’t locked into sick care institutions in the same way.

(Maria, 848- and 947-).

By discussing the WHO targeted policy of health for all by 2000, Maria demonstrates her engagement with the officially sanctioned health care discourse that characterised the years of the establishment of CNEP. I take this to mean that there was an explicit orientation of nursing education towards a health and wellness focus, and that this was anticipated by the participants as an important quality that their graduates would work to uphold in their registered practice. This said, my analysis suggests that the women’s comments are underpinned by memories of the dominance of a sickness-focused organisation of the health care sector. Such comments foreshadow the topics that are discussed in subsequent sections, the resistance of health sector staff to comprehensive nursing paradigms, and the heroic metaphors bestowed on nursing graduates who worked to establish transformative health-focused institutional models in the state health sector.

Comprehensive registration and an holistic view of patients

An associated characteristic of idealised constructions of graduates involved their ability to draw on a broad and multi-faceted understanding of their patients. A holistic model of nursing practice implies that the psychological, physical and socio-cultural dimensions of individual patients will be considered in an effort to promote optimum wellness. An integral aspect of was this the decision to replace all specialised single registration forms of nursing education (psychiatric, general and obstetric and psychopaedic) with a comprehensive registration programme. Kate, Beth, Fiona and Rachel spoke about the qualities that comprehensive educated graduates could bring to their nursing work.

* I used to argue that I might be [working as] a surgical nurse, but [if] I’m comprehensive in some sense you’re dealing with anxiety, grief, fear... You can have all that on the surgical floor. You have got to think about discharge planning, of what support is going to be in place... And to me it didn’t matter where you practised: if you were thinking comprehensively, you brought all of these things in and didn’t put [them] in boxes and say, ‘That belongs there’. It’s part of looking after a person in a holistic
manner, of seeing the total person, they are more than the sum of their appearance.

(Kate, 1239-)

With comprehensive programmes here was the opportunity to produce a professional image, not only in terms of being seen to be a profession, but actually behaving and acting as a profession, with values and skills and knowledge all being important, not one particularly overriding the other.

(Beth, 257-)

Professionalism is the way of conducting oneself and going about one's work. So you have a sophisticated body of knowledge that relates uniquely to nursing, having that knowledge and using it differently depending on the context in which you are practicing.

(Fiona, 399-)

As well as taking a holistic approach to individual people, the following comment by Rachel serves as a reminder that in health-oriented settings (for example, in the work of practice, occupational and public health nurses) the comprehensive understanding of wellness and illness exist within a broader social context.

I think that the values of a very skilled nurse initially involved meeting the needs, focusing on the individual patients, and that's broadened to groups of people, families, communities.

(Rachel, 412-)

The construction of idealised graduates as described in these comments connects the comprehensive, holistic forms of nursing care with a professional identity for at least a few of the participants. In claiming this holistic model of nursing practice, I suggest that nursing educators were posing a challenge to the pervasive medical discourse that had traditionally dominated the health care provision in Aotearoa New Zealand and which compartmentalised people's state of ill-health by systems of medically organised and specialised knowledge. As such it can thus be understood to connect the development of comprehensive nursing in this country.
with the burgeoning new nursing systems that developed in the British and North American nursing sectors over the same period.

**Knowledge and theory for practice and a commitment to ongoing education**

The ability of graduates to theorize their practice has been a required component of comprehensive programmes since they were first established. Upholding nursing theory as a core component of comprehensive qualifications can be understood as a strategy employed by nursing educators to promote the reflective practice of comprehensive graduates and the unique professional epistemological knowledge basis of their practice. The women in my research construct graduates as an ideal type to explain and reflect on their own work in the clinical sphere, and that of the nursing staff with whom they worked, from a theorized model of practice. For example, Gwyneth and Liz offered the following explanations.

*The graduates today can articulate their practice, the model that they are practicing from. And it’s not just, ‘I can use this theorist or that theorist’. They actually know how they are practicing nursing. [They] can articulate the strength of their practice.*

(Gwyneth, 760-)

Liz illustrated this characteristic of comprehensive nursing practice by recalling a senior comprehensive nursing student’s reflection on the nursing practice that she observed in a clinical setting:

*I think another thing is that professionals do have an articulated philosophy from which their profession derives its existence. One of the things that was important in the school [was that] we spent a lot of time looking at the philosophy of nursing and its development. ... One of their assignments was to try and describe what they thought was the prevailing philosophy of nursing in the environment that they were in. She was working in a ward that had cancer patients, so that death was quite common. And she said it was just awful, because the whole philosophy of dying of the staff was negative. [The student] said she would like to go back and do some work with that group of nurses and doctors. One student could see that it was having such an impact on the way people were being able to die. I mean they were getting good care and all the rest of it, but they weren’t allowed to talk about dying.*

(Liz, 561-)
Liz was clearly impressed by the astute assessment the student offered of this health care setting and her desire to return to the area in order to promote positive change. Liz also depicts such affirmative action as advantageous to the patients, but I think she is also implying that her student saw the benefits of change impacting on the unit’s nursing and medical staff. By sharing this reflection with me, I suggest that Liz was conveying her image of an ideal type of reflective comprehensive nursing practitioner as a positive agent of change. What will become clearer throughout the remainder of this chapter and the next is the impact that less than supportive responses by health sector workers have had on comprehensive students and graduates and even their teachers. The belief that nursing graduates would be appointed to health care services and work to transform the prevailing philosophy and the rareness of their reported success is part of the provocation for heroic status conferred on the pioneering comprehensive graduates.

The participants in my research also identified an ideal comprehensive graduate as upholding a commitment to learning about their discipline through formal and independent study. Maria explained this principle in relation to students’ clinical practice, but I suggest that this value is no less relevant to idealised registered comprehensive nurses’ practice. Specifically, Maria and her colleagues as nursing educators encouraged comprehensive nurses to act professionally by being honest about their level of skills and knowledge in clinical situations:

And [students in clinical placements would say], ‘Oh I don’t know how to do that’. [Gasps] Shock, horror!. We were glad to hear them say, ‘Oh, I don’t know about that, I don’t know how to do that’, because that was something you didn’t say before. But it’s very important to be able to say, ‘This is outside my sphere of experience and knowledge and it would be better if I didn’t do that’. [Laughs]. I can remember as a student nurse doing many things I would have been much better not to because it was quite outside my sphere of knowledge and experience.

(Maria, 641- ).
By drawing a comparison with her own apprenticeship-style nursing training, a distinct model of idealised comprehensive graduate practice becomes evident. The importance placed upon graduates’ need to value post-graduate nursing education are conveyed in comments by Cathy and Delia:

The idea of making them different was that their aspirations would be different at the end. And then we would say, “O.K. we are preparing you to be a clinician. If you want to go on later and become an administrator or teacher, you are going to need to increase your educational background as well. You are going to need to build on that”. Initially it was post-basic diplomas. ... And Massey [had begun]. So you might like to go on and do a Masters. And that’s exactly what some of our graduates did over time.

(Cathy, 744-)

I think the new graduates are stunning... Of course they come out bare, well grounded, and some will go on to do Masters, and some will go on to PhDs. Some will have a clinical line and do post-grad’ certificates. But they will actually do it in a way that is recognized and respected academically.

(Delia, 786-)

Valuing on-going education for nursing graduates also served to remind these new nurses of the diverse range of fields of work which they could move into after they became registered. This reiterates the holistic nature of comprehensive programmes for the development of the whole person, rather than only for occupational potential, while serving to underpin the idea of the versatility of the comprehensive qualification per se. This involves the graduates’ sense of freedom and confidence to move between what had been quite self contained nursing disciplines, for example between psychopaedic and orthopaedic nursing. Implicit in these comments is an aspiration for nursing to be accepted as a legitimate field of academic study which I understand connects to the professional development of nursing.

**Power relations, advocacy and ethical responsibilities**

A significant number of the participants refer to power relations which have dominated the organisation of the health sector in which they and their students
and graduates have worked. This group includes Maria, Liz, Gwyneth, Delia, Cathy and Helen. Traditional constructions of nurses’ experiences of powerlessness are dominated by the legacy of doctors’ professional sovereignty in the secondary health sector. But beyond this, the ideal/ised nursing graduates were aware of the power that nurses themselves can wield in relation to their patients. Graduates, as described by this group of nursing educators, were expected to practice in ways that empowered patients, while maintaining an awareness of their authority over patients’ whanau, health sector support staff and nursing students. At the same time, an awareness of the cultural clout wielded by nurses was simultaneously reconstituted as an assertiveness to be employed to support the patients, through an advocacy model of nursing work. The following comments evoke this ideal/ised quality.

[Students] were certainly more willing to discuss and be assertive in their opinions, and to take less for granted. It wasn’t easy, [nursing educators] could not have expected to say, ‘Do it this way because I say so’. We could certainly have done that in the olden days.

(Maria, 532–)

By encouraging students to gain confidence and assertiveness in their ability to talk with their teachers in the education setting, the women suggested that nursing educators were working to facilitate an “ideal type” of graduate who would communicate effectively throughout the health sector. In terms of their clinical nursing roles this is exemplified in the following quotations.

I think the key thing that comes through for me is that I had suffered medical arrogance. I have suffered nursing arrogance as well. I would like to think that the students would have learned from me that the whole notion of a profession requires a humble approach.

(Liz, 1166–)

Polytechnic education re-focussed nursing on patients as opposed to systems.... People looked at people holistically. And the nurses were much more adversarial, they were much more advocates for their patients than the old style of nurse.

(Gwyneth, 723–).
How can you be a nurse and accountable, for example for an absolutely dependent and vulnerable person, if you don't know how to advocate for them?...
Of course you make them advocates, of course you make them strong.
(Delia, 675- and 809-)

The above comments are explicitly about advocacy relationships with patients, and implicitly reflect issues of power relations. In doing so, they reconcile the principles employed through New Nursing models of practice. Less common were comments that were overtly concerned with power at a socio-cultural level. In one such example, Anne commented about an approach to nursing work which moves beyond the clinical to the political, and an extension from nursing advocacy for individual clients towards graduates’ employment of a community-based understanding of health and illness. Anne explained:

I want a nurse in South Auckland to understand the context in which children get glue ear, and not to blame the parents for not taking them to the doctor. To me the well educated professional nurse is someone who knows how to not only work with those children, but he or she sees the next step that has to be done and that is political activism.
(Anne, 879 -)

Anne’s comments provide a challenge for comprehensive graduates to a radical reconstruction of the ontology of nursing. A vision of ideal/ised nursing practice can therefore represent challenges to institutional hierarchies which discouraged groups of health workers from communicating effectively for the benefit of individual clients as well as organizational systems. Such an awareness of the power dynamics as played out in the health sector emphasises the importance of effective communication skills for comprehensive graduates and how they promote greater partnership models of practice with medical and other health care professionals.

The participants also talked about their promotion of open communication with their students. In adopting such roles, they demonstrated a model of professional accountability which they suggested forms part of the foundation of comprehensive nursing graduates’ idealised practice. Cathy and Helen discussed similar issues to Anne’s comment above, in the importance of being able to reflect
on and assert the nurse’s own personal and professional opinions on ethical issues. This was often encouraged in CNEP by the allocation of course time for “professional studies” where students could consider how they might confront dilemmas as graduates. In the following quotation Cathy draws on principles of assertive communication as integral to professional practice.

It was an attempt to try to get across that one had to be rational and logical and have considered positions. I don’t care what position they had on an issue, provided that students had a strong, solid justification. If it was ‘I just think that’, well I’m sorry, that won’t go anywhere. But if they say, ‘Well I don’t think that I could nurse someone that is going to have an abortion because I have these beliefs about da de da de da’, O.K., fine. ... In other words, saying ‘It’s OK to dissent, but you have to be responsible and accountable for the way in which you exercise that dissent’. I just felt that it was important that those issues be on the table. Now what decisions people made in regard to all kinds of things, that is over to them.

(Cathy, 1085-).

This point is reinforced by Helen’s comment concerning her work to encourage students to reflect upon ethical issues:

We tried to certainly work at professionalism through ethics, so when ethical issues came up, we used those to say, ‘You’re the decision-maker in that’, and so on. And got them to see that they could stand as a professional and make ethical decisions, because students come up against things, for example, not feeding very handicapped new-born babies and things like that, that used to just bring students to you in tears. They didn’t know what to do, and all the rest of it. And we used to get them working through models to show them that they actually could make ethical decisions, because they were professionals. And that they didn’t have to throw out their own belief system to do it. They could work it through objectively.

(Helen, 1419-)

Nursing educators considered the curricular component that concentrated on specific nursing ethics and an awareness of power relations was important for helping students aspire to professional practice and a professional identity. Implicit in Helen’s quotation is the construction of comprehensive graduates who not only reflected on what their ethical values were, but who also learned that they
had a legitimate entitlement and a responsibility to voice such views. I believe this is an important attribute of registered comprehensive nurses as judged by the women in my research. These qualities involve comprehensive graduates being aware that they are entitled to their own personal values, and that practicing responsibly involves upholding a coherent and articulate belief system across the breadth of nursing contexts. Concurrently, Helen recommends that students should work through professional ethical dilemmas “objectively”. I understand this to imply a form of rationality which upholds practitioners’ entitlements to personal value systems.

**Partnerships with patients and medical staff, and an all-qualified workforce**

Associated with the transfer of nursing preparation to the tertiary education sector, has been the cessation of hospital employment of nursing students and the concomitant establishment of an all-qualified nursing work force. A principle of all-qualified health care staff has moved from a goal to a reality between the 1960s, when a transfer of nursing education was initially mooted, until 1991 when the last hospital-based nurses registered (Hunt, 2000). It reiterates the philosophy that underpins models of New Nursing, in particular the upholding discourses of professional practice including accountability, autonomy and a devolution of responsibility to individual practitioners. This discourse also placed value on a partnership model between nurses and their empowered, responsible, knowledgable patients (Grace, 1989). Simultaneously, the decision to employ only qualified nursing staff complemented a strengthening discourse of patients’ rights, which entitled people to be cared for by a legally sanctioned and accountable practitioner. Emily has explained the principle of an all-qualified nursing workforce:

*The whole justification for doing that transfer was to actually have an all-qualified work force. ... In that lead-up to the beginning of the programmes, the literature indicates that what they wanted was the nurse who knew her job to be the person who was the front line person with the patient. Trained, ready to work, not needing supervision.*

(Emily, 658-)
The shift to an all-qualified work force has coincided with the heightened complexity of the nursing care that clients of the Aotearoa New Zealand health system have required. This is connected with increasingly sophisticated medical technology and procedures which have kept seriously ill clients alive, and the nursing care which complements these developments. It is also associated with the ability of the medical and nursing systems to be able to treat clients with a variety of health problems:

_In the 1980s, the acuity of patient care was increasing so there was a need for qualified staff in the area._

(Helen, 614-)

The reorganisation of the health sector evokes a particular orientation to how nurses enact nursing work. Specifically, the shift from an institutionalized routine of nursing work to a more client-centered focus on care has been a key issue in the development of CNEP. Emily commented:

_The changing pattern of medical care has had a profound influence, the technology, the science, the huge amount of drug development ... All of which changed the pattern of and the predictability of what you might find out in the clinical setting. If you stop giving all those injections at six o'clock in the morning, you stop all sorts of things._

(Emily, 1084-)

In focusing on individual patient needs rather than routine systems of work, the participants’ talk suggests that nursing educators sought to prepare graduates for a new construction of nursing subjectivity. Implicit in this was a way of relating to patients that was based on a partnership model. Comprehensively prepared nurses would negotiate how they cared for people in a way that optimised the control and lifestyle choices of the patients, as Tracy, Beth, Anne and Maria suggest:

_We carried the idea that [graduates] would work with healthy people._

(Tracy, 313-)
It was very clear to me that interpersonal relationships and communication go hand-in-hand ... and if you followed that through you developed a paradigm.

(Beth, 676-)

[It is important in] nursing... to set up a trust relationship and that [nurses] analyse the follow-through of what [they] say, behave in ways that show that [they] are listening and empathetic and concerned and will respond.

(Anne, 1049-)

I think they came at the whole thing from a different perspective. I think they were, we were still talking about patients rather than [a] client focus. And I believe that they threw away the rules and said, ‘How can I?’ I mean, they’re small things, but that’s what really counts.

(Maria, 1876-)

By conceptualizing their students and graduates as practitioners who might discard rules in order to give their clients the most effective care possible, the participants are constructing an image of graduates as exemplary nursing practitioners. They are also reflecting an idealising of comprehensive graduates who would place the needs of their clients before the practices which traditionally dominated the health sector.

Descriptions of idealised types of nursing graduates portray an optimal model of relations between the medical and nursing professions. With the widespread changes to nursing work implicit in the comprehensive model, there was a need, according to the nursing educators, to reorganise and foster new collegial partnerships between nurses and medical staff:

I think medicine is a bit fearful of nursing. Certainly I think [doctors] are afraid of nurse practitioners. General practitioners are under a great deal of stress and threat, because they largely monitor, do first diagnosis referrals, assessments. And you see if you actually get some kind of easy assessment like walking through the door, inserting your card in and getting a read-out of what is wrong with you. Every system in your body, which they are developing at the present time, that’s a huge amount of general practitioners’ work gone. So there is an uneasy relationship especially when you start talking about whether patients can choose either a nurse practitioner or a doctor. I think unless we are very careful, we um,
could feed into that unease. I still don’t have any problems working along
side them in an educational setting as well as in a practice setting because
I think we come from different places. And to some extent you may have to
drag them, screaming and shouting into that kind of reciprocal,
complementary relationship.

(Emily, 1518-)

The theme of the relationship between these two groups of health workers
continues in these comments offered below:

Another professional value is that new graduates will go in, and they will
take opportunities. And I think it’s happening. I mean prescribing rights
will change totally what we do. We will be independent and autonomous.
We are not, at the moment. And but we will require a lot more post-
graduate education to do that, and we will have to be very, very careful
and not go, because I don’t believe in becoming doctors, but I think you
can work together, it has been demonstrated.

(Delia, 680-)

Our emphasis was that we wanted our people to be nurses, not doctors.
And some criticism was, ‘Oh, they’ll get too much intellectual education.
They’ll try and be doctors and they will tell doctors what to do’. We
weren’t in the least bit interested in trying to be doctors, we wanted our
people to be competent, accountable nurses.

(Cathy, 329-)

A final group of comments by participants attend to new types of epistemology
unique to comprehensive nursing in Aotearoa New Zealand. The two that I
discuss specifically are the development of hauora takirua or “nursing
partnerships” as developed by Judith Christensen (1990) and Kawa
Whakaruruahu, or cultural safety as articulated in curricular documents authored
by Irirapeti Ramsden (1991). Both models reflect the fine-tuning of
comprehensive nursing practice that nursing educators have worked towards since
the programmes were first trialed. Each provides a significant contribution to
international nursing research, while offering comprehensive nursing practitioners
a theorised yet clinically-focused model by which to form holistic, therapeutic and
professional relationships with their patients throughout the health sector.
The Christensen model of nursing partnership is premised on the unique relationships that develop between nurses and the people they are caring for, across the breadth of the health care sector. The model promotes the notion that both parties are experts who can creatively negotiate optimal health-related experiences (1990). The nursing educators I interviewed spoke in generalised terms about the importance of this nursing model for their work as educators. Similarly, a small number of the participants expressed opinions about the development of the cultural safety curriculum and the socio-political context in which it has been taught in CNEP. The concept of preparing comprehensive students to care for people in the context of Aotearoa New Zealand, emerged from a series of hui and initiatives from the Department of Health between 1986 and 1990 (Murchie and Spoonley, 1995: 10-13; Ramsden and Spoonley, 1994). A formal inquiry by the Nursing Council prompted by a spate of media criticism of the programmes in 1994 vindicated the importance of cultural safety in nursing education, but concluded that the curriculum “... should be better defined, better taught and better explained to the public” (Dougherty, 1999: 55; Papps, 1997). Comments offered by Jane, Liz, Rachel and Tracy refer to the issue of cultural safety in various ways, including the conflating of this curriculum with Maori issues.

*I think the whole cultural safety development has had a major impact in nursing and despite all the negative things that have happened as a result of that, it has put New Zealand at the forefront of cultural issues ... I think New Zealand has got a long way to go in terms of racial issues really. I think it's something that nurses can be proud of, in this country, really.*

(Jane, 981-)

*Nursing was often the group that took a polytechnic into having to grapple with Maori issues.*

(Liz, 1021)

*I think that legislation is catching up with nursing. In many ways the cultural safety and the Treaty obligations, I think nursing lead the way in what are our Treaty obligations and how can we actually translate that into a way of practice. That is reflected now in many areas, but it started off in nursing.*

(Rachel, 810-)
We worked with women who initiated cultural safety ... The idea developed that [graduates] were going to work in all sorts of communities and places. The Maori women [who worked as educators] could see that given the right training they could have the kind of health care they had envisaged.

(Tracy, 340-)

The first three of these comments suggest that nursing educators understood that comprehensive nursing programmes would prepare students for uniquely indigenous professional models of nursing practice. Their idealised understandings of such graduates encompass the ways that nurses would relate to patients, staff and to the theory and knowledge that formed the basis of their practice. They would also be primarily oriented towards wellness, and would understand deficits in people’s health as a threat to their whole wellbeing. The graduates were also depicted by nurse educators as being aware of the power relations that underpin the health sector generally, and specifically the ways that patients are likely to be disempowered by their state of ill-health.

Change, compromise and contradiction: The participants’ accompanying narratives.

But anybody knows that you can’t rely on a new graduate to change a system. All the new graduate wants to do ... is fit in and get on and do her work. And sure, if she’s been taught patient-centered care and she goes into a ward situation where that isn’t operating she has to do as everybody else is doing. And although she may mutter under her breath, it’ll take her a year or two before she is able to inflict any change. By that time it’s probably all knocked out of her, what she has learnt in polytech’ she has forgotten.

(Olivia, 777-)

The second component of this chapter about idealised nursing graduates is introduced by this quotation from Olivia. My goal in this section is to consider the extent to which nurse educators actually portrayed the efficacy of comprehensive programmes in developing graduates who would work in these idealised ways. I have called this section “Change, Compromise and Contradiction” to consider the
extent to which participants’ images of idealised graduates have actually come to fruition. Overall, I am suggesting that there was a mixed response among health sector workers to the development of CNEP. Furthermore, among the nursing educators and their graduates there has been ambivalence to a new comprehensive mode of nursing identity through these new programmes. I believe that Olivia’s comment incorporates all of these issues. By depicting the health sector as something of a bully, that “knocks” the graduates valuing of patient centered care “out of her”, there is an indication of the oppressive nature of the health sector for new graduates from comprehensive programmes. At the same time Olivia’s comment that “all the new graduate wants to do ... is fit in and get on with her work” depicts graduates in an ambiguous way. She represents comprehensive practitioners as striving to work in ways that complement their employing environment, potentially at the expense of any committed comprehensive ontologies of practice. Finally, I believe that Olivia’s choice of the term “inflct” suggests her personal resistance to critical facets of comprehensive nursing within the organisation of health care. In describing each of these issues in greater detail, I seek to explore the complex and inherently contradictory construction of an ideal type of comprehensive graduate as explained by their nursing teachers.

The health sector’s responses to the ideal type of comprehensive graduate

In an affirmation of the health oriented conception of nursing work, Tracy, Olivia and Delia recalled the successful employment of their graduates in wellness-based forms of nursing.

_We carried the idea that the [graduates] were going to work with healthy people. And if we had any input into it, as many of them would work outside of hospitals as would in. We had a real coup in that a number of our first graduates went [directly] into public health. That was unheard of, people always said you had to do two years in hospital before you could be a public health nurse._

(Tracy, 306-)
Quite a few of the graduates went straight out into the community, G.P. practice jobs, and the principal public health nurse would take one or two.

(Olivia, 855-)

We put a lot of energy into preparing students who could go out and work in the community. But still the idea that you need to have done your time in hospitals first remains alive and well. We couldn’t get new graduates jobs there, it was disappointing.

(Delia, 1422-)

Tracy and Olivia understood the integration of comprehensive graduates in the health sector as a general success. Delia’s comment introduces the awareness of nursing educators to the resistance of the health care sector staff and other vested interest groups that were opposed to the transfer of nursing preparation away from the health services. Resistance to the discourse of idealised comprehensive graduates centred on a mismatching of comprehensive preparation with the needs of a medicalised model of health care. The attitude that secondary care is the dominant form of nursing work has existed concurrently with an historical lack of awareness by vested interest groups – doctors, hospital-qualified nurses, patients and the public – of the comprehensive nursing project. The resulting lack of understanding and accommodation by hospital staff forced the participants, their students and their graduates to struggle and/or compromise the values they had acquired to nurse effectively within secondary health care settings. In the next three quotations Helen, Delia and Kate are centrally concerned with the refusal of the secondary health care sector to accommodate comprehensive nursing graduates.

The initial concept of comprehensive nursing, we thought we were heading to a type of community care that has never eventuated. Our students were being prepared for that but getting clinical experience in a hospital setting ... We were teaching them in a vacuum.

(Helen, 913)

We hoped that while we got busy with nursing education, the nursing administration would get busy and re-orient nursing from being task-
dominated to patient centered ... But [the local] nursing administration was hoping that our graduates would change it when they came out.

(Olivia, 760-)

I think comprehensive graduates were enormously under-utilised. I think it depended on the environment they found themselves in, and the knowledge and the expertise of their colleagues and their vision of nursing. Most of it was medical, they were socialised into the obedience, subservience model of working in a medical-model based hospital.

(Kate, 1253-)

And so we never really paid enough attention to what nursing practice would look like with an all-qualified work force. I think that’s the fundamental thing that went wrong. We never actually made a complementary change and explored the consequences of the complementary change. ... I asked [employers], 'What do you want the nurse who comes out of this programme to do? How are you changing your practice to prepare for these people?' And they would say to me, 'Well, you tell me what you are going to produce, and we will tell you if we like it or not'. And I was saying, 'No, no, you tell me what it is that you want'. But they were unable to do that because there was just too much change going on (including the cessation of student nurses as employees and the reorganisation of health funding) and they didn’t really have a perception of what practice might look like.

(Emily, 719-)

Olivia and Emily depict an important power struggle between the nursing educators and hospital management about the nature of comprehensive graduates and the work they would perform in registered practice. Olivia’s comment involves the view that there was a devolution of responsibility to individual comprehensive graduates for potential institutional change in the health sector. Emily implies that hospital staff did not want to articulate a coherent model of practice they sought in nursing staff. It is possible that the hospital staff might have actively sabotaged efforts to reorganise health systems to complement the preparation of nursing graduates. To what extent difficulties for CNEP staff, students and graduates are derived from disinterest or disapproval can not be assessed in the parameters of this research. There is, however, the suggestion of a deliberate resistance by health sector staff in the following anecdote offered by Gwyneth:
I remember just after the first graduates had come out, a principal nurse told me with huge amounts of pride [about] the graduates who had been employed locally; [that the principal nurse] ‘...couldn’t tell the difference six months later’. And I thought that was the most appalling thing I had ever heard, because that meant they had to conform that much.

(Gwyneth, 556-)

This is a complex comment, which reinforces a number of points I am making in this chapter. The subsuming of the graduates’ comprehensive identity to the hospital-qualified staff is understood by Gwyneth to be about the graduates’ powerlessness in the context of a dominant hospital culture. The principal nurse’s pride at the graduates’ rapid transformation to (in)visibility suggests that the process of “fitting in” was perhaps forced upon them rather than something the students themselves pursued. The comment also captures the senior nursing administrator’s misinterpretation, whether by ignorance or defiance, about the intention of the entire comprehensive nursing project. When I recall my previous discussion of Judith Butler’s theory of performance, I believe Gwyneth’s comment reflects the emphasis placed on nursing as a performance. It serves to confront the dominant cultural discourse by resistance and/or conformity with traditional models of nursing practice.

Finally, in relation to the emergence of New Nursing, it is interesting to consider the lack of articulation by participants concerning this or associated epistemological innovations. I believe New Nursing underpins much of what I am saying in this chapter about ideal/ised nursing practice, yet none of my participants mentioned it by name. In my reflections on the reasons for such silence, I am left to conclude that there may have been a reluctance on the part of nursing educators to explicitly engage with such apparently divergent forms of clinical practice from traditional models of nursing work. Instead, it is the emphasis primacy of practice and a medicalised model of nursing subjectivity that remain strategic in the participants’ efforts to have CNEP socially accepted.

Such an impression would be consistent with the point made by Jane Salvage in her review of New Nursing in Britain during the 1980s, that these initiatives “face
many material and structural barriers" (Salvage, 1992: 17-18). She describes these barriers as including recruitment and cost effectiveness, as well as the reticence of nursing staff to engage in and patients to experience new forms of nursing (ibid). At the same time, she draws on Keyzer’s (1988) point that a reluctance to engage with new forms of nursing work inevitably necessitates the reorganisation of power. “A truly patient-centered model would challenge the boundaries between the roles of the doctor, the nurse and untrained female health care workers. It is unlikely that such a model would be welcomed by those whose power it seeks to remove” (Salvage, 1992: 21).

**Graduates’ clinical nursing skills**

The idealised form of comprehensive nursing practice that is described in various ways by the participants has been understood to have fostered some positive effects on the shaping of nursing practice in Aotearoa New Zealand. Delia’s comment attributes the changes in the health sector and the shift from an illness to a wellness-based model to the presence of comprehensive programmes and in particular their graduates:

> I would like to think that the level of understanding of the graduates, the critical thinking that they have, being aware that you don’t have to carry all the information in your head, but you’ve got to know how to access it, has certainly helped the rapid change in health. That acuity, that illness, the people that turn over, it’s not something you can put your hand on, but for the past 25 years most of the people doing that are comprehensive nurses. And I think we have developed people who have actually got the skill to cope with that change that the old system never would have.... I think we have actually presented a workforce that has actually allowed some of those changes to happen.

(Delia, 1375)

While Delia’s comment is optimistic, I am aware that there are qualifications in her choice of language. For example, her cautionary “I would like to think…” comment casts some doubt about her opinion about the relative success of CNEP. In a more negative light, Helen, Cathy and Fiona suggest that the graduates themselves have been reluctant to engage in forms of practice which might
transform the traditionalised models of nursing care into an idealised construction of nursing work.

I've never forgotten one student who had been in the programme for a while, and she said to me, 'All I ever really wanted was to be dressed in white from head to toe'.

(Helen, 183-)

Some graduates were very anxious just to shed the comprehensive [status] and get in there and be the same as everybody else. So we had graduates who would forget to wear their medal because it had 'comprehensive' on it. One graduate who got her first employment at [a particular hospital] told me a year later, 'Nobody on the ward has found out yet that I am comprehensive'. And I thought, 'Isn't that incredible?'. She had borrowed her sister's medal because her sister was hospital trained.

(Helen, 1192-)

When people graduate they are the most junior people in the organisation. They don't want to stand out like sore thumbs, they just want to merge in, they don't want to be seen to be anything different. ... There's that natural impulse not to be noticed, and knowing that people, if they know, they will just look at your badge and see "R.Cp.N", they are going to be stalking for you. And they will be acting towards you on the basis of their perceptions which may or may not have anything to do with reality.

(Cathy, 2457-)

The hospital culture is just so powerful, all encompassing, and I think that culture is just as relevant today as it was twenty years ago. So the desire to fit in hasn't actually changed. I thought that things would change when the critical mass of comprehensive graduates as team leaders, [and] charge nurses got to a certain point. But it hasn't turned out that way, and all too often [in my senior position] I heard about team leaders giving students a hard time. And they were our graduates.

(Fiona, 1000-)

The graduates are, in a variety of ways, described as actively seeking to blend in with their hospital-trained colleagues. This suggests that to some extent graduates were “forced” to compromise their aspirations to work in ideal ways and survive in the different and hostile health sector. Such comments can be understood to reflect the desire of comprehensive students and graduates to engage with secondary care models of nursing, and to seek hospital-based offers of nursing
work. It is my opinion that to some degree the participants identify a counter-cultural value held by their students and graduates. I am referring to the women’s awareness that part of the vision of an ideal type included the pleasure that nurses feel in enacting forms of ritualised nursing work. Further support for my hypothesis comes from the comments that focus on issues of appearance as suggested in the participants’ reference to uniforms and medals as nursing insignia.

Such a proposition is further supported by literature that has reviewed the development of CNEP. In one of the earliest qualitative theses presented by nursing educators in this country Judith Perry (1985) documents the experiences of comprehensive graduates as they began practice in a clinical context. Her work offers a valuable insight into the contradictions experienced by groups of new practitioners in the mid-1980s, between their knowledge and skills and the expectations of their workplace. She also reflects on the inability of the graduates to act as agents of institutional change. Along with Heather Forbes’ thesis five years later, Perry partly attributes blame to CNEP staffs’ ineffectiveness in preparing graduates for the realities of health sector employment. (1990). A similar assessment of comprehensive graduates’ experiences of initial employment is offered by Margaret Horsburgh (1987), but her work assigns responsibility for such a mismatch to the health care sector’s ineffective orientation to clinical practice for new nursing employees.

By employing these culturally powerful discursive repertoires, I believe that the participants understand nursing graduates as actively engaging with traditional nursing representations. Such issues also raise questions about the surveillance of new graduates by senior hospital staff and the employer’s sense of ownership and success when polytechnic graduates had been subsumed within “their” institutional milieu. This suggests the importance of performance to both parties: the graduates wanted and needed to work in ways expected of hospital trained registered nurses, and the employing staff sought graduates who would work from the same discursive practices.
Preparation for practice

The participants offered ambiguous messages to their students about the idealised construction of comprehensive graduates and the work they should aspire to engage in as registered nurses. In particular, comprehensive nursing has sought to develop knowledge systems specific to Aotearoa New Zealand. A few of the nursing educators expressed concerns about the shortsightedness of a specific nursing knowledge base without a foundational engagement with medical discourse:

There was a total rejection of anything that reeked of disease process. And I think that has been a disastrous mistake. If you focus on the experience you have to have at some point some understanding of what is going on with that person. Which means that you can't take a totally socio-political-cultural-critical perspective. You have actually got to look at this particular person in this particular set of circumstances. And the fact that the person has cancer, that may be a medical diagnosis, but it is part of that person's story. And I think we denied a lot of safety and increased the risks of nurses in practice by suggesting that every time we talked about a disease process or an illness experience, you were doing something called, "the medical model".

(Emily, 404- and 442-)

**DW:** I'm interested in the relationship between the medical profession and what happened in comprehensive nursing.

**Olivia:** Yes, very good in this area, we were lucky. Gosh we were lucky. But the Medical Superintendent sort of set the standard here. And he used to hold regular clinics with the nurses. And have them in operating theatre, for his patients, and describe what was going on. He also used to teach the medical students of course, but the comprehensive students were part of this, he'd take them on rounds with him. So it was very good. The [medical staff] could see that ultimately patient care would improve hopefully.

(Olivia, 1655-)

**DW:** I've heard some nursing educators say that they resisted medical staff or doctors teaching nursing students. Have you got any comments about that?

**Olivia:** In the hospital school we were always taught by medical people [laughs]. We'd been used to doctors being active and we enjoyed them and
I mean we had a lot to learn from them. Why not? Sure, it wasn’t nursing care I know, but it was specific conditions, and it involved them and got them interested. And they were good value and they enjoyed teaching too. Particularly the obstetricians were great in the clinical areas. They would teach, and it meant that if they were coming up to the classroom to talk, they would also grab the students when they saw them in the clinical areas and take them on their rounds and, you know, get them integrated into the system. And teach them.

(Olivia, 1830-)

[Nursing] has been so intent on developing that body of knowledge that’s not borrowed from medicine that in part we’ve shot ourselves in the foot, because collectively we don’t have enough research skills, particularly in the quantitative areas. It’s changing a little now, but it’s OK to get alongside our medical colleagues, pick their brains, learn their research methodologies and then apply them to nursing. And we haven’t done that.

(Fiona, 964-)

It is interesting to reflect that Olivia’s first comment complements Emily’s to offer a reasoning for advocating a rapport between the medical profession and nurses, based in the benefits that this would accrue to patients. This reiterates a particular construction of nursing professionalism where the goal is to serve the interests of the patients before any self-interest, such as that proposed in an idealised type of comprehensive nursing professionalism. Olivia’s second quotation depicts a clear defiance to non-medicalised forms of nursing education and an attraction to helping nursing students to learn to fit in to the secondary health sector. Alternatively, Fiona’s comment suggests a more pragmatic use of medical knowledge, by applying medical-oriented research methods to advance nursing’s development.

A number of the nursing educators explain their own contradictory responses to the dominance of the culture of medicalised secondary health care. Simultaneously, polytechnic staff intent on not being seen to be out of place in clinical areas wanted to be seen as different from the traditional system of nursing. As Olivia commented when I asked:

**DW:** What values did you convey to your students regarding professional identity, and/or their responsibilities as future employees within the health sector?
Olivia: Well, they always knew they had to have their toe on the line when they went into the hospital. We spelt that out to them the first time they were going into a place where there were sick people, and they had to behave in a professional way, and they had a responsibility to care for people while they were there. They could relax and kick their shoes off and run around barefoot at the polytech but not in the hospital.

DW: OK, So you were saying ‘toes on the line’, what do you mean by that?

Olivia: Yes, being responsible while they’re there.

(OLivia, 817- and 862-)

In demanding that the students, “behave responsibly” while in the health care settings, but that they could, “...kick their shoes off...” at the polytechnic, Olivia is constructing a particular model of professional identity: one that is perhaps at odds with some of the other participants. By establishing patterns of expected appropriate behavior in particular settings, Olivia sets comprehensive students up for particular professional subjectivities as registered nurses. The notion of conformity as a component of professionalism is also discussed by both Jane and Rachel.

_I think the standard of dress and personal presentation has deteriorated, and I think that is to our detriment as a profession. I remember going into a Postbank or something like that, somewhere where people wore uniforms, and I thought to myself, ‘Well actually, these people look smarter than some of the nurses I was seeing around’. And I think it’s quite important, because I think the message that the nurse who doesn’t take some pride in his or her appearance is saying, ‘Well, you know, I don’t care enough about myself, how is he or she going to care for me?’_. I think there’s a subliminal message there really. And I think you get more confidence if someone comes up to you, and they are neat and they are tidy and they are clean.

(Jane, 220-)

_They weren’t as slick initially in a hospital so our values were very much influenced by the demands of the work force and where students were going to work. That ideal of total patient care was hard to keep to the forefront when you had those criticisms and when the students themselves had to get jobs._

(Rachel, 388-)
I think that when I was first involved in nursing education it was really tough, not fitting in. I think many of us were influenced by our own nursing education and by the setting we were working in with students, and in which they were going to work after graduation. I think we tended to teach tasks, and that our curriculum was medically based.

(Rachel, 528-)

Such comments bring together the theories of performativity in clinical nursing work and the Foucauldian idea of surveillance within institutional settings as incentives to account for these nursing educators’ actions.

A pragmatic use of theory is also implicit in the comments offered by Helen, for the ways the educators sought nursing students to make sense of the theorising of nursing work in relation to their own nursing practice experiences:

_We kept our programme very much feet-on-the-ground. We weren’t into much theory that we felt beginning students didn’t need, but we used theorists as professional models. So we talked about these women and dug up every story we could about them and used them as models of how far you could go in nursing. And looked at their theories from that point of view, that here was a professional._

(Helen 1411-)

Whether Helen’s attitude demonstrates a commitment to engaging with nursing theory at a particularly accessible level for these undergraduate students, or whether her representation can be judged as superficial and tokenistic and even unprofessional, remains unclear. In a similarly pragmatic comment, Fiona expresses her concern that CNEP need to be more closely integrated with the needs of the health sector than they have in the past.

_We haven’t got right what we produce as a graduate [and our graduate profile] and the things that we see as being important are not the same as the health sector’s. And that has been the case as long as comprehensive nursing has been in existence, and I believe it is the major weakness, and if nurses don’t do something about it, it has the potential to be the demise of the comprehensive programme._

(Fiona, 806-)
An important aspect of this research is the various ways these women depict a compromise between the idealised model of comprehensive registered practice, and the reality of what they sought to teach their students.

There are certainly comprehensive graduates who have done wonderful jobs. One of my colleagues said to me a year or two ago, that some of our first graduates are now charge nurses in [quite diverse] areas. So it’s something about getting the experience in whatever you do and then getting appointed to positions that acknowledge it. And then it might be a secondary question, ‘So, are you comprehensive or what?’

(Kate, 1128-)

This comment offers a slightly different way of understanding the same issue: that comprehensive graduates continue to be judged in relation to the expectations of the health sector, where their educational background and comprehensive registration are considered of secondary importance to their ability to succeed within the secondary care system.

Discussion

In exploring nursing educators’ constructions of idealised comprehensive registered nurses, I am left with an overwhelming impression of the mismatch between the rhetoric of the participants’ descriptions of an ideal type of nursing graduate and the more pragmatic descriptions of how graduates were actually working in clinical practice. The idealised type of nurse has been portrayed to demonstrate a strong sense of empowerment and unique epistemological and ontological qualities associated with comprehensive nursing practice. Also logical is the participants’ acknowledgment of the comprehensive graduates’ desire to conform to hospital-style nursing rather than the models they had been taught to value. As they have explained in the introductory chapter’s comments and in the experiential reasons for change sections, all the women had critical reflections to offer about their studentship in hospital-based programmes as incentives to participate in the development of CNEP.
What I find more difficult to reconcile is contradictions within and between nursing educators' constructions of an ideal type of graduate. This involves messages about health and illness, secondary and non-institutional forms of nursing work, and conflicting messages about how nurses should understand their relationships with the medical profession. My feminist poststructural reading of the participants' narratives draws me to understand such mixed messages as internalised ambiguities in the nursing educators' subjectivities. I believe that such differences have emerged as participants' creative and pragmatic responses to the unwelcoming health care context alongside which CNEP have developed. The ways that the women live with the contradictions defines them as having negotiated and continually reflected upon how best to respond to the needs of their students and the health sector.

Chapter Nine extends the analysis of nursing education rhetoric and reality by considering the participants' employment of heroic metaphors to explain their personal experiences, and those of the first cohort of nursing graduates to emerge from the polytechnic programmes. Alongside my analysis of the four epistemological discourses that characterise the women's philosophy of comprehensive nursing and this chapter's representation of an ideal type of graduate, heroic qualities define comprehensive nursing educators as an emergent feminist profession. The relationship between the articulated intent of a form of professional nursing and the resistances employed by the workers, their employers and teachers, interfere with efforts to prepare students for practice. My research can therefore be read as an exploration of the unique and complex conditions that have framed the development of nursing education in Aotearoa New Zealand.
Chapter Nine: The Heroic Metaphor

With the transfer process...New Zealand was forging the way in a totally new concept, and there was no duplicate process in any other part of the world to be of much assistance. There was much discussion about this, by hospital board representatives and the nursing profession, with the Department of Health; some of it was heated and emotive. One of the tragedies of this was that the new comprehensive nursing courses, the education system and the upholders of this change were accorded the blame for any difficulties at the workplace. This was an extremely difficult time for those involved in those first courses; nursing educators and students often met a very hostile environment in some clinical areas.

(Grant, 1990: 2-3).

This description of the consequences of the transfer of nursing education is worth quoting at length, to illustrate the motivation for a particular discourse that the participants have woven through their narratives. Little has been written by commentators of comprehensive nursing education about the nature of this hostility and the responses of staff and students to the resistance they experienced. Judith Clare (1991), Heather Forbes (1990) and Judith Perry (1985) indicated that problems experienced by students and graduates in clinical areas are attributable to their teachers’ difficulties in balancing the educators’ vision of comprehensive registered nurses with the health sector’s need for an effective nursing workforce. A grounded theoretic analysis of the experiences of nursing educators by Antoinette McCallin (1993) explores the problems new teaching staff faced in clinical settings and Rosemary McEldowney (1995) offers her own life history as a narrative to explore the development of nursing educators within the challenging contexts in which they work. I suggest that although there has been little scholarly critique of the conditions under which an heroic discourse has emerged, recordings from the NERF Oral History project and sections of Gay Williams’ doctoral thesis (2000) capture the magnitude of the difficulties comprehensive nursing educators and indirectly their students faced since the transfer process began.
In the processes of talking with nursing educators and in analysing the transcripts of our meetings, I identified a particularly important metaphor that was employed by the women to explain their comprehensive programmes. The sense of the struggles their students encountered prompted a metaphor of heroism to permeate the nursing educators’ narratives. This reveals much about the tenacity of comprehensive nursing educators to foster change in nursing preparation. I also interpret the women’s comments as drawing attention to the challenges to - and continued engagement with - traditional iconography of nursing and the resistance of institutional health care providers in Aotearoa New Zealand to accept the legitimacy of alternative models of nursing education.

This chapter is of crucial importance as I review the ways nursing educators themselves have employed a heroic metaphor to make sense of their colleagues’ and their own experiences in the early years of the development of the comprehensive programmes. At the same time other groups of people associated with the development of CNEP are characterised in similar terms. The participants reflect upon their own studentship to recall nursing educators who had been important role models. These hospital-based educators are portrayed as heroic, as are a small group of employees of the state sector who were proactive in the development of early CNEP. A third group who have been conferred heroic status by the women in my research are the first cohort of nursing graduates to be registered from each of the CNEP programmes throughout Aotearoa New Zealand.

I begin with a review of how heroism fits within the breadth of my thesis. I believe the varied and extensive ways the women employ the linguistic metaphor of heroism indicate its status as a discourse in the context of this research. As briefing for the narrative comments that are later presented, I offer an exploration of the term “metaphor”, and how, as a linguistic device, metaphor represents an illuminating component of feminist poststructural discourse analysis. This is followed by a review of constructions of the notion of heroism and the associated nomenclature of militarism and pioneerism that reiterate and extend the heroic motif. I explore the connections between the range of associated language and cite a diverse array of women’s talk to substantiate the claim I make in this chapter,
that the degree to which the hero metaphor is employed is significant in understanding the politics of nursing education in general. In summary, this chapter can be understood as the final prominent discourse to emerge from the nursing educators’ reflections in talking with me about CNEP. The interconnections and implications of these characteristics are explored in the concluding chapter.

Furthermore, I chose to devote a whole chapter to the issue of heroism as a metaphor because I have been intrigued by the complexity of this evocative figure of speech. The very meaning of the word, “heroism” as a metaphor can be read in different ways. As this chapter demonstrates, the metaphor is evoked through an engagement with traditional nursing discourse, but at the same time the heroism is bestowed on pioneers who sought to challenge and even reject historically potent constructions of nursing education and nursing subjectivity. As in previous chapters, I analyse a range of participant quotations to demonstrate how the discourse of “heroism as metaphor” simultaneously constructs and is constructed by the women to explain developments within comprehensive programmes.

**Explaining “metaphor”**

It is important to outline what I mean by the term “metaphor” in the context of this thesis. Beyond the simplicity of its grammatical usage, I take metaphor to mean the use of a lexical expression of meaning that is employed to evoke and enhance understanding of a similar concept of idea or experience. In this particular text the use of heroism as a metaphor has enabled the participants to reflect upon aspects of their own and their colleagues’ experiences over the first two decades of comprehensive programmes. The ways nursing educators applied language which relates to the concept of heroism has thus been an enlightening one to explore as an element of the discourse analysis method I have employed. From such a review, the discursive practices the women rely upon, and the boundaries of the discourses within which the participants worked as nurse educators become apparent.
Methodologically, I understand the value of exploring the use of metaphor in texts for discourse analysis. The origins of poststructural deconstruction of metaphors are found in the work of Maurice Merleau-Ponty and Michel Foucault. Their studies of phenomenology and discourse respectively share the fundamental value of language as the, “matrix by means of which we are woven into the fabric of human life and thought” (Gill, 1991:16). Michel Foucault’s use of metaphor pervades his work, for example in the panopticon’s symbolic and literal representation of surveillance and the construction of the human body as “metaphorical custodian of knowledge and power” (Kanner, 1993: 163, cited in van der Riet, 1997). More recently, feminist poststructural theorists have discussed the valuable interpretations that can come from analysing and re/employing metaphor as discursive strategies. Following examples of poststructural nursing research concerning metaphors by Trudy Rudge (1997) and Judith Parker (1997), I offer this component of my dissertation as an illuminating deconstruction of the metaphor of heroism as a discourse employed by comprehensive nursing educators.

In suggesting the presence of this heroic metaphor, it is important that I provide the following qualifications. Firstly, I propose that the majority of the women in this study speak about heroism as a legitimate subject position employed to make sense of their experiences as early nursing educators in the comprehensive programmes. But I am not offering judgments about the extent to which this can be seen as self-ennoblement, or that the lack of such self-identity can be understood as self-effacing modesty. The purpose of my work is rather to extend the connections between the women’s talk and the various potentially useful readings that develop from discourse analysis. Secondly, while I review references to heroic discourse as a metaphor, in some ways these are not merely a figure of speech. I propose that sometimes and in some ways the participants were acting in heroic ways, and thus their determination was literal and not merely figurative. But overall I am most interested in the discourse around a heroism metaphor and the understandings of comprehensive nursing and nursing educators’ roles within them.
The health sociologist Clive Seale (1995) offers an important contribution to the theorising of death and dying by critiquing constructions of heroism. He reviews the traditional construction of heroism as a rare and masculine concept. His work proposes an alternative understanding of heroism that is distinctly feminine and integrally part of a “humanistic process” (:599). While Seale’s work offers a useful deconstruction of paternalist language, I believe that blurring the boundaries between the masculine and the feminine by reconstituting ideas of heroism as somewhere between everyday life and the extraordinary, is much more useful to my project.

The participants in my research construct notions of heroism about their students and graduates as somewhere in between the everyday and the unique. The participants’ descriptions of their work alternated between periods that were depicted as predictable and pleasant, and other times when the staff and students are represented as heroic for their continued, ongoing daily struggle to develop and maintain burgeoning comprehensive programmes. So for these participants, narratives around heroism come from the everyday as well as the extraordinary. In fact it is the heroism that comes from perseverance, and continued commitment, which is implicitly the basis of my understanding of the term. I am therefore suggesting that while Seale’s work represents a “loosening up” of language constructions of heroism, my work draws on a less precise deployment of an heroic metaphor. The usefulness of this is to expand the range of language that feminists can use to describe women’s lives. By reclaiming masculine constructs such as the notion of heroism feminists can modify, adapt and change understandings of language, to challenge and rearrange constructions of history and the present.

The deployment of metaphors by nurses has been dominated by language used to evoke an understanding of the ways people embody nursing in idealised ways. For example, Helga Kuhse (1997) explores the powerful place metaphors have played in the construction of nursing ethics. She traces the use of metaphorical language back to Florence Nightingale, who wrote of nursing equating with female identity and motherhood. One example of Nightingale’s comments, in the preface to her Notes on Nursing (1969: 3) is the comment “... every woman is a nurse” (also
Kuhse, 1997: 15). Kuhse explores the powerful effects of such metaphorical language, but she also cautions us about the limitations implicit in metaphor. She wrote:

Gerald Winslow puts it well when he says that metaphors are not mere ‘niceties of language’. Rather, because of their capacity ‘to focus attention on some aspects of reality while concealing others’, they are powerful shapers of our understanding of the world. Depending on whether they are forward or backward looking, they can be a tool or a toil – being supportive and productive for change or giving implicit support to practices and institutions that we would be better off without.

(Kuhse, 1997: 16)

It is intriguing and difficult to try to tease out the interplay between the discourses and the metaphors that are employed by the participants, as evidenced in the above quotations. I have called the dominant metaphor “heroism” because I understand the women to be talking about their displays of power, bravery, strength and perseverance in the face of difficult conditions. Given its usage as a traditionally masculine concept, perhaps it would have been more effective to describe the metaphor as heroine-ism. I agree with feminist theorists who regard the addition of a suffix to masculine terms to imply less status in the female version, for example in terms such as actor/actress, waiter/waitress or manager/manageress (Spender, 1980: 22). Furthermore heroines are usually cast in roles that are romantic, weak and feminine, the very antithesis of the fighting, struggles and the fraught displays of hostility the participants evocatively convey in their narratives (Weedon, 1997: 25).

Heroines aside, heroic language is traditionally associated with masculinity. In the context of this research, such assumptions seem contradictory, quite simply because of the pervasiveness of nursing as a women-dominated workforce. It is also profoundly ironic that such language is employed by people who are centrally oriented towards health (in contrast to the inflicting of injury, for example) and towards an acceptance and respect for difference (whereas intolerance manifests in aggressive language, rejection and hostility). On a deeper level, though, it can be understood as one, if not the only possible lexicon of language available to the
participants to explain their memories of their work in comprehensive programmes in the early years of the transfer process.

Trudy Rudge offers a critical review of the ways nursing work has been explained through the metaphors of embodiment of meaning. She offers a warning about the unquestioning engagement in metaphors, however, when she suggests the following:

Metaphor has the potential to reinforce hegemonic beliefs and in so doing may act to suppress certain forms of thinking and acting. This occurs from the way that metaphor renders the conditions of experience as if they are common sense. Authors who suggest that metaphor is creative, in that it forges new links, seldom highlight how metaphor can just as well render the world in a taken-for-granted way. Similarly, metaphors may well enhance our predilection for explaining our experiences through the use of dichotomies because in metaphor we relate one meaning to another. In doing so, we may well be privileging one element of the metaphor and as a result suppressing other potentials offered within the metaphor.

(Rudge, 1997: 77, italics in original.)

Rudge's work cautions me about accepting the women's use of a heroic metaphor in unchallenged ways. Is their use of heroism implicitly constructing the view that people outside the CNEP, or who chose to exit from these programmes, are the opposite of heroic - namely cowardly? This choice of metaphorical discourse serves as a reminder that the women's choices of language are always imbued with their hegemonic authority and power associated with their positioning in CNEP. I return to consider the potency of the heroic metaphor and the forms of hegemony such language can promote in the closing pages of this chapter.

**Heroism and the development of comprehensive nursing programmes**

Continuing with the preview of the issues in the body of this chapter, I now turn to a review of constructions of the notion of heroism, fighting and pioneerism. The connections between values and the biographies of nurses who have been constructed as embodying these characteristics form an important association. For example, the Englishwomen Elizabeth Fry and Florence Nightingale are socially
constructed as pioneers in the development of private (home based) and modern hospital nursing systems respectively (Williams, 1980: 49). In the Aotearoa New Zealand context, the enduring pioneering legacies of French nun Suzanne Aubert and Sybil Maude have perpetuated understandings of these women as heroic nursing figures. Such identifications can be understood to reinforce the gender, pakeha and middle class stereotypes of heroic nurses, as the commentator Mick Carpenter notes:

Empiricist nursing history is also shown to be selective in the frame of reference it has adopted towards its chosen subject-matter. It has focused primarily on the politics of reform and the lives and activities of nursing reformers. Nursing is reified into an occupation which is "reformed" and attains ever dizzying heights of recognition. Reformers are portrayed as heroines who led the public battle to glorify the good name of nursing. In the process, nursing history has mainly glorified the good name of elite members of the occupation. It is their efforts which seemed sufficiently significant to record as history. The daily work of the rank-and-file nurse at ward level is hardly examined at all, let alone what she might think about her work.

(Carpenter, 1980: 124)

The vision and tenacity of legendary pioneering figures promulgate a discourse of heroism which I suggest illuminates the deployment of this same discourse by the group of senior comprehensive nursing educators. This iterates my analysis that the participants blended innovative with traditional nursing-related discourses to make sense of and explain to others the development of comprehensive nursing programmes.

Mick Carpenter’s employment of a militaristic metaphor of leading “the ... battle to glorify nursing...” heralds the need to consider the close associations between nursing and war-related metaphors. Foucault’s The Birth of the Clinic traces not only established systems of clinical medicine, the clinical gaze and the disciplining of the body, but the concomitant establishment of the formal organisation of nursing (Traynor, 1999: 37). This is not surprising given the close links Florence Nightingale and her nurses had with the British military establishment. The most obvious physical enactment of this was the architecture of Nightingale wards, where the panopticon allowed nursing staff to “watch over” groups of patients in
both the protective and disciplinary meanings of surveillance (ibid, 38). Other theorists who have discussed the military origins of nursing include Cynthia Woods (1987), who offered a review of the shift from task-based and hierarchical organisation of nursing work to new nursing as a patient advocacy-centered model. She discusses the important shift in nursing discourse away from the use of a military metaphor that related nursing to ideas of fighting battles against disease, and the military-like virtues of loyalty, obedience and confidence in people who are in positions of authority (1987: 168). In this work she also draws on the writing of Gerald Winslow. In recognising the power of the military metaphor to nursing, she notes:

Winslow sagely commented, ‘It would be surprising if professional nursing had not early adopted the metaphor of military service’, based as it is on Florence Nightingale’s experiences in the Crimean War and Victorian concepts of acceptable behaviour for women. Both fostered conformity, deference to rank, obedience and the key virtue, loyalty... not autonomy. Though loyalty of the nurse meant faithful and self-sacrificial care of patients, ‘Most of the discussions of loyalty were occupied more with another concern; the protection of confidence in the health care effort’.

(Woods, 1987: 169)

Such orientation towards the continued authority of the medical institution is depicted in a slightly different way by Geoffrey Hunt. He discusses the ethical responsibilities of nurses as being implicitly connected with their relationship to medicine:

If nursing is a “mediated profession”, the executive arm of a “true” profession (medicine) then accountability cannot be expected of it except in what might be called the military sense. To be accountable in this sense is to scrupulously follow orders, as a soldier does.

(1994b, 130, italics in original)

While staying with the notion of fighting, I want to consider the ironies involved in using such a metaphor. To women who uphold their sense of themselves as nurses as well as teachers, the notion of fighting could be understood as the very antithesis of what they would choose to employ as meaningful discourse to describe their work. In other words, this metaphor seems surprising when it is
recounted about their own strategies to promote comprehensive programmes. By casting themselves as active protagonists, the women are constructing themselves on both sides of a range of binary opposites. In turn, these include roles as fighters/carers and qualities of force/nurturance. These are curious complements especially given nurses’ traditional images of “attendance” in wars, in healing, behind-the-lines, non-aggressor roles. Such neutrality is not important, of course, when the individuals are supporting the “right” cause. For instance, the legacy of Edith Cavell, a British nurse who was court-martialed and executed by a German firing squad for assisting allies returning from enemy-occupied territory remains an heroic image in Anglophone cultures (Pickles, 1997). A second group of binary opposites is also evident around masculine/female, or more complicately, feminist/feminine constructions where nursing has been traditionally associated with feminine qualities. To extend the binaries with regard to work, such oppositions as authority/service, professional/vocational, educated/trained and even taught/known are all useful. The use of the fighting metaphor as embraced by nursing educators is thus an enlightening tool for understanding that these women are constructed through non-unitary subjectivities and understand themselves as non-unitary subjectivities.

The metaphor of battles is also ironic given the proclaimed commitment of nursing educators towards a health, rather than an illness-focused understanding of nursing work. Susan Sontag’s understanding of illness as a metaphor, and the deployment of fighting as descriptors of struggles against disease – initially regarding forms of cancer (1978), and later AIDS (1989) – raises questions about the ways these educators have made sense of their roles in the health sector (Sontag, 1991). Their struggle, to “fight for health”, is ambiguous, as is the notion of “fighting for peace”, by engaging descriptors that can be understood as contradictions in terms.

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1 Article Four of the Geneva Convention of 1950 assigns “... neutral powers ... to the wounded and sick, and to the members of the medical personnel and ... chaplains of the armed forces of the Parties to the conflict, received or interned in their territory.” (Online. Available: http://www.unhchr.ch/html/menu3/b/q_genev1.htm)
The fighting metaphor can be further used to understand the ways participants use language to reveal the pervasive discursive practices they draw on to make sense of their lives as nursing educators. The women describe their action, their assertiveness, their hard work and the ways they manipulated aspects of institutional systems to achieve the outcomes they wanted for comprehensive students and the programmes they worked to develop. Here again, binary opposites are blurred and contested in the complicated subjectivities that the participants use to describe their lives as nurses who teach and educators who retain their identity as nurses – they are at once aggressive and modest, agentic and passive, noisy and subdued, strategic and hesitant.

This aside, I believe that the employment of a hero discourse is not co-incidental for nurses: the notion is closely associated with systems of order, and organisation (Florence Nightingale), martyrdom (Edith Cavell) and "sainthood" (Mother Theresa). These are all culturally familiar iconography for and about nurses. The chapel in the Christchurch Public Hospital grounds is believed to be the world’s only war memorial to nurses who died in action. Although prompted by the death of three locally trained nurses in the 1915 torpedoing of the ship Marguerite during the First World War, it was later also used to commemorate nurses who died in service during the 1918 influenza epidemic (Ciaran, 1990; Friends of the Chapel, 1989). Such legacies and iconography are familiar whakapapa or ancestry for nurses educated in Aotearoa New Zealand. At the same time, as women who identify as professionals, feminists and leaders, there is profound ambiguity in the deployment of a hero discourse. Constructs of heroism imply authority, vision and potential self-sacrifice, characteristics which do not necessarily sit well with the qualities upheld by some forms of feminism, and some discourses of professionalism which value objectivity. Overall then, it is important that we understand the use of an heroic discourse and a fighting metaphor as qualities of the newly emerging profession of nursing educators. These women share contradictory qualities, which they sometimes proudly, sometimes apologetically, use to construct themselves as both individuals and a group. They embody an ambiguity of poststructuralised occupational selves which celebrates the juxtaposing qualities of these women, and their deployment of this discourse to make sense of the development of CNEP in Aotearoa New Zealand.
Much is revealed by examining transcripts as texts, and considering the ways participants have used language to construct a sense of their lives as nursing educators. Beyond the interplay of metaphors around fighting and heroism, what underpins these constructions of the nursing educators' subjectivities is a juxtaposition of a complex range of issues that involve power, professionalism, authority, knowledge and the legacies of nursing traditions.

Military metaphors

The participants employ language that connects militarism and the historical development of Anglophone nursing systems. I believe these form a powerful discursive foundation by their engagement with a metaphor of heroism. While most often this is implicit in the narratives offered by the women throughout this chapter, occasionally the associations with militarism are explicit. For example, the organised campaign to trial comprehensive programmes, “Operation Nurse Education” evokes a sense of the battle cry, or an orchestrated and precisely organised process reminiscent of military strategies. Such comments are offered by Maria and Delia. Maria recalled the variety of ways in which she was involved in:

*the great Operation Nurse Education.*

(Maria, 147-)

while Delia reflected:

*I use professional in that way, because I think nursing comes from a history of military, Christian stuff.*

(Delia 742-)

While these comments merely refer to a discourse of militarism underpinning nursing, Tracy and Anne talk about this in relation to the dissatisfaction they feel on behalf of patients who have not been nursed optimally under a military-influenced nursing model. Tracy offers an explanation of this:

*In the original hospital programmes you were there to get the work done. They might have said you’re there for the patient, but you were there to get*
the work done. It was routine, it was army, it was very army oriented. And if you didn’t like it, well, then, you could have the religious bit [laughs]. You know, you were dedicated. And they used to say you were there for the clients, but if you actually look at those two models, in the army you are responsible ultimately to serve the king. And in the religious model you’re responsible to God. The client doesn’t get a look in, either way. It was very much routine, obedience, discipline.

(Tracy, 968–)

I came through the [hospital] course very socialised as a nurse in that period, which was highly militaristic, very power based in that we gave people almost no information about their illness.

(Anne, 153–)

Delia and Tracy’s mention of the Christian origins of nursing is frequently offered by nursing educators as an explicit consideration in understanding the work done by nurses. It is possible that the lack of such reference could be justified on the basis of commitment of the state education and health system to a secular orientation. I think it more likely that the women connect ideas about militarism to the masculine and institutional power structures that are relatively straightforward and easy to explain in such a critical manner. These comments suggest this dissatisfaction with the power relations inherent in military organisation, which is precisely what the women seek to reorganise in the comprehensive model of nursing education. Given this clash of cultural values, it is ironic that a military discourse is employed in the women’s narratives concerning their students and their own experiences in the transferred nursing programmes.

**Heroic school of nursing educators**

The women employed an heroic identity about a number of their own nursing teachers who had left an enduring image of charisma and exemplary nursing practice with the educators in my study. Their portrayal as practitioners who embody nursing qualities suggests that here again, there is an implicit valuing of the enacting of nursing identity. The strength of such modeling seemed to be a significant factor for a number of the participants in their career move into nursing
education, and something that they later sought to enact in their own teaching relationships.

*I took my utter passion for nursing [to the nursing educator role]. And I knew from that nursing educator way back, that it wasn’t necessarily what she taught, it was her commitment to nursing. So I had a sense that people don’t always remember, but they remember the passion and the commitment and what it can be.*

(Kate, 359-)

*I often said to students, ‘I must have learnt a lot about nursing and anatomy and physiology but I can’t remember that. What I do remember is the nursing educators that I greatly admired’.*

(Fiona, 213-)

*The nursing educator that stood out from my own training epitomizes these lines, ‘It’s not what you taught me that I learned so well, while we walked side by side. It was who you were that I remembered, long after our ways did divide’. Everything that she did came back to a strong philosophy of caring, she didn’t necessarily articulate in the way we would now, but it just shone through.*

(Liz, 337-)

Kate, Fiona and Liz are depicting a primacy of practice discourse in the ways they reflect on their own nursing educators. As such, their comments reiterate the practice-focused discourse and emphasises the primary importance nursing educators seem to place on nursing as performance. Kate’s and Liz’s comments extend this idea to explain that their teachers’ character as nurses were of much greater value than the knowledge the students acquired. The nursing educators’ comments are imbued with a sense that their teachers passed on enduring values which the participants in my research have utilised to influence their own nursing education practice. Furthermore, by reflecting on nursing educator role models with her own students, Fiona is encouraging a new generation of nurses to consider their teachers in a similarly charismatic light.

**Heroic support from civil servants**

Jan Grant’s opening quotation to this chapter identifies the blame assigned to “the upholders of this change”. I take this to include the public sector workers who
developed and oversaw the transfer of nursing education. Jane and Tracy offered tributes to the people who worked within the civil service towards the transfer of nursing education from the control of hospitals to the tertiary education sector. Such ennoblement comes from the recognition of the particular struggles these people engaged in, and/or their under-valued role in the establishment of CNEP. One such example offered by Jane recalls:

[There were some] people who fought really hard for a new system of nursing education in this country.

(Jane, 426-)

And later, Jane went on to reflect on the effect of state restructuring for nursing education:

The changes in the Departments of Health and Education to the Ministries, those support groups that you had there, either their role went, or it was diminished, so you didn’t have them to help you fight any battles.

(Jane, 662-)

Regarding the people who worked for the establishment of comprehensive programmes, Tracy explained:

The real movers and shakers were people who hung in behind the scenes. It’s not the people that were fronting, it wasn’t the Director of Nursing, it was the people who were behind her.

(Tracy, 193-)

These examples evoke heroic identity for some of the people the nursing educators worked with during the development of comprehensive nursing. By emphasising their support and contribution to the development of CNEP, the overwhelming evidence of the resistance and hostility of the health and education sectors to the transfer of nursing education becomes illuminated.

The heroism of the first students

There is a commonly shared view among the participants that the first comprehensive graduates were unique and brave. This involves an unequivocal assignment of nobility and admiration for the first group of students to graduate
from each of the participants' respective programmes. To understand this metaphorical reference I present nurse educators' comments in three groupings. The first concerns a portrayal of the students as risk takers and particularly special people. The second section presents the women's comments about the bravery of students in facing a hostile and un receptive health care and educational milieu. The third aspect of heroic identity conferred on the first cohort of comprehensive graduates is their tolerance to put up with the pressures imposed upon them as they studied within fledgling and under-supported programmes.

Part of the reason nursing educators conferred heroic identity on their first students concerns their acknowledgment that in the majority of centres throughout Aotearoa New Zealand, candidates had a choice between the hospital-based programmes or the new CNEP. By choosing to enrol in the comprehensive courses when the hospital schools were still training nurses, at least some students were consciously rejecting the cultural traditions of nursing training as well as the security of salaried employment. Comprehensive students were affirming the same commitment that the participants as teachers themselves had made to the new courses. This said, it was never a completely "free" choice for many people who sought to become registered nurses. The simplest example of this is students with family commitments who would have found the night and weekend shift work unmanageable. Such candidates could seemingly only opt for comprehensive programmes. For others who had begun hospital training and for various reasons had left their studies uncompleted, polytechnic represented a second chance to achieve registration. Whether as active support of the fledgling programmes or as committed nursing candidates who were unable to complete the obligations demanded of hospital studentship, the participants construct the first groups of nursing graduates as being united in their risk taking and heroic identities.

The first cohort of nursing students shared a pioneering identity. In part, this was because of the absence of graduate comprehensive nurses to act as role models and to conceive what comprehensive graduates would actually be like. One of the ways this had consequences for students was the lack of vision. The first groups of students had no one to mimic, emulate, or look up to or who embodied the
identity they sought to attain. Through comments by Maria, Beth, Helen, Cathy, Liz, Olivia, Fiona and Rachel, it is possible to make further associations between the importance of embodiment and the construction of heroism for the first cohort of graduates in each polytechnic:

*I realised [when the students first met a comprehensive graduate, that it] was the first time there was concrete evidence that there was something real at the end of their course. Because we had not been able to show them something that they were going to become in a year or two.*

(Maria, 497-)

Maria had earlier indicated that the unproven success of comprehensive programmes influenced the construction of first generation comprehensive graduates as risk takers:

*I think that the first students who came in, many of them were risk-takers. It was new, many people had a negative view of it and thought that you couldn’t possibly be a good nurse coming out of such a course. ... There was an enormous effort of will to stick with it and to succeed in it, and a doggedness required. I think they were the bravest of the brave. ... They had a clear view of why they were there.*

(Maria, 399-)

She later went on to explain the unique qualities of the first CNEP graduates and Beth offered similar reflections:

*There was a doggedness, and they also wanted to be qualified nurses, and that’s an end in itself. They were the most disparate group of people, that first lot. But they were very close knit, the survivors.*

(Maria, 517-)

That first group of students ..was really different from the students who come in from there on. They know that they are part of an experiment, [and] they know that they are the first. They are out there as groundbreakers who will need a lot of support, a lot of nurturing. You have to support and encourage these students in a clinical environment which is totally artificial and often hostile.

(Beth, 430-)
It is apparent that the pioneering and independent spirit of the first comprehensive graduates is still vividly recalled by some of the women in my study. Part of the students' strength of character involved a desire to initiate positive change in the health sector when they became registered nurses. Helen described the assertiveness of some of the first graduates:

*Looking back on our first graduates, some of them were determined to get out there and change, and they were excellent. We could have picked on day one, who were going to do that ... And some worked really hard, and some have been extremely successful. They were usually thought of as being 'bolshie', but they were very successful. Some who've got very successful started out that way as graduates. They caught the fire, and could see the potential.*

(Helen, 1187-)

Such assertiveness was a desirable attribute of nursing candidates in the face of resentment and hostility from a community that had historically understood nursing and its preparatory programmes to be sited within secondary care areas working with sick people. A major problem that the nursing educators sought to overcome for their students was the programmes' inevitable reliance on clinical environments which were strongly imbued with the traditions and work ethos of generations of nurses who had trained in the hospitals system. The small numbers of comprehensive students and their nursing educators in clinical areas caused them to feel isolated and under surveillance from hospital employees, who identified their presence as unwelcome and open to criticism.

*You've got a real problem when you have got pilot programmes, because you have got a small output, and every one of those is going to be highly visible.*

(Cathy, 461-)

The first nursing candidates were assigned heroic traits because of their strength of character and struggle to work through the first three years of the programmes. The reliance on an heroic identity for the first generations of comprehensive graduates from each polytechnic is evident in the comments offered by Liz, Olivia, Helen and Beth.
I remember students, tears streaming down their faces because their mothers had said to them that their medal didn't have any value. That was awfully hard. The students who went though the programmes, particularly in the early days had a whole weight of public opinion upon them which was quite heavy... How can you know how much that's affecting them? How much of that was the reason we lost some, in those early days.

(Liz, 1260-)

For all the lack of resources at polytechnic, they seemed to have something that, I suppose, the first course in any course are pioneers, but they suffered for it, I am quite sure of that. Suffered because they were the new course, and because they lacked facilities like library resources.

(Olivia, 383-)

In those early days ... everything was run for the hospital-based programmes, and we had to abide by nursing regulations, of course. The first few students had to sit the same state examinations to prove they were as good as. They had to sit five: paedopaedic, psychiatric, and the three general exams.

(Olivia, 1159-)

The students in that first intake just rolled with the changes. They were incredible, incredible. I look back at them and think, 'What wonderful people', because they all were. And apart from a couple of mature age, they were all pretty young and they just rolled with it.

(Helen, 361-)

The frustrations often were with nurses themselves, particularly in the clinical area. Having to battle for students' placement with your own profession ... was enormously frustrating and very wearying, as you needed to support the first group of students every inch of the way.

(Beth, 911-)

Such resentment and hostility prepared many of the first graduates for the very similar struggles they went on to face as health sector employees. For example, the lack of acceptance by hospital staff to recognise graduates as comprehensively registered, is illustrated by Fiona who recalled one of the first new graduates who was employment in a psychiatric hospital:

She was the first comprehensive graduate, and had an awful battle with the Principal Nurse, who was determined she was going to wear brown epaulets because that was what registered general nurses wore. And the
graduate was determined to have blue ones, because she had her psychiatric registration.

(Fiona, 45-)

This demonstrated the struggle that pioneering nursing graduates faced in their efforts to be respected and acknowledged as nurses across a range of clinical settings. The story also constructs graduates as principled trailblazers, who are not merely self-interested, but who are concerned to establish systems where future generations of comprehensive graduates might also be treated with respect. At the same time the legacy of epaulettes on nurses’ uniforms that have historically been used to signify status is a powerful military motif.

Not only did the students have to contend with rejection by the staff in institutions unprepared for their presence, but they were also expected to conform to the excessive demands of nursing educators who were mindful of the judgements being bestowed on them and their students. One way that comprehensive teachers could minimise the potential for students to be judged as inadequate in the clinical sphere was to over-prepare them. This is reflected in the following comments by Maria and Rachel.

_We were ridiculously fierce in our requirements of them._

(Maria 428-)

She later explained

_The programme was ridiculously packed. We were out to prove something, and we loaded those people in a ridiculous fashion, knowingly I think. .... We were very conscious, you couldn’t help but be conscious, every time those students went out into a place where they were under the view of other nurses or other health professionals and patients. If they appeared to be inept, that was another marker against the programme, and the whole concept and the individual. So you were tempted to prepare them as much as possible for every eventuality._

(Maria, 610-)

_In the early days when the environment was hostile, educators did focus on helping students fit in, especially in the hospital setting. That created tension for us, as we were committed to a different sort of preparation for nurses. I think we tended to focus on behaviours which were seen to be_
professional, things like punctuality, reliability, appearance, that uniform again, not wearing it to and from clinical, no jewelry, makeup for instance. And these things were noted on clinical assessment forms and contributed to whether students passed or failed.

(Rachel, 1075- )

In these comments there is an underlying emphasis placed on the performance of being a clinical nurse that pervades the nurse educators’ construction of the first nursing students as sharing an heroic identity. The nursing educators drew on the metaphor of heroism to convey their memories of the how they and their students – and in particular their first group of students – responded to a reluctant and inhospitable health and education context.

Nursing educators as heroes

Turning to the most extensive range of representation in this chapter, I want to present the ways in which nursing educators have constructed their colleagues and themselves through an heroic metaphor discourse. Not suprisingly, there is a close connection between the values conveyed for the first nursing graduates and their teachers as they were experiencing the same struggles and hostility, and explained these using similar patterns of language. I begin by examining the comments offered by a range of participants who speak about the shared identity of comprehensive nursing educators as risk-takers. This is followed by a section of comments that attend to the hostility and resistance experienced by the participants in their efforts to furnish comprehensive students with the optimum conditions within which they could study nursing. A third section of work that parallels the tolerance as an heroic quality of the first graduates, constructs nursing educators as proactive in their attempts to promote the development and prosperity of CNEP in Aotearoa New Zealand. In addition, I offer two further groupings of comments that I believe characterise nursing educators within a heroic discourse. These concern the patriarchal organisation of the education sector in which the nurse educators struggled for women’s equality, and a shared concern for the more recent developments within, and external to, the nursing education programmes.
A number of the participants engaged with a heroic discourse to explain the difficulties faced by comprehensive nursing educators. Jane offered an explanation of the ways hospital staff demonstrated forms of sabotage to make nursing educators wary and defensive. Her comments illuminate the precariousness of these women’s experiences as comprehensive programme staff in areas where they had previously worked as employees of the health sector:

_The nurse educators would prepare the wards for the students coming and they would send information to the hospitals. The nursing educators and the students would turn up on the day and the charge nurse would say they didn’t know they were coming. In some cases that was because the administration hadn’t sent on the information, but we would get the blame. So you were always sort of treading on tiptoes, and you always had to tread very carefully and I think sometimes in the earlier years you felt you were going into an alien country. Although you knew the country very well, it had a few land mines in it, you know? You were very careful. ... Sometimes you were quite defensive about it, but I think it just got to the stage where you thought, blow this, I don’t have to adjust. I don’t have to, what’s the word? Defend isn’t the right word, because the decision’s been made, that this is going to happen in nursing education, and we’ve just got to get on and deal with it._

(Jane, 446-)

In this quotation Jane employs a particularly evocative metaphor of physical embodiment and constraint to convey the experience of what it was like to return to a clinical environment where she had once felt accepted and at ease. The “well known country” had become “alien”, with hidden “landmines” that demanded a “tiptoeing” and “careful ... treading” to work successfully as a comprehensive nurse educator. She explains educators’ initial defensiveness as a means to cope with the pressures faced throughout the health sector and the subsequent replacement by a sense of assertiveness about the legitimacy of CNEP as something of an heroic achievement.

Jane’s comment foreshadows a cluster of remarks which evoke the idea that nursing educators constructed themselves as risk takers by accepting employment opportunities and working successfully within CNEP. A comment offered by
Rachel describes an heroic identity, by reflecting on colleagues who had resigned from their work in comprehensive education:

When you are working in a climate of criticism and there is a lot of questioning, I know a lot of nurse educators who didn't stay in the system, partly because they just got tired of the battles. I think you had to be a very strong person and very confident professionally to withstand it.

(Rachel, 623-)

Similarly, Gwyneth offered a reflection of the attitude that characterised the culture of hospital-based forms of nursing training that would account for some of the hostility displayed towards polytechnic nurse educators and students. This makes reference to the degree of physical work performed by hospital-qualified nurses and the belief that such efforts would train nurses to be strong. She recalled her own ability to assert herself as a teacher within the hospital nursing education system, but she muses over how things may have been different for her younger colleagues:

If you are twenty, twenty one, you have to be a pretty special person to stand out in a crowd. And it's that tall poppy thing, isn't it? Let's knock them down, what was good for me is good for you, and I had to work these terrible shifts and six days a week, and you should do it too. Because it's good for the steel.

(Gwyneth, 615-)

The assertiveness of other participants is captured in comments such as those offered by Beth, Anne, Kate and Cathy. Beth explained:

I am one of those people who if somebody doesn't say no, I will try it anyway, and push the edges out, and if they don't shout, well, we will keep going.

(Beth, 336-)

While Anne reflected:

I went [to teach in comprehensive nursing education] and it was a baptism of fire. I couldn't get the other staff to understand what it was I believed they needed to do. So there were terrible clashes of ideology.

(Anne, 241-)
For Kate there was an awareness of her personal strength, which influenced her career development:

*I decided nursing education needed me more than [another discipline]. I didn’t see a lot of leadership in my own discipline and I felt that I could make more of a contribution to [it].*

(Kate, 399-)

Cathy made several comments that evoked a sense of heroism as an aspect of her subjectivity:

*I was a product of the local system. So in one respect it was kind of thought by some, ‘Well, she will do as she is told. She should know what to do’. And yet I was the repressed individual seeking to do something quite different. And trying to walk a fine line between being diplomatic and ensuring that you got reasonable access, but not compromising on things that you thought were critically important to the eventual outcome for the practitioners.*

(Cathy, 46-)

Further on in our interview, she recalled her attitude to making one of her career decisions:

*Job vacancies were coming up... and I said, ‘OK, which is the toughest one?*

(Cathy 399-)

Reflecting on her career more generally, she offered the following comment:

*One of the toughest things was the anxiety about what if, inadvertently, we do something stupid that makes it fail? The anxiety about making sure that it didn’t fail. But because you believe that what you’re doing is right, you don’t lose too much sleep over it, but occasionally you think, ‘Oh, I don’t want to let down those people who have had enough faith to say, ‘Look, you guys can do it’. ... That’s an anxiety producing thing, although you don’t externalise it too much.*

(Cathy, 57-)

With such an expression Cathy explains the enormity of the burden of the responsibilities associated with a leadership role in fledgling nursing education
programmes. On reflection, I am surprised that only a handful of the participants spontaneously spoke of such concerns. I am left to consider if it had perhaps been an important issue that had faded over time, or that, as senior nursing educators perhaps the participants in my study had a well developed sense of self-confidence to overcome such anxiety. A possible alternative rationale might be connected to a sense of heroic modesty, whereby the nursing educators were reluctant to explain the magnitude of the difficulties they experienced. None-the-less, Cathy's evocation of the burdens of such responsibility further iterates the heroic construction of nursing educators in the first decades of CNEP development.

In connection with the grouping of comments offered by nursing educators that evoke an heroic image, the following quotations capture a sense of the construction of the participants as disloyal to their training hospitals in response to their decision to work with the comprehensive preparation of nurses. A component of an heroic discourse is thus the imagery of traitorhood, on the basis of the women's broken allegiance to their schools of nursing. Cathy and Jane explained:

... you were caught in this dilemma, 'You are one of us, what are you letting us down for?' and, 'You shouldn't be involved in this. You are one of us.' Because I had studied and worked there and I knew my way around the place. So you had the feeling that you were a bit of a traitor.

(Cathy, 548-)

It was easier by the fact that you still had strong networks and you knew a lot of those people and you worked with them or they were your contemporaries. And... a lot of the nursing educators knew those people and were going back into areas [where] you tended to be looked at as if you had gone off, on to the other side, as it were. If only they knew that the polytech' was a bit alien at the time as well.

(Jane, 523-)

Here again, Jane employs a physical metaphor to prompt an understanding of her treachery by the use of the term, "...going off to the other side". By way of a final comment, it is interesting to consider the dominance of this section of work by quotations offered by Jane and Cathy. Perhaps their similar responses to these
issues reflect a similarity in time and context between these women’s experiences as nursing educators. Alternatively, their constructions of heroic discourse may simply resist constructions of modesty about the extent of the difficulties nursing educators encountered.

The explicit descriptors of the battles, the fighting, and the aggressive resistance by groups of people involved in the health sector, are indicated in comments such as the following, which all centre around the ways nursing educators confronted hostility. Here again, there is a physicality that underpins many of the comments from Fiona, Delia, Jane, Rachel, Helen and Emily that enhances the imagery of nurse educators as having attained heroic identities:

*The real problem nurses were the ones who were passively aggressive, that really created chaos behind the scenes and they would smile sweetly as you walked into the ward.*

(Fiona, 186-)

Delia recalled a speech she gave to a group of nurses:

*And I sort of asked them to stop nurses beating up on each other. Because most of the criticism actually comes from nurses.*

(Delia, 469-)

And later she expressed her feeling that:

*We’ve just got this culture out there of nurses knocking nurses.*

(Delia, 582-)

Other participants explained the situation in the following ways:

*At the time of the transition process, you began to wonder about the professionalism of some nurses because of the hostility that the students in particular were seeing from nursing staff. I think it was a very good example of horizontal violence.*

(Jane, 419-)

*In the early days … the environment was hostile.*

(Rachel, 1078-)
The lowlights [of my role as a nursing educator] were just the sheer having to fight every inch of the way in those early years. Just fight, fight, fight, fight, fight. One thing after another, and you just got utterly immersed in fighting. ... And I think we were all like that. It was 'we are all in this together, and we've got to fight'.

(Helen, 2090-)

Emily explained that some of the hospital staff promulgated an attitude throughout the health sector that the qualities of comprehensive programmes and the clinical nursing skills of the comprehensive educators were less than adequate.

The messages that the students got from the nurses who are out in practice, the damage that does in the way they approach their learning. The constant berating of how hopeless the programmes are, and, 'Don't take any notice of what they do, do what we do', and, 'What they are doing is really sloppy, sloppy work'.

(Emily, 544-)

The nursing staff's counter-discourse represents an enormous challenge to the efforts made by nursing educators to have CNEP accepted as a legitimate alternative to the hospital-based programmes. It also poses a significant slur against the primacy of practice that nursing educators upheld about their personal nursing subjectivity - that they were employed as nursing educators on the basis of their clinical nursing excellence. Similar accusations of nursing educators' poor standards of nursing skills is reiterated in Antoinette McCallin's thesis of 1993. She wrote:

Even though the vehemence has gone out of the debate, comprehensively trained nurses continue to be criticised by their hospital trained colleagues and members of the public for a perceived lack of practical skills and an inability to fit quickly into existing institutions. .... Although research evidence is not available, nurse educators are often perceived as the ones responsible for these difficulties.

(McCallin, 1993:4-5)

Furthermore, my discussion in the earlier chapter about students and graduates wanting to fit in and blend into the culture of hospital-based nursing work makes
Emily’s accusation all the more revealing. The desire to fit in may actually indicate the efficacy of such a counter-discourse, in that groups of students may not have been able to resist the beliefs of health sector staff about the inadequacy of comprehensive models of nursing care.

At the same time as nursing educators had to be defensive and protective of their students and themselves, they discussed the ways they and their colleagues were assertive in promoting the development of CNEP. Such proactivism enhances the participants’ portrayal of heroism as a metaphor to capture the commitment and efforts of nursing educators. Hence my analysis suggests that the women’s reflections concerning heroic identity are a reasoned and strategic response to the need to inform vested interest groups about the reasoning behind the transfer of nursing preparation. Delia described her earliest encounters with the proposed changes in nursing education by depicting a powerful image of a nursing leader in a heroic stance:

[I took on a new job at the local hospital] and it was about the time that comprehensive nursing programmes started [locally]. And [the Head of the programme] was on her white charger, going around, trying to explain it all.

(Delia, 68-)  

This image of gallantry evokes heroic qualities of the women who worked hard to ensure the successful development of comprehensive nursing in Aotearoa New Zealand. More commonly participants explained the work they engaged in to maximise the public and professional awareness of the developing programmes. This is apparent from comments by Fiona, Olivia, Liz and Gwyneth.

A lot of my time was spent describing what the learning needs of the students were, and why it was not desirable to just put them in and let them survive, why we were, in other people’s description, ‘Being so protective’ of our students.

(Fiona, 173-)  

...public opinion is pretty important, and in my first year I think just about every women’s group in the city had me talking about nursing in the
evenings. ... There was always somebody coming up and asking ‘What about this new nursing programme?’

(Olivia, 1907)

[As a senior nursing educator] you had to carry the torch for change. And you had to do it in all sorts of arenas that were not just within nursing, and yet you also had to do it within nursing, because the harshest critics were those who felt they had the most to lose.

(Liz, 101-)

I really needed a lot of guts to stand up and be different... to challenge people on the deepest level of their phobias [about the transfer of nursing education].

(Gwyneth, 365-)

In the education sector, this assertiveness manifested as an insistence on the programmes being as effectively resourced as possible. For example, Beth discussed the role of the nursing Head of Department as attending to the needs of the programme, and the importance of using threats to bargain for departmental needs:

[In the education sector in] those first years, it meant a lot of hard work, and you found that your time was not just spent on the programme and nursing and staff, but also spent politically on making sure that you were getting the resources that you really ought to have. Nobody was going to give it away, some of their share, and you really have to fight like mad for it. That was very difficult, nurses are not used to doing that... Your Head has got to get up there and say, ‘Well this is my share’. ... If they don’t give it to you, you have got to be prepared to stand up and jeopardize your own job and say, ‘Well if you don’t give me the resources we’re not going to take in that intake next year, we are going to take less’. Now I know you risk getting fired... but that’s what it’s about at the end of the day.... You really had to push very hard for things. ... You had to really kick and struggle for every bit that you got.

(Beth, 814-)

Cathy and Maria explained that a particularly effective strategy for negotiating their demands within the education sector was the authority of the Nursing Council of New Zealand to which the qualities of each programmes had to conform.
[The senior polytechnic administrator] saw the polytechnic as the salvation of nursing. ... and he had his own ideas. It was quite tough to get him to realise that the Nursing Council were going to register our students. [He would say] 'Oh, but we can do what we like..', and I would say 'I'm sorry but we can't'. I remember having to get reinforcement from highly respected [nurses, who would say] 'when you are talking to him, just let him know that the Nursing Council...'.

(Cathy, 433-)

The Nursing Council did come in handy, because if [the polytechnic administration] wanted you to do something which really got in the way of good integration of theory and practice, you could point out that they wouldn't approve our curriculum if we didn't show that. ... There were [polytechnic administrators] who were determined to buck the Nursing Council, they didn't want to be told what to do in their own place.

(Maria, 1049-)  

Cathy and Maria signpost a complex layering of Foucauldian power/knowledge issues at issue here, alongside a gendered struggle for authority and independence. There is a sense of arrogance conveyed about the senior staff members' attitude to CNEP in Cathy's choice of the term “salvation” and Maria's explanation of their desire to “buck the Council”. The development of strategies to manage successful comprehensive programmes further enhances the imagery of a heroic discourse among nursing educators.

In a similar way, the nurse educators were mindful of setting standards that the colleagues who came after them would benefit from. Helen employs the language of fighting and conflict to convey the sense of why she had to fight hard for the remuneration she felt that she was entitled to:

*I had a feeling that [we needed to] fight for recognition [of tertiary qualifications in the salary scales]. I forever felt as though I was fighting because I would not go in on the scale that they put me in. I said, 'No, I'm worth more than that' [because of my tertiary study]. ... It was a really hard struggle, I had to fight and fight and both the principal and the Polytech [administration] couldn't understand what I was fighting over.*

(Helen, 268-)
Less surprisingly given the cultural embeddedness of a differing model of nursing, the health sector demanded many struggles from the educators to obtain the best possible conditions for their students. This involved acceptance from the nursing hierarchy that the polytechnic-based staff and students would want to work differently from nurses and nurse educators employed within the health sector. Maria and Jane recalled struggles with senior hospital staff concerning the appearance of comprehensive students in clinical areas.

*I fought against the matrons* [about the uniforms].

(Maria, 1774-)

*We did have a running battle about uniforms that went on for some time.*

(Jane, 531-)

Cathy and Liz found gaining access to clinical sites was problematic:

*It was a big fight* [to get effective clinical access in local hospitals for the comprehensive students].

(Cathy, 233-)

*Initially at the local hospital, it was pretty hostile. ... You were constantly on guard.*

(Cathy 523-)

*Task-based and hierarchy-based was still the kind of orientation of the bulk of the nursing work force. And in come these comprehensive students, who only come in to learn what it is they’re there to learn. So there was an immediate conflict there.*

(Liz, 630-)

There is a sense of physical embodiment implicit in such comments, in how the students appeared in the clinical contexts and the struggle to be accepted within the health sector institutions. This connects with Foucault and feminist poststructural analyses of subjectivity as being constructed through discourse - in this context, the institutional discourses that valued hospital-based models of nursing subjectivity and actively resisted threats to the status quo.
Gender conflict

The arrival of comprehensive nursing challenged “technical education’s [historic] handicap of the stigma of social and intellectual inferiority ... that attached to blue collar occupations in which people got their hands dirty” (Dougherty, 1999: 57). It also altered the traditional male dominated staff and student populations (ibid: 42-44). The decision to site nursing education in polytechnics was, according to some participants, greeted with a continuum of responses, from blatant hostility and gender isolation through to acceptance and hospitality. Jane, Cathy and Beth characterise the resistance to their arrival in the education sector in a range of ways:

When I started there were more male staff in the polytech than female. And I always remember walking into the staff tearoom one day, and the only females were the tea lady and myself. And I sat down at a table with these two men, who didn’t include me in the conversation at all during the time I was there and it was most uncomfortable, and I got out as soon as I could.
(Jane, 845-)

...You had to prove that you were O.K. I’ll never forget when I was... first woman head of department; I had all these fellows sitting around, especially trade fellows. ‘What’s this woman doing?’ kind of thing. ... It was a very masculine environment.
(Cathy, 489-)

The most difficult of things that most of us encountered at that time was going into a male dominated tertiary institution. You had to be very confident within yourself to cope with that. Certainly the staff had problems with that as well, and it was very clear that it was very chauvinistic. ... At the meetings of Heads of Department you would be the only woman; well there were two actually, because there was the secretarial school head of department. Sitting with this table of men. ... We also had an extraordinarily difficult senior administrator at that time, who was also very chauvinistic. He didn’t communicate well with women, which made it very difficult for all concerned.
(Beth, 790-)

Later on in our meeting, Beth explained more about the ways she experienced this gender bias:
We won a lot and we lost a few. You have to go in being prepared to win some and lose some, and we won quite a few very large battles. Certainly in terms of staffing, for instance. Inevitably male members of the interview panel would want to take someone else for a very different reason than you did in terms of... the qualities that you needed. You used to have enormous battles even at that level, in terms of actually saying why that person was the best person for that particular function. Not because she was beautiful, young or all of these lovely things.

(Beth, 865-)

Such comments offered by participants have been relatively rare. The most likely reason to account for this silence relate to the newness of CNEP to the education institutions and the lack of overt gendered resistance and hostility comprehensive staff experienced across the health sector. It was perhaps only after an extended period of time that senior nurse educators might be able to identify explicit gendered inequalities in the education sector. Alternatively, as I have suggested in relation to other forms of silence, perhaps the participants witnessed such power plays but did not mention them in their time with me; or perhaps because they were senior staff in CNEP, their struggles to develop nursing education rarely gave them time to attend to gender politics. I believe that issues of gender inequalities are inherently confused given the concurrent relations of power that manifests by occupational status in the health sector.

A final group of comments offered by participants can be understood to construct nurse educators as sharing heroic identities. I am referring to the common practice of expressing concerns about recent developments in nursing education since the end of the particular period of my study, in 1992. While I understand that these views are based around a concern for the political reorganisation of health and education sectors away from a welfarist model, I also believe such viewpoints are underpinned by a nostalgia for the organisation of programmes in the early pioneering years.

And... I get really angry and frustrated now, when I have heard in latter years... when [restrictions on student intakes] came off, and nursing departments were pushed to increase enrolments. [And there were Heads] without... enough courage to stand up and say, 'We can not take any more
students, we haven’t got the clinical [capacity]. And, ‘I am not going to take them’. 

(Beth, 824)

Such protectiveness, and their regard for the recent demise in standards of comprehensive nursing education, reinforces the notion of the participants as heroic agents, and continues to employ the lexicon of aggression. In discussion about the potential for a competitive provision of health care services, Rachel explained:

We need to be careful not to allow ourselves to be used as a sort of weapon against the medical profession.

(Rachel, 571)

Continuing with debate around the developments in professional authority of nurses, Delia commented:

You have got to look at titles like ‘clinical nurse consultant’, ‘nurse specialist’, ‘nurse practitioner’, and be very careful we don’t muddy them. ... I mean there are too many schools of nursing and I have a huge fear we will develop too many post-graduate schools and you will dilute what you mean. If there’s a different stream of nurse specialist in [two different education providers], then we are not united again, and we will get picked off.

(Delia, 761-)

In a similar way, Cathy describes this as a sense of conflict among tertiary institutions:

One of the things I have seen was the internecine wars occurring between [post-graduate nursing providers].

(Cathy, 1239-)

Helen focussed on the sense of futility in regard to the development of degrees for the three year programmes:

I just think they jumped in a wee bit fast... I have a great fear that the degrees will be fairly useless. So we have got to be careful.

(Helen, 2193-)
Such comments enhance my thesis that the nursing educators involved in the burgeoning tertiary education sector employed a discourse of a heroic metaphor to make sense of their subjectivities as nursing educators, their experiences, and the people they worked with in developing comprehensive nursing education.

Discussion

The dominance of language that involves action or performance throughout this chapter is worth exploring in greater detail. Of particular interest is the discourse of heroic “fighting” employed by the participants as a metaphor for the ways they recall their work. This represents a particular version of the metaphors of movement - in this case, metaphors of fighting and heroic struggle - which Bloom suggests as often important for “characteris(ing) subjectivity as a process that takes place within the world” (Bloom, 1998: 4). This form of activity reiterates the notion of agency upheld by the participants, as well as indicating connections with the wider social, political and cultural contexts in which these nursing educators were working. The participants speak about their own battles, and their personal struggles to support the development of nursing education in their geographical region. They also link this with their understanding about how such struggles are shared by their colleagues who were involved in comprehensive nursing education across the country.

In these ways, the participants are echoing Leslie Bloom’s idea that in theorising subjectivity, the relational and the contextual components must be considered. As Bloom explains (1998: 5), “assertions of subjectivities as being produced relationally are critical, for they suggest that feminist coalitions may be positive sites for the production of subjectivity”. The nursing educators I interviewed employ language that moves between discussion about their personal reflections, to events in nursing education and comments about the generalised experiences they recalled being shared by their colleagues. These patterns of language are important for revealing the sense of commonality and collegiality among nursing educators. As has been discussed earlier, nursing language is pervaded by
militaristic terms that acknowledge the dominant understandings of organised systems of nursing through the legendary Florence Nightingale. The continued use of militaristic discourse not only pays homage to such beginnings, but it engages with the continued cultural dominance of medicalised constructions of nursing work. Such discourse implies that nursing is about action, acting and performing work for or with people.

By the continued engagement with iconographic nursing discourse that implies active performance, being “on duty” in clinical contexts and fighting against disease and pain, there is a continuing prioritising of general medical-surgical nursing over other forms of nursing work and care. Performance as nursing remains seemingly all-important, and the participants in this study continually strengthen this legacy. This reinforces the idea that general and secondary care models of nursing are more legitimate than other ways of caring for people as registered nurses. There is an implication, too, of what Emily called the primacy of practice, where nursing knowledge is assigned a secondary status to clinical nursing skills. A contradiction thus emerges. On one hand the rhetoric of CNEP emphasises a “knowledge first, then practice to build on knowledge” as the foundational approach to nursing education. On the other hand there is an enduring and powerful discursive valuing of nursing as performance, being seen to work as a nurse, being able to function in a secondary care environment and to care for one’s patients effectively. I believe that these contradictions are an important aspect of nursing’s professional identity that need to be reconciled in order for groups of nurses to practice optimally in the Aotearoa New Zealand health service. Without a reconciliation or at least an acceptance of the legitimacy of difference between alternative nursing ontologies and epistemologies, nurses will continue their internecine wars.

While staying with the troublesome use of aggressive and fighting aspects of heroic discourse, an alternative to the enduring legacy of militarism can be read in the women’s texts. By reorganising this discourse around militancy rather than militarism, the whole heroic discourse can be reconstructed as a feminist project, wherein the participants struggled as heroic pioneering change agents to emancipate women employed as nurses in the medicalised health care sector from
the shackles of paternalism and subservience. Embodied in the total patient care models of comprehensive nursing practitioners, the struggle was not so much about fighting against the old system, as much as fighting for the legitimacy of the new. Here again, by simply rereading the discourse, various understandings become apparent.

Returning to the layers of complexity in reading the language offered by nursing educators, it is insightful to consider the notion of “horizontal violence” to explain the aggression by employees of the health sector towards those involved in CNEP. On one level, I have come to understand this is not horizontal but vertical violence, because the people employed in health care settings held power over the clinical settings in which they worked. Furthermore, the difficulties hospital staff imposed on CNEP staff and students represented their power as “legitimate” members of the health care sector, where nurse educators were polytechnic employees and their students were unqualified. I believe an enormous amount of power accompanies those who have dom(a)in/ance over physical spaces such as health care institutions. The reverse is similarly understandable: the nurse educators and comprehensive students were implicitly vulnerable because entry into clinical sites was not theirs of right. This return to issues of power provides a useful springboard to move from the final substantive chapter to the concluding discussion chapter.
Chapter Ten: A Concluding Discussion

The purpose of this final discussion is to present a coherent review of the range of issues that I have explored throughout the thesis. I find comfort in embracing feminist poststructuralist epistemology because there is no expectation that my work will offer a specific central thesis encompassing all I have written about and which represents a final conclusion to my research. Never-the-less, I am offering a number of informed hypotheses which reflect my analysis of the narratives of nursing educators who were employed in developing CNEP. They illuminate this group of women’s contributions to nursing in Aotearoa New Zealand. I hope that such theorising, like my thesis as a whole, might represents more than an academic exercise. My thesis documents the vital contribution this group of educators and their colleagues have made to the development of the nursing profession. Furthermore, I believe that my dissertation may assist future generations of nursing educators to convey to groups of nursing students the complex and rich cultural legacy which they are preparing to join. Furthermore, other women-dominated occupational groups may utilise such reflections in relation to their educational, industrial and professional development.

I began this dissertation by reviewing the women’s engagement with six discourses that reflect the complex social, cultural and political milieu of CNEP. I discussed each individually and collectively in relation to the Foucauldian ideas of power/knowledge. This is done to illuminate the nursing educators’ narratives of their involvement with the development of CNEP and the ways they construct their subjectivities as nursing educators. I also explored the extent to which my research represents a Foucauldian genealogical project. In the final part of this chapter I move away from the specific focus on the educators to offer a commentary from my perspective as an “onsider” to the establishment of comprehensive nursing education in Aotearoa New Zealand.

It is necessary to return to the work of Michel Foucault and in particular the pertinence of his work on power/knowledge to illuminate the reasons why this group of discourses is prominent in the nursing educators’ narratives. I have indicated in earlier chapters that power is most usefully understood as a complicated and diffuse construction that reinforces and/or undermines socially
potent discourses. As it is played out across the range of issues that make up the
diverse context of nursing educators' experiences of CNEP, power remains
obscure, unquantifiable and intangible. Foucault's concept of power manifests
through omnifarious systems of surveillance, and these in turn are associated with
"disciplinary systems": disciplines which are developed by legitimating and
refuting particular discourses that promulgate knowledge in various guises
(Foucault, 1980: 106). Far from being a one way process, power/knowledge
works both ways, as Foucault explains: "The exercise of power perpetually creates
knowledge and conversely, knowledge constantly induces effects of power"
(1980: 52).

The power/knowledge relationship offers a way of exploring professional
discourses. Beyond the immediate connection to characteristics of professional
groups (namely the professions' specialised knowledge and the sovereign form of
powers their members hold in society), power/knowledge can be employed to
conceptualise occupational status. This allows professionalism, constructions of
work and subjectivities to be understood in illuminating ways and the changes that
occur in these over time can be seen more clearly.

To understand the complex ways that nursing educators have made sense of their
experiences in CNEP, it is necessary to understand the context in which
comprehensive programmes have been established. The ways that the women
have each negotiated their own route through the health and education sectors
reflects the enduring values of social welfarism and the radical challenges
introduced by the neoliberal political reforms in the mid 1980s. But I argue that
even the magnitude of political regimes were of less consequence than the
enduring cultural legacy of the traditional apprenticeship models of nursing
training, associated with the medicalised organisation of the health sector.

By working in fledgling comprehensive programmes, nursing educators faced a
struggle to have the new programmes accepted. The discourses that the women
have engaged with represent a strategically sound and astute range of descriptors
of the new programmes. At the same time, each of the discourses constructs
comprehensive nurses as honourable and legitimate students and registered nurses,
different from their apprentice-style trained peers, possibly with less honed
clinical skills but potentially more effective ways of working with patients. At the
same time that they were expected to fulfil education and Nursing Council obligations, they were experiencing resistance from stakeholder groups to the establishment of an alternative to traditions of nursing education. The group of characteristics I have reviewed, bear testament to the creative and original ways they managed to find space for themselves to be effective nursing educators amid these expectations. I will explain these characteristics by reviewing the breadth of my analysis of each, and by proposing in what ways these characteristics are different from modernist patriarchal professional discourse.

Firstly, the employment of a discourse of education as emancipation has been used by the women to understand their own experiences of nursing and other forms of education, both on a professional and personal level. Education as emancipation represents an important value for the women’s explanations about their careers in nursing across clinical and teaching roles and liberation beyond their employment-related identities. This is also an important value that participants have clearly sought to impart to their students, to encourage them to develop a critical consciousness of their undergraduate nursing experiences, their registered nursing practice and to orient them towards maintaining a professional commitment to ongoing post-registration study.

A Foucauldian regard for power/knowledge suggests that the participants’ employment of education as emancipation represents a strategy to promote comprehensive programmes as a legitimate alternative to the apprenticeship-style hospital-based preparation of registered nurses. A significant component of this discourse has been considerations of power. Power is traditionally regarded as an important aspect of professional forms of education, one that classically liberates the professional by wielding power over their client groups. Knowledge in professional traditions is elitist, exclusive and exclusionary, it is only able to be held by sanctioned members and remains privileged and inaccessible to the members of the public and to clients. The women in my study were offering an alternative model of education as emancipation, one that involves the empowering of clients (be they student nurses in the education sector, or patients in the health sector), and a partnership model of working “with” patients rather than “in charge” of them. This also involves the nursing value that education is empowering by focusing on health, rather than sickness-based care. Patients might learn skills so they avoid or minimise potential ill-health. In this variety of
ways the nursing educators employ education as emancipation as an economically rational, pedagogically sound and professionally strategic justification for the development of CNEP.

By drawing on a discourse of legitimacy of difference, the participants in my study have employed a valuing of diversity as a professional characteristic. This valuing of difference and respect for alternatives is important for the ways the women not only organise their programmes of study, but also through the values they convey to their students. As I have discussed in Chapter Four, the freedom that the senior educators in CNEP were permitted in the organisation of their programmes (given limited requirements from the Nursing Council of New Zealand) facilitated a diverse range of approaches to the brief of developing pre-registration comprehensive courses. At the same time the women convey a strong agreement about the qualities they sought in potential nursing educators. Many explicitly discussed the diversity they sought among staff, while others sought out nursing educators who upheld similar values to the participant, but who were able to be assertive in the context of health care settings. Finally, the integral value of nursing educators to respect differences between nursing candidates and to encourage a diversity of students into their programmes reflects this professional commitment to the legitimacy of difference.

In displaying the characteristic mentioned above, comprehensive nursing educators are enacting a Foucauldian power/knowledge construction in ways that I believe represent a valid alternative form of professional nursing discourse. Historical constructions of professional power give little attention to the politics of difference, let alone positively consider that difference is legitimate or worthy of being upheld. At the same time it is the traditional lack of knowledge about alternative forms of culture, treatment, or spiritual values that renews such disregard. Here the interrelationship of power/knowledge becomes clear. As a new profession, nursing educators celebrate and embrace differences in ways that connect their professionalism with their recognition of the fractured poststructuralist understandings of the world, and the health education sectors. They pursue diversity in the students they work with in CNEP and their curriculum is imbued with such discourse, as evidenced in the respect for biculturalism and the Treaty as issues of cultural safety. It is through the examples being demonstrated by these women as an astute group of educators and nursing
practitioners that I have every confidence in the preparedness of comprehensive graduates to work in respectful and informed ways as nursing practitioners.

The importance of a discourse of valuing clinical nursing skills is clearly explained by the participants in Chapter Five. This discourse has been employed by the participants in a variety of ways that refer to the importance for both students and staff of acquiring nursing experience in sickness-focused hospital settings. The women in my study frequently discussed the problems and their often creative solutions to provide students with nursing practice often under difficult circumstances. The women's talk is also interspersed with comments concerning the changing systems of care over the past decade or more, and the consequences this poses for understandings of clinical experience. Comments which raise important questions about the innate or learned inclination to nursing skills and the dilemmas faced by nursing educators as to their nursing and their teaching identities are also offered.

Power/knowledge is, in Foucauldian terms, just as much concerned with the perpetuation of forms of authority as it is with strategies to transform systems of power and knowledge. In narratives concerning the primacy of nursing skills I believe the women are focusing on the importance of traditional models that concern "the primacy of practice". I believe the women are drawing on two contradictory representations of power/knowledge through their engagement with this discourse. On one hand the women can be understood to perpetuate nurses' hand-maiden status to medical staff within a sickness-oriented model of health care in which skilled nursing is a ritualised performance. In this model, nurses' power is limited and their knowledge base can be limited to the technical skills necessary to work in routine-focused and medically-oriented ways. On the other hand, perhaps a primacy of nursing skills is a forum through which nurses can assert their own domain, exclusive of medical or other health professional intervention, and one which may allow nurses to work from a nursing-specific epistemology.

I believe the participants are referring to the primacy of nursing practice as representing something between these extreme views. I propose that nursing as performance is a creative strategy employed by the women to make sense of their own experiences and values about nursing as work and the philosophy they need
to uphold as senior staff of CNEP. The final point to make here concerns the Foucauldian theory of surveillance. As discussed in Chapter Seven, stakeholder groups throughout the health sector, most notably medical and hospital-trained nursing staff, operated systems of surveillance over CNEP staff and students in the clinical settings. Proficiency at clinical skills was an important way of demonstrating the comprehensive programme’s legitimacy and a way of subverting preconceptions that comprehensive students studied theory at the expense of acquiring clinical skills. Finding a “way through” these differences represents a unique yet shared characteristic among the women in my study. The discourse of valuing nursing as clinical skills represents an important characteristic of nursing educators such as the women in my research.

Experiential reasons for change is the fourth important discourse employed by the participants to make sense of their identities as senior nursing educators in comprehensive programmes. This is developed upon the premise that nursing educators have critically reflected upon their own experiences and adapted these to impart new forms of knowledge to new nursing candidates. All the participants shared with me experiences they recalled from their own nursing studentship, whether positive or negative, and the influence this has had on their work as nursing educators. Most often their reflections dealt with negative issues which included both theoretical and clinical-related knowledge, and issues of power and powerlessness through their own nursing preparation. These have clearly been an incentive for many of the women to support and pursue employment within CNEP. Each participant had registered other experiences which reinforce the importance of a primacy of nursing skills, and at the same time there is a connection between experiential reasoning and the emerging nursing epistemology of reflection on practice. The women’s reflections include cross-cultural experiences, teaching roles in the hospital programmes and the impact new forms of knowledge through post-registration education had in influencing the women in my study in what and how they taught students.

The Foucauldian notion of capillary power is illuminating in reflections about the ways the women draw on this discourse. As I explained in earlier chapters, Foucault’s analyses of education drew upon the pervasiveness of capillary-like power relations between teacher and student. By reflecting on their own nursing and other life experiences, the participants have demonstrated their awareness of
the connections between issues of power and related knowledge "...into their actions and attitudes, their discourses, learning processes and everyday lives" (Foucault, 1980: 39). The ways the women drew on their experiences also brings up the Freirian theory of reflexive practice. Reflection on their own experiences clearly inspired the women to teach comprehensive students in particular ways and to instil in them certain professional values. In combination with Foucault's work, I am proposing that the experiential knowledge discourse employed by the women represents a shared characteristic of the comprehensive educators. This is different from traditional models of professional reflexivity in the constant awareness of power relations between nurse and patient and more specific to my research, between nursing educator and student.

In exploring their work, the participants describe an ideal type of nursing graduate they sought to foster through comprehensive programmes. This model represents a fifth characteristic of professional nursing educators. I suggest that the model of an ideal type of graduate as explained through the participants' narratives is closely connected with the theory of performance as proposed by Judith Butler (1990). I am connecting Butler's work with the Foucauldian theory of surveillance in which comprehensive graduates need to perform nursing in standards that match the demands of groups with vested interests in the new programmes' success or failure. In their enthusiasm for their students to acquire both theoretical and clinical expertise, the participants pre-emptively concentrate on the legitimacy of the programmes the women in my study represent. A way of theorised practice, as expressed through New Nursing and empowerment models, similarly informs the model image of graduates in practice. The unique focus on power sharing with patients, and an emphasis on educating patients to understand and manage their own ill-health and more importantly to take responsibility for their own wellness, are all parts of the professional characteristics of comprehensive nursing educators. Another shared quality of nursing educators involves the unity of power with knowledge in the overall organisation of CNEP. The fundamental valuing of theory prior to nursing practice, and the complementary nature of the two to optimise students' learning potential, represents a third and final professionalised characteristic concerning educators' idealised model of a nursing graduate.
The final discourse the nursing educators all engaged with concerns the commonly used heroic metaphor, to explain how they have made sense of the context in which they and their students worked in the early years of CNEP. The fighting, battles and struggles the participants frequently reflect upon are implicitly bound up in issues of power and powerlessness. In situations where students and staff were forced to manage their work amid distractions, hostility and poor facilities, they explained their strategies for survival. In some situations, such as the issues of resourcing in the education sector, participants reflected upon the usefulness of gaining extensive knowledge about department entitlements, for example, to benefit their programmes. Here the power/knowledge coupling is apparent. Such victories alongside the pioneering nature of being involved in an unproved education initiative, promulgate the idea that the participants have of their colleagues and sometimes of themselves as embodying professional qualities. The classic models of professionalism are by definition well established, so the engagement with a historically-familiar metaphor of heroism represents a new way of understanding professional identity. More specifically, the complex ways participants shift between gendered discourses are a creative feminist professional strategy. At the same time, the logistical difficulties and uncertainty about enrolling in a CNEP in the foundation year of each programme’s development leads the participants to view this cohort of students as heroic. As a final unifying feature this is important to the professional characteristics of CNEP staff.

A genealogy of nursing educators’ experiences

I have already explained that I understand genealogy as employed by Foucault to refer to the study of historically subverted, repressed and underrepresented forms of knowledge. A central tenet of this dissertation is that as an academic exercise my work might usefully be considered as a genealogy of comprehensive nursing education, as an example of an “underrepresented form of knowledge”. In his reference to such subjugated knowledge, Foucault describes two specific issues. One of these involves the awareness of erudite knowledge that has buried or concealed aspects of history within “functionalist or systematising theory” (Foucault, 1980: 82-83). The other involves the dismissal of knowledge held by local or undervalued groups in society, for example indigenous or radical knowledge which holds potential to subvert traditional hegemonic forms of social order (ibid: 83). In the case of this latter genealogical type, Foucault identifies
genealogy as concerning the re-emergence of ‘...low ranking knowledges, these unqualified, even directly disqualified knowledges such as that of the psychiatric patient, of the ill person, of the nurse, the doctor - parallel and marginal as they are to the knowledge of medicine - that of the delinquent’ (ibid). Here I understand Foucault is emphasising that knowledge held by groups of people is marginalised in relation to dominant discourses that pervade social life, for example those concerning the scientific legitimacy of medicine.

I understand my thesis to represent a genealogical project in a variety of ways. In seeking to explain this effectively, I have chosen to tease out the qualities of genealogy as Colin Gordon, the noted Foucauldian theorist and translator, describes the term. Gordon writes,

Since 1968-9 ... Foucault’s work has ... pursued a progressive re-working and re-formation of ... a characteristic set of basic questions: A genealogical question: what kind of political relevance can enquiries into our past have in making intelligible the ‘objective conditions’ of our social present, not only the visible crises and fissures but also the solidity of its unquestioned rationales?

(1980: 233)

The breadth of my dissertation can be understood in answer to this genealogical question. I deal with each issue in turn. By “... political relevance”, I believe this concerns the usefulness of my research beyond its submission as a doctoral dissertation. It is important for a number of reasons. Obviously, this is original research: the literature that is available concerning nursing education in New Zealand is most commonly localised or written with a particular evaluative purpose in mind. Moreover, this dissertation gives a particular representation of the development of CNEP from the perspective of nursing educators. It simultaneously offers an extensive archive of women’s voices with unique stories to tell about their work lives, of which there is an increasing selection in Aotearoa New Zealand.

Where Gordon wrote “... making intelligible the objective conditions of our social present” I understand my work to illuminate the situation which groups of comprehensive nurses face in today’s health care sector, as well as the context in which nursing educators and their students experience contemporary tertiary education provisions. This refers to the Foucauldian principle that genealogy is the
history of the present and that the context in which nurses study and nurse and teach is imbued with the legacies of the past. The dissertation offers a history of the ways nursing education has been in the two decades since pilot programmes were trialled in 1973. Beyond this, the women offer comments about the ways they reflect on the present, their concerns about the costs involved in tertiary study and their personal responses to the development of degree-level registration programmes. With an awareness of this genealogical project in mind it is my hope that readers will be able to develop new and differently informed judgements about the current health and education sectors.

The "... visible crises and fissures" described by Gordon refer to the troubling aspects of the history of CNEP as described by the participants. The women’s anecdotes deal with the troubled relationships with nursing staff and other workers in the health care sector and the difficulties confronted by nursing educators as a result of the dearth of resources and support from the polytechnic administration and staff. I understand these to be the "crises and fissures" referred to in Gordon’s comment. At the same time, the contradictions and ambiguities that I expose in the discourse analysis of the women’s comments are also implicated in these disruptions. Most notably I am referring to the difference between the rhetoric of health-focused and partnership-oriented nursing paradigms and the enduring enchantment nursing educators and students have had with illness-centered and feminine performative constructions of nursing work.

The final component of Gordon’s text is "... the solidity of its unquestioned rationales", and is presented as complementary to the "crises and fissures". My work explicitly considers only a limited number of these "unquestioned rationales" in relation to the scope of my research. From nursing to education, models of health care interventions and particular pedagogical paradigms, gendered discourses of work and politics, the range of such premises extends beyond what is manageable in this dissertation. Two particular examples of research which should be explored more extensively in subsequent work include the assumptions of “nursing as caring work”, and “nursing work as emotional labour”. As an example of the complexity of such research, this second enquiry would necessitate revisiting Arle Hoschild’s (1983) seminal thesis concerning the commercialisation of emotional “work”, and the more recent feminist poststructural reviews (for example Steinberg and Figart, 1999) in relation to the
contemporary neo-liberal context in which comprehensive nurses work as practitioners, students and educators. The "unquestioned rationales" I have examined are contemporary discursive formations of professionalism and vocationalism, the paternalism of the medical profession, and the construction of nursing as women's work. Each is grounded in modernist discourses of scientific positivism and patriarchal social structure. I believe my participants have demonstrated their negotiation of these discourses by the descriptions of their experiences as nursing educators and the type of nursing practice they sought to develop in these new programmes.

Final reflections

In concluding this dissertation I would like to offer some final comments. In doing this, I shift beyond the specific focus on nursing educators and the nuances of course development to offer a commentary on the national establishment of comprehensive nursing education from my perspective as an "onsider".

I am left with an overwhelmingly awareness of the lack of coherence between the planned transfer of nursing education from the health to the education sectors and an acceptance from the groups of people who have managed the provision of health care across the country. Here I am referring to people in positions of responsibility from Department of Health staff, hospital administrators and senior nurses and medical staff who should have led by example and actively accepted the responsibility to accommodate the transfer of nursing education. The absence of obligation for health sector staff to embrace the consequences of the transfer of nursing preparation has had enormous consequences for different groups of people. As I see it, the difficulties experienced by nursing educators and their students in health settings including the lack of hospitality, and the hostility, was evidenced by the participants' common use of metaphor of fighting and heroism to explain their memories. In terms of the differences between the models of care they sought to employ in their work, and the compromised reality of fitting into a differently focused health care sector the costs for groups of staff, students and graduates of CNEP has therefore been vast.

As a new graduate in 1985, I can personally attest to the difficulties faced by fellow graduates by the mis-match between our education and the realities of
working in the public health sector. Yet for me, the processes of engaging in this research have given me a greater understanding of why there were differences between my preparation and my registered practice. My understanding of contemporary initiatives in the health sector to support new graduates in their initial employment is a significant advance. However my concern remains that graduates in some forms of initial employment have unrealistic expectations assumed of their clinical performance. Until the state makes provision for a national orientation programme for newly registered nurses, the potential for graduates to be unhappy and disenchanted with their employment remains. The hegemonic dominance of the medical profession to imbue the health sector with medical discourse has offered a continuing legacy for staff and clients to focus on priorities of care that are different from those sought by registered comprehensive nurses. Interestingly, however, over the period 1973-1992, the sovereignty of medical staff has been seriously undermined by the imposition of managerial discourse which has accompanied the establishment of neoliberalism throughout the Aotearoa New Zealand state sector. In health, managerialism has superseded the medically-oriented triumvirate system of institutional administration. I believe that the dominance of medicalised cultural constructions of health and illness continue to pervade the health sector in ways that still do not precisely complement the orientation of CNEP graduates.

While I have suggested that senior health sector staff can be held responsible for a lack of institutional orientation to accommodate the differences associated with the development of CNEP, the central government must also take responsibility for their continued assignment of independence to regionalised health care administrators. I am referring here to the freedom afforded hospital-based nursing schools to continue offering their pre-registration courses for another nine years after the decision to transfer nursing education to the tertiary sector was confirmed. In my opinion, the concurrence of hospital preparation has inhibited people’s acceptance of the transfer process by continuing to perpetuate the sickness focused, single-registration and performative stereotypes of nursing care.

Beyond the organisation of health care services, the lack of public acceptance of the reasons for transferring nursing education into the tertiary sector has played an important role in the mismatching between the CNEP orientation and the different expectations within health provision. I am suggesting that there was a lack of
understanding about how forms of nursing work could be approached differently from task-oriented and sickness-focused performative nursing work. This has exacerbated the unevenness between comprehensive nursing preparation and the social mandate of the public’s expectations about what nursing involves. Associated with this is the coinciding of the transfer of nursing education with significant fiscal and organisational challenges to the quality of health care services that has prompted people to assign blame for poor health care experiences to the new organisation of nursing education.

As I have already discussed, people within CNEP have had their own ambivalence about various models of nursing work. Nursing students during their training and after registration sometimes sought to embrace traditional nursing paradigms in their practice. Their teachers have similarly expressed their mixed orientation between old and “New” styles of nursing care. Such fracturing of values is central to this mismatch, and I believe the pressures to fit into certain expectations by teachers, members of the health care team, patients, and the general public, have presented comprehensive nurses with contradictory models of nursing subjectivity. The consequences of this mismatch are potentially vast, both from the proportions of registered comprehensive nurses who leave nursing employment and for the potential nursing candidates who choose not to enroll in nursing education programmes because they are unable to see a clear and effective model of what nursing work encompasses. My decision to title this thesis “Transforming nursing education: a legitimacy of difference” reflects the tensions between the pressure to conform to traditional models of nursing education and practice, and the discourses comprehensive educators employed to promote the legitimacy of newly organised models of nursing preparation.

The alternative to finding responsibility amid stakeholder groups for the mismatch between the preparation of CNEP graduates and the health sector would be to find nursing educators at ‘fault’. For example, had they more closely oriented their students to the contemporary realities of a medically-dominated organisation of health care their graduates would have felt much more at ease with the institutional provision of care offered by the health sector. I do not believe that to be an adequate response, given that the nursing educators’ brief was to create an alternative model of nursing service, one that involved holistic and wellness-focused care which would focus on patient rather than a task-centered
performance-based orientation. I believe the women have been largely successful in achieving this goal. Beyond this, it is my contention that an even greater legacy is their struggle to have comprehensive graduates accepted as members of a legitimate and honourable profession. From this, other groups of women workers and those with an interest in the development of the Aotearoa New Zealand health sector can learn.

At the time of writing this concluding discussion, nursing in Aotearoa New Zealand is represented in the media by three issues. First, strike action is planned by nurses in my community over unsettled wage claims. Second, there are national concerns about nursing shortages and debates about campaigns to lure overseas registered staff to this country. In my opinion, these two issues intertwine with the enormous burden placed on nursing students by the "user-pays" system of student fees and loans. The situation where nursing graduates face untenable levels of debt and are offered low rates of remuneration and potential earning power compared with almost all other degree-qualified professions, must be urgently addressed by the Government. Nurses will continue to seek work overseas and to leave the profession if the group’s unique financial contradictions are not accommodated by education reform. The final issue being publicised through the media is the build-up to the 12th of September 2001 centenary of the first nurse’s registration in this country. I believe nurses have much to celebrate. I join this celebration by offering my dissertation for submission on this day as my contribution to nursing’s literature in Aotearoa New Zealand.
Acknowledgements

There are many groups and individuals I wish to thank for their support and assistance. Firstly I need to thank the University of Canterbury Scholarships and the Nursing Education Research Foundation for their financial support to assist me in this research. I wish to record my gratitude to the University of Canterbury Department of Education, the Health Research Council, and the New Zealand Association for Research in Education, for financial support provided through employment and conference funding which has aided my research. I have had considerable help from staff at the University of Canterbury libraries, in particular from Interloans and the MacMillan Brown Collection. Assistance from librarians employed in the New Zealand Nurses Organisation, the National Archives, the now defunct Mary Lambie Nursing Library, and the Christchurch Polytechnic Library and Learning Centre, has been most appreciated.

The vital role of the people who have supported me in the academic endeavors of completing this dissertation must be acknowledged. My first supervisor, Dr Liz Gordon encouraged me to consider writing a dissertation about comprehensive nursing. Her advice as the “Nike-supervisor” to “just do it” and her untimely election to Parliament seemed less than helpful back in 1996, but I have come to appreciate the changes they demanded. In early 1997 Dr Elody Rathgen and Missy Morton agreed to become my supervisors. I thank Missy for sharing her enthusiasm and passion for qualitative research. And Elody, many thanks for your patience at my continued inability to comprehend apostrophe’s rules, for the integrity you have demonstrated as my supervisor, and for always finding time to listen to me talk about my work when you were so very busy as HOD, researcher and senior lecturer. Finally, when in late 1998 Missy Morton left the University of Canterbury, Elody and I lured Dr Daphne Manderson of the Nursing and Health Sciences Faculty at the Christchurch Polytechnic to become my second supervisor. This arrangement formalised the support she had given me as a post-graduate student, and some years before that, as a comprehensive nursing candidate. I am grateful to you Daphne for your wisdom, nurturance and continued encouragement.
There are some vitally important people who have given me support in different but equally marvelous ways, to that given by my supervisors. To Lesley, for always having time to listen to my thesis worries, for Bob and for the sweet and funny early morning emails. To Anne, for the continued support, the lattés and the empathy. To Elisabeth and Liz for accompanying me through our ‘Spinster’ of Arts degrees and cheering me on through the journey towards a ‘Matron’ of Philosophy. To my friends Allistair, Brendan, Bruce, Denise, Lydia, Mike, Nicki, Pia, Richard and Tatiana, many thanks for your encouragement and kindness. Thanks too, to my special friends Helen and Janice for your evening-time friendship. And to the women as friends who have stayed around over the years, and the men as lovers who haven’t, thank you for the happiness you have shared with me. Finally to my family, the love and strength you have provided has kept me going when things were very hard. To my brothers older and newer, Mark and Dan, my darling sister Marisa, and to Pam and John, kind, wise and generous parents who have taught me so much. My love to you and thank you for your never-ending and unconditional support.

And finally, I want to thank the nursing educators who were generous in their participation in this research. The thesis is dedicated to that group of women and their colleagues who envisioned a change in nursing education, and have worked incredibly hard to establish comprehensive nursing programmes in Aoteroa New Zealand. Thank you too.
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Appendix I

INFORMATION SHEET

Ph. D. Thesis Research:
To what extent have notions of professionalism shaped changes in comprehensive nursing programmes since their inception?

The ways comprehensive nursing programmes have developed and changed in the two decades between 1973 and 1993 can be understood to document much about the authority and changing ideology of the state, and the vision of nursing educators who have worked to promote excellence in entry to practice programmes. By exploring ideas about professionalism embraced by agents of the state and key nursing educators, this thesis will analyse the relationship between comprehensive education and the shaping of occupational identity of nurses. It will also explore the relative autonomy of nursing educators to negotiate developments in comprehensive programmes within political and social institutional constraints.

My interest in this field stems from my identity as a comprehensive registered nurse, having trained at Christchurch Polytechnic in the early 1980s. More recently, as an NZNO representative and a student of the sociology of education, I have developed a keen interest in the place of nursing in contemporary New Zealand. I am also concerned about the future of nursing in relation to challenges posed by political and economic variables. Through this thesis I hope to gain a heightened awareness of the history of comprehensive nursing programmes which may help to clarify directions for nurse education in the future. Because there has been little research done in this field, I believe that this thesis will be of interest to past and current nurse educators and students, as well as those involved in planning the provision of health and education services at a regional and national level.

An vital aspect of my research is to talk with some of the people involved in changing aspects of the comprehensive programmes, and to represent their views about the ways in which ideas about professionalism have affected the style and form of nursing education. My intention is to focus on a small group of people who have been ‘key players’ in the leadership and management of comprehensive programmes within the period of 1973 to 1993, and over a series of recorded interviews represent their ideas as a significant part of my research. As such, I am seeking assistance from a number of people who have been involved in nursing education across New Zealand to share their ideas with me.

Your involvement in the research would require a commitment to between two and three sessions of hour-long interviews which would be tape-recorded. I will return complete transcripts of interviews to you so that you could edit and review these for clarity of meaning, before I would utilise such data in my dissertation.
Your involvement would be purely voluntary and your decision to participate must be yours alone. Confidentiality will be assured at all times, limited to each individual participant, my supervisors and myself, and anonymity will be maintained by use of pseudonyms. You also remain free to withdraw from the research at any time. I have enclosed a copy of the consent form which we would both sign at our first interview if you agree to participate in this research.

I will be contacting you by telephone within the next two weeks to ask whether you consent to participate in my research, and to answer any questions you might have about this project. If you agree to participate, I will send you a copy of the key questions I would like you to respond to, in the interview. I will enclose a ‘timeline’ of some key political and social events since the 1970s, which you might find useful as a prompt in your reflections of your involvement within nursing education. A space is provided within the timeline format if you chose to write notes about your own history over this period, and I would welcome the opportunity to discuss these with you, when we first meet.

Please feel free to contact me or my supervisor if you have questions or concerns about your involvement in this research at the following addresses:

Debra Wilson,
Education Department
Private Bag 4800
University of Canterbury
Christchurch
Email: dsw26@student.canterbury.ac.nz
Ph (03) 3667-001 ext. 8212

At home: 39 Auburn Avenue
Christchurch 8004
Phone (03) 348 9992

Supervisor

Dr Elody Rathgen
Education Department
University of Canterbury.
Private Bag 4800
CHRISTCHURCH
Phone: (03) 364-2271 or (03) 364-2258
CONSENT FORM

I have read and have understood the information sheet provided by Debra Wilson concerning her thesis topic in general, and the role that interviews with a group of people involved in nursing education, such as myself, have in her research.

I agree to be involved in her Ph.D. thesis research and understand that the information I share with her will remain anonymous, with knowledge of my real identity limited only to Debra, her academic supervisors and myself. I understand that pseudonyms will be used by Debra to disguise participants' names and our particular places of employment. I realise that my involvement in the project will also remain confidential, that it will not be accessed by other participants, and that all research data will be securely stored.

I understand that the interviews will be recorded by audio tape, but that I retain the freedom to stop the recording at any time, and that I can decline to answer questions if I choose. I also have the right to edit the transcripts of our conversations before Debra utilises such material for her thesis, or for possible journal articles or conference papers associated with her thesis topic. I understand she will retain copies of the edited transcripts for related future study but that the cassette tapes will be returned to me or destroyed after they have been transcribed.

I understand that I can ask Debra questions about this research at any time and I retain the freedom to withdraw at any stage from my participation in the project. I understand that ethical approval has been given for this thesis research by the University of Canterbury Human Ethics Committee and the Southern Regional Health Authority Canterbury Ethics Committee. I know that I am able to contact either Debra, or her principal supervisor, Dr Elody Rathgen at the Education Department, University of Canterbury, at any time to discuss my involvement in this research.

I consent to participate in this research  Yes  No

I wish to receive a copy of the findings of Debra’s thesis research.  Yes  No

Signed or initialed .................................................

Co-signed by Debra Wilson .................................

Date .................................................................

Debra Wilson
Education Department
University of Canterbury
Private Bag 4800
Christchurch
Phone (03) 366 7001 ext 8212 or home (03) 348 9992
<table>
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<tr>
<th>Year</th>
<th>Health/Nursing Event</th>
<th>Education Event</th>
<th>Political - Other Event</th>
<th>Other Event</th>
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<td>Nurses’ and Midwives’ Board Report</td>
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<td>1965</td>
<td>Reid Report</td>
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<td>1969</td>
<td>Department of Health Review</td>
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<td>1971</td>
<td>Carpenter report; Nurses’ Act est. Nursing Council</td>
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<td>1972</td>
<td>National Govt announces trial programmes</td>
<td>Labour Govt elected, Kirk PM</td>
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<td>Trial comp programmes, NANCE est.</td>
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<td>Board of Health report reviews nurse education</td>
<td>Kirk dies, Rowling as PM</td>
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<td>1975</td>
<td>Labour’s White Paper proposes restructuring of health system, Nurses’ Amendment Act allows reg’n of RGNs</td>
<td>National elected under Muldoon</td>
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<td>1976</td>
<td>Nurses’ Act (1977) passed</td>
<td>Royal Commission on Sterilisation and Abortion Report</td>
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<td>1978</td>
<td>National re-elected</td>
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<td>Mt. Erebus disaster</td>
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<td>NERAC replaces NACNE</td>
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<td>1981</td>
<td>Taylor Report released</td>
<td>National re-elected</td>
<td>Springbok rugby tour</td>
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<td>1982</td>
<td>Health Amendment Act remodels Board of Health</td>
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<td>Area Health Board Act</td>
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<td>Ministry of Women’s Affairs estb’d, Voluntary unionism legalized</td>
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<td>First Area Health Boards established</td>
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<td>WHO/UNICEF Report; “Choices for Health Care” published; RePIENS replaces NERAC</td>
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<td>CTU formed, Stock market crash</td>
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<td>Cuylll promotes “Health: A Prescription for Change”; Anderson Report recommends funder-provider split; National Action Group promotes RePIENS recommendations</td>
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<td>1989</td>
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<td>Voluntary unionism legalized</td>
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<td>1990</td>
<td>Nurses’ Amendment Act Cartwright Report released</td>
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<td>1991</td>
<td>Upton’s Green and White paper promotes RHAs, Kiwi cards, Nat. Interim Provider Boards</td>
<td>Study Right and NZQA established</td>
<td>Employment Contracts’ Act, Richardson’s “Mother of all Budgets”</td>
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<td>1992</td>
<td>Nursing degree programmes begin. Kawa Whakaruruhau launched. Community Services Cards introduced</td>
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<td>1993</td>
<td>Health and Disabilities Services Act, Ministry of Health, CHEs and RHAs formed. NZNU &amp; NZNA form NZNO, cultural safety debate in media</td>
<td>National Government re-elected</td>
<td>Women’s Suffrage Centenary</td>
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<td>1994</td>
<td>Whistle blowing debate</td>
<td>Todd Taskforce Report released</td>
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Appendix III

Professionalism and the politics of nursing education

Note for participants: Here are the three main areas I would like us to focus on during our discussion. I will ask you to give examples and dates as best you can to clarify my understanding of the issues.

1. Tell me about your involvement in comprehensive nursing education (CNE) programmes?
   - Career/history
   - Values upheld?
     - How have these changed?
     - why have these changed?
   - Highlights and frustrations?

2. What has the term ‘professionalism’ meant to you personally, in relation to nursing?
   - Has this view changed over your career in CNE?
     - how and why?
     - effects on your work in CNE?
   - Connection between CNE and professional nursing identity?

3. In what ways do you think agents of the state have affected comprehensive nursing education?
   - health system
   - education system
   - other?
   - Non state-agents who have shaped CNE?

Debra Wilson
First Question Sheet
Professionalism and the politics of nursing education

*Note for participants:* Here are the three main areas I would like us to focus on during our discussion. I will ask you to give examples and dates as best you can to clarify my understanding of the issues.

1. Tell me about your involvement in comprehensive nursing education (CNE) programmes?
   - career/history/biography?
   - Values upheld? how have these changed?
     - why have these changed?

2. What has the term 'professionalism' meant to you personally, in relation to nursing?
   - Has this view changed over your career in CNE?
     - How and why?
     - Effects on your work in CNE?
   - Connection between CNE and professional nursing identity?

3. In what ways do you think agents of the state have affected comprehensive nursing education?
   - health system
   - education system
   - non-state agents who have shaped CNE?
   - Other?

4. Highlights/frustrations of your involvement in comprehensive nursing education?

Debra Wilson
Second Question Sheet
Professionalism and the politics of nursing education

*Note for participants:* Here are the three main areas I would like us to focus on during our discussion. I will ask you to give examples and dates as best you can to clarify my understanding of the issues.

1. Tell me about your involvement in comprehensive nursing education (CNE) programmes?
   - Career/ history
   - Values upheld? -how have these changed?
   -why have these changed?
   - Highlights and frustrations?

2. What has the term ‘professionalism’ meant to you personally, in relation to nursing?
   - Has this view changed over your career in CNE?
     - how and why?
     - effects on your work in CNE?
   - Connection between CNE and professional nursing identity?

3. In what ways do you think agents of the state have affected comprehensive nursing education?
   - health system
   - education system
   - other?
   - non state-agents who have shaped CNE?

Debra Wilson
Third Question Sheet
Professionalism and the Politics of Nursing Education

Note for participants: Here are the three main areas I would like us to focus on during our discussion. I will ask you to give examples and dates as best you can to clarify my understanding of the issues as we discuss them.

1. Your involvement in comprehensive nursing education programmes (hereafter CNEPs) over time.

   (i) What was it like for you personally to work as a comprehensive nursing educator?
       • In hospitals and other clinical settings?
       • In polytechnic(s)?

   (ii) How have your own educational experiences influenced your involvement in CNEPs?

   (iii) In your opinion, what differences were there between comprehensive programmes and hospital based nursing education?
       • Can you tell me about some of the ways you have experienced those differences?

2. Your meaning(s) of the term ‘professionalism’ in relation to nursing and nursing education, and how these might have changed over time.

   (i) What changes did the change to comprehensive education mean in terms of:
       • Nursing ‘work’ in hospitals
       • Teaching and learning in polytechnics

   (ii) What values did you convey to your students regarding professional identity and/or their responsibilities as future employees in the health sector?
       • How did your ideas about nursing professionalism work on a day to day basis?

   (iii) Nursing education has traditionally been sanctioned by hours of both practice and study as prerequisites to registration.
       • What consequences did this have for the way CNEPs were organised?

[continued over]
3. **Your perspectives regarding internal and/or external factors that have affected comprehensive nursing education over time.**

   (i) Can you tell me about the conditions (e.g., constraints/supports) CNEPs operated within?
   - With regard to the health sector?
   - With regard to the education sector?

   (ii) In what ways were the medical profession involved in the changes of nursing education?
   - In your opinion, how do you think they perceived such changes?
   - What impact has this had on (a) programmes, and (b) you, personally?

   (iii) One participant has spoken about the importance of comprehensive educators and students ‘fitting into’ the health sector? How would you respond to this comment?

   (iv) What impact do you think public opinion had on the way CNEPs evolved?

   (v) What qualities did you seek in nursing educators for CNEPs?
   - Re the clinical health setting?
   - Re the classroom setting?

4. **Are there any issues that you wish to raise?**

Debra Wilson  
Fourth Question Sheet