NURSING STUDENTS' PERCEPTIONS

OF THEIR EDUCATION

A thesis
submitted in partial fulfilment
of the requirements for the Degree
of
Master of Arts in Education
in the
University of Canterbury

by
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University of Canterbury
1990
What is essential about experience in nursing education is that students learn to analyse the sources of their own interpretations, to question and resist the predefined meanings we educators encourage them to adopt, and to develop the tools to negotiate a world of nursing in which the twin goals of autonomy and responsibility are achievable.

Allen, Benner & Diekelmann, 1986:36

To My Daughter, Alicia
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ABSTRACT

This thesis provides an interpretation of nursing students' perceptions of their education, exploring these from the perspective of four themes - curriculum, socialisation, professionalism and power. Two methods of data collection were used: the in-depth interview, the principle research method, which produced critically reflective dialogue, and structured questionnaires which provided a chance to generalise the data to the wider nursing student population.

This study differs from previous studies of professional socialisation by addressing the subjective experiences of nursing students as they complete their education. It emphasises the influence both formal and informal education has on the students' perceptions of nursing. It is contended that explicit acknowledgement of this influence is critical in order to understand the development of these perceptions.

The results of the study revealed constraints experienced by the students within their nursing education. It demonstrated that the environments in which this education takes place influence nursing students' interpretations of their social worlds. Contradictions reported between the idealised, client centred objectives of the nursing courses and the actual practices of nurses within bureaucratic institutions, exemplify a socialisation process which promotes acceptance of institutional constraints on professional practice. The evidence suggested that the dominant ideologies, or hidden curriculum, of both the polytechnic and the hospital systems socialise the nursing student into existing hierarchical structures.

It is argued that both nursing educators and students need to openly acknowledge the relationship between the overt and covert aspects of the curriculum, if nursing education is to encourage graduates to be critically reflective of their professional practice. Lack of acknowledgement of the hidden curriculum exacerbates the difficulties students encounter when attempting to challenge existing institutional practices. Discussion is made of the study's implications for programme and curriculum development and suggestions for further research are identified.
ACKNOWLEDGEMENTS

I am most grateful for the assistance and guidance so many people have given me in this work. I am particularly indebted to my supervisors, Professor Graham Nuthall and Judith Clare (Perry) for their advice and guidance. Their comments and perceptive criticisms have been of immeasurable value. The support of Judi Miller and Taffy Davies has also been very much appreciated.

To the students who took part in the interviews, those who answered the questionnaire, and the staff of the Nursing Studies Departments in the participating polytechnics - special thanks. Many people have helped, and provided the support without which this thesis would not have been either started or completed. In particular, I would like to mention Nick Fitzgerald for his assistance with the quantitative data, Margaret Wade-Wilson for her proof reading and ongoing support, Lynley Clarke for help in preparing this manuscript, the long-suffering Interloans Department staff of the University of Canterbury Library and Lynda Gill and Kathy Jacques for their support and suggestions offered in frequent discussions.

Finally, sincere gratitude to my parents, Alan and Isobel Candy, family and friends, my daughter Alicia and Robert Shrigley for their support, various forms of assistance and tolerance during the writing of this thesis.
CHAPTER ONE

Research Issues and Thesis Outline

This thesis explores nursing students' perceptions of their nursing education. It is the belief of the author that it is critical to ascertain the perceptions of the students, if nursing education is to fulfill society's mandate for health care. However, literature on nursing education reveals little from students themselves on their educational experiences.

Following the Carpenter report (1971) moves were made to situate nursing education in tertiary institutions instead of service based education within hospital schools of nursing. The move was supported by nurses themselves in an effort to promote nursing as an autonomous profession (Burgess, 1984; Kinross, 1984). As Perry (1985:5) outlines, it was thought that an education based rather than service based system of nursing education would:

allow greater flexibility and integration of curriculum content, greater freedom and control over curriculum, pedagogy and evaluation, and greater professional control over the induction of neophytes into the profession.

The transfer of nursing education from the hospitals to polytechnics has continued, and in 1988, when this study was carried out, there were 3,878 students enrolled at fifteen institutions, with an approximate total of 1,100 third year students. Since this transition in nursing education there have been a number of studies of nursing education and nurses in clinical practice. As recommended in
Carpenter's report (1971:26), progressive assessment of the new programmes was carried out for the first five years. This entailed questionnaires administered to students and graduates of the polytechnic nursing courses over a five year period (1973-78), with an interim report published by Small, Taylor & White in 1979, and the final evaluation by Taylor, Small, White, Hall & Fenwick in 1981. Several studies have considered the socialisation of students and graduates in terms of role change. Miller (1978), for example, examined the problems experienced by graduates of comprehensive nursing courses as they provided care in general hospitals. She provides an analysis of nurses as professionals in bureaucratic organisations, with an emphasis on their role conception. Perry (1985) examined the professional socialisation of nurses within the framework of critical social theory. Her focus was on induction of nursing students and graduates into the professional culture of hospital based nursing and a set of institutional practices. Horsburgh (1987) utilised natural field work research methods to investigate the experience of initial employment for new graduate nurses.

While these studies were concerned with professional socialisation and the move into graduate practice from the perspective of the individual, they were conducted after the commencement of that practice. It is felt, however, that the best time to question students regarding their perceptions of nursing education is during the time they are completing that education and before they enter the workforce as a registered nurse. This study was therefore carried out at the time the students were finishing their formal nursing education and involved the use of interviews and questionnaires.
In 1986 the Department of Health established a review of the preparation and initial employment of nurses. Following submissions received (by letter and public advertisements), a workshop was held to "review the issues and develop strategies for future action" (1986:3). There were a number of specific issues discussed; among these were curriculum development and the recruitment of new graduates into specific nursing areas. It is pertinent to note that, within the issue of curriculum development, the point was made in the review that "students have a legitimate stake in both development and design" (1986:21). With regard to recruitment it was noted that "concerns have been identified regarding the recruitment of new graduates into psychiatric and psychopaedic hospitals ... registered nurses are required to provide nursing care in these areas, and for this reason the graduate must be encouraged by nurse educators and nurses in practice, to recognise the satisfaction that can be gained and the expertise that can be developed in these areas" (1986:24). These two issues will be addressed within the themes of curriculum (chapter three) and socialisation (chapter four).

The aims of the curricula for the comprehensive nursing course espouse professionalism and professional socialisation. But it appears that, while the formal curriculum may well express such desired outcomes, students undergo dichotomous experiences regarding the achievement of these aims, both within the polytechnic and in clinical practice (Perry, 1985). To the extent that the actual curriculum is a definite selection and organisation of knowledge from an almost infinite variety of possibilities, it may be regarded as being grounded in the educational and nursing assumptions of those controlling it. The
processes of the curriculum are an important and potentially powerful arena in which compliance to existing power structures may be secured by the control of knowledge by those who have the stake in maintaining the status quo. This point is crucial, and in such a situation, power may be present in an almost intangible way, where for instance, the curriculum content may never be questioned over long periods of time.

This thesis was not designed to be an evaluation of the comprehensive nursing course, although it is hoped that those actively involved in nursing education will critically reflect on the information interpreted and presented in this study. The thesis has been developed from what the students themselves had to say, and the data from the questionnaires served to complement this. Four themes - curriculum, socialisation, professionalism, power - were identified from the interview transcripts and together with the quantitative data became the focus of the analysis of the theory and data. While these themes are considered separately, they also interrelate and intertwine, and this relationship is discussed in chapters three, four and five.

However, before one can hope to offer any interpretative analysis of nursing students' perceptions of their education, the basic theoretical concepts which underpin the discussion of the themes and on which the interpretations are based must be outlined. The fact that much of the formal content of curricula is dominated by a consensus ideology needs to be acknowledged. Both the everyday experience and the curriculum knowledge itself display messages of normative and cognitive consensus. The very choice of knowledge is often based on ideological presuppositions which provide commonsense rules for
educators' thought and action. Schools not only "process people"; they
"process knowledge" as well. They act as agents of cultural and
ideological hegemony and help to create people who see no other viable
alternative to the current cultural mandate. Hegemony serves as a
means of saturating consciousness; therefore, the educational, economic
and social world we see and interact with, and the everyday
interpretations we place on it, becomes the only world we think possible
(Apple, 1979; Giroux, 1983).

The prevailing forms of knowledge, values, social relationships
and evaluation do not exist in isolation from the larger society. They
are linked either directly or indirectly to the prevailing cultural
hegemony. Students tacitly learn certain identifiable social norms
mainly by coping with the day to day encounters and tasks of classroom
life. The fact that these norms students learn penetrate many areas of
later life is critical, since it helps to document how schooling
contributes to individual adjustment to an ongoing social, economic, and
political order. Writers have suggested that institutions of cultural
preservation and distribution, like schools, create and recreate forms of
consciousness that enable social control to be maintained without the
necessity of dominant groups having to resort to overt mechanisms of
domination (Bourdieu, 1977; Apple, 1979).

Thus it is contended that knowledge is embedded in social practice
and must be seen as being produced within particular historical/socio-
political contexts. This contention needs to be kept in mind during
consideration of the content of this thesis; it is argued that a particular
form of knowledge is required for nurses to overcome current
constraints operating within nursing.
The purpose of this thesis was to attempt to gauge students' perceptions of their nursing education. It is argued that that education cannot be clearly understood without critical consideration of the points of view of the students themselves. What educators and researchers believe students experience within their education appears to be based on taken-for-granted assumptions; as already mentioned, there is little written from the students' perspective on their educational experiences.

The thesis is divided into three parts. **Part One** (chaps. 1-2) presents a general introduction to the study, the methodology utilised, accompanying rationale, and specific procedures followed.

**Chapter one** offers background information on nursing education in New Zealand and the purposes of the thesis. **Chapter two** presents an explanation of the qualitative and quantitative research methods used in the study; limitations of each are addressed. Ethical concerns arising within the study are discussed; and a summary of the general study design is included. An introduction to the four themes contained within the theoretical and data analysis concludes the chapter.

In **Part Two** (chaps. 3-6) of the thesis a theoretical commentary for each of the four themes extracted from the data is presented, with accompanying data and analysis.

**Chapter three** presents a theoretical commentary, data and analysis of the curriculum theme. While the outcome of the curriculum may be a professional who is both competent and dedicated to the service of society, students seem to experience control and coercion within their education. Critical examination of educational practices
within the nursing courses suggest the presence of a covert curriculum that helps to maintain confinement to a predetermined definition of reality. This curriculum, which is hidden within objective educational criteria, may well have a greater influence on the students than the skills and knowledge nursing educators seek to convey (Pitts, 1985). The hidden nature of this covert curriculum, and a failure to make it explicit, may therefore contribute to nursing's subservient state by transmission of a professionalism vastly different from the characteristics synonymous with autonomy.

A discussion of this dichotomy between theory and practice leads into Chapter four, which presents a review of the theme of socialisation. Too often, nursing educators perceive their students solely as recipients of the learning process which occurs during their course. However, the process of enculturation to a professional group, known as professional socialisation, is also occurring and must be given credence. The influence of the socialisation process must also be recognised. One might consider this process hegemonic, because as Perry (1986:11) suggests, it "produces a particular world view and a relatively rigid set of behaviours based on that world view".

Chapter five provides a theoretical outline of the themes professionalism and power, with presentation of data and analysis. It has been suggested that nurses need to be motivated to become aware of how their social conditioning has affected them (Le Roux, 1978). The preparation of the professional nurse requires considerably more than specific technical skills. However, scrutiny of the concept of professionalism reveals that there is no fixed agreement on its characteristic criteria (Speedy, 1987).
This discussion extends into the final theme - power. An important consequence of nursing's predominantly female image is that the profession may well be excluded from policy and decision making roles - roles society reserves for males. If nursing is to increase its status, it must not only understand the intricacies of power, but it must also actively use that power to its advantage in a system that equates power with prestige.

**Part three** (chaps. 6-7) comprises a summary of the four themes presented in the preceding chapters, and resulting conclusions.

**Chapter six** offers a synopsis of chapters three to five, with integration of the theoretical concepts presented.

**Chapter seven** is a discussion of the implications of the study for nursing education and practice. The advantages and disadvantages of the theoretical viewpoints employed are addressed and their usefulness for further research. Limitations of the present study are identified and recommendations made for future studies.

This study is an attempt to address issues within the current polytechnic nursing courses, as they affect students' perceptions of aspects of that nursing education. It reflects concerns that have not previously been given attention and, therefore, offers scope for future study.
CHAPTER TWO

Methodology and Study Procedures

This chapter begins with a statement of the research question. Following a brief outline of the research methods, an explanation of the rationale for the methodology is then offered and the specific tools utilised within the study are discussed. Included in this discussion is a profile of the case study method as it relates to this research project. The ethical procedures adopted in this study are then addressed. The chapter then leads into a discussion of the design, data collection and analysis involved. It concludes with an introduction to the themes focused on in chapters three, four and five.

RESEARCH QUESTION

A major research question guided this study:

What are nursing students' perceptions of their education?

The objective of the study was to develop a descriptive, analytical framework in which to consider this question and to present an interpretation of the data collected from interviews and questionnaires during the course of the study.

RESEARCH METHODS

The study involved the collection of descriptive data from third year comprehensive nursing students. Data collection resulted from interviews with seven students, and the use of a structured
questionnaire completed by 506 students offered quantitative data. Therefore, quantitative data resulted from highly structured questions allowing only limited answers, whereas the questions within the interview situations were open-ended. The responses to the questionnaire were quantified before analysis, that is, they were converted to frequencies to facilitate analysis. It is this 'quantification' of responses which, in essence, characterises traditional research. However, although the data was analysed as descriptive statistics, it is still the meaning of the statistics which determines how analysis proceeds and is the basis for interpretation of results. Thus a distinction between these methods is that quantitative data is analysed by interpretation of frequency values and qualitative data by interpretation of the language of the respondent, and a predetermined interpretive framework (refer p. 28).

However, actual research strategies frequently cannot be categorised simply as quantitative or qualitative. In this research, survey methods have been employed in ways that enabled the researcher to analyse and present both quantitative and qualitative data. This suggests that these methods straddle the qualitative/quantitative distinction; and that "this distinction is primarily one of methods of data collection, analysis and interpretation" (Goodwin & Goodwin, 1984:378).

METHODOLOGICAL RATIONALE

I mean by methodology the study - the description, the explanation, and the justification - of methods, and not the methods themselves. (Kaplan 1964:18)

The methods of data collection within this study were selected as
appropriate tools by which ideas on nursing students' perceptions of their education might be determined. At this point, evidence appears to suggest that instruments that yield both hard and descriptive data about the topic will help to establish a basis for future study (Polit & Hungler, 1978). The debate between quantitative and qualitative research is not new. Glaser & Strauss (1967) indicate that this dialogue has been ongoing for several decades. The researcher involved in this study came to the conclusion that qualitative data, in conjunction with quantitative data, would be the best means of developing, supporting and explicating propositions on nursing students' perceptions of their education.

Methodological argument in research is often couched in practical or technical terms. For example, the discussions concerning quantitative versus qualitative research are often centred on a choice of what method or technique should be utilised for a particular study. In many instances, there is either a stated or assumed hierarchy: quantitative data is preferable, but qualitative research may be a helpful, initial step to developing quantitative information.

Whatever the reasons, it can be said that research has tended to take a quantitative approach (Melia, 1982). However, researchers are now recognising that there are a variety of ways to investigate questions and that the nature of the question is a significant factor in choosing from among the alternative methods. To gain insight and understanding about phenomena relevant to nursing a variety of approaches are necessary, including qualitative research that complements quantitative studies. No matter how thorough the questions in quantitative research, the data will yield findings which
are superficial in nature, in so far as the questions do not draw on the depth of experience available in qualitative data (Jayaratne, 1983). Even the most complex and sophisticated quantitative research report cannot impart the same "in-depth" understanding of the subjective experiences of the respondents as, for example, a case study. Sieber postulates (1973:1337):

the integration of research techniques within a single project opens up enormous opportunities for mutual advantages in each of the three major phases - design, data collection, and analysis. These mutual benefits are not merely quantitative (although obviously more information can be gathered by a combination of techniques), but qualitative as well - one could almost say that a new style of research is born of the union of quantitative and qualitative methodologies.

It therefore seems apparent that quantitative research can benefit from the addition of qualitative data; certainly qualitative data can support and explicate the meaning of quantitative research. In this study, replies to the questionnaire were able to provide leads for the interviews and eliminated the need to ask routine background questions. They therefore afforded greater meaning, enhanced rapport, and offered guidelines for probes within the interview situations.

INTERVIEW METHOD AND RATIONALE

As a distinct research technique, the interview in this study did the following. First, it was used as the principle means of gathering information with direct bearing on the research objective(s). As
Tuckman (1972:196) outlines:

by providing access to what is inside a person's head ... make it possible to measure what a person knows (knowledge or information), what a person likes and dislikes (values and preferences), and what a person thinks (attitudes and beliefs).

Second, it may be used to test hypotheses or to suggest new ones; or as an explanatory device to help identify underlying processes, variables and relationships. And third, the interview may be used in conjunction with other methods in a research undertaking. In this connection, Kerlinger (1970) suggests that it might be used to follow up unexpected results, or to validate other methods or to go deeper into the motivations of respondents and their reasons for answering as they do.

The major appeal of this qualitative method is its flexibility. Rather than each respondent being asked precisely the same questions, it allows the interviewer to pursue subjects which arise and which have some conceptual promise. Its flexibility makes the interview a far superior technique for the exploration of areas where there is little basis for knowing either what questions to ask or how to formulate them. It is the more appropriate technique for revealing information about complex, emotionally laden subjects or for probing the sentiments that may underlie an expressed opinion. If a verbal report is to be accepted at face value, it must be elicited in circumstances that encourage the greatest possible freedom and honesty of expression (Selltiz, Jahoda, Deutsch and Cook, 1959). As the researcher, I wanted

to create a situation in which the students could tell me what they really felt about nursing (education), not merely what they might think a nurse researcher would want to hear. (Melia, 1983:25)
While one can never really know if the respondent is telling the story as she really sees it, or as she would have one believe she sees it, in this research situation three factors seemed important in increasing the chances of obtaining worthwhile data. First, the students should volunteer to be included in the study rather than being co-opted; second, they should feel in control of the situation and third, that they should regard my interest as genuine. I believe that these criteria were met. The students who took part in the interviews volunteered to do so. Several made comments such as:

1. *Thank you for offering to talk to me.*

2. *Oh, that’s fine, I was keen to do it. Now I come to think about it, I realise that we have never had the opportunity to evaluate the course as a whole ... so it’s great.* (Amy, r65)

The timing of and venue for the interviews was the decision of each student; and the student was at liberty to decline an answer to any question or to stop the tape recorder if they so wished.

3. *I don’t really know. I can’t comment on that ... and I don’t really want to do so.* (Sarah, r20)

The rapport established between the researcher and each student is indicative of their regard for my interest. In the words of one student

*Because you’ve been a comprehensive nursing student I know you understand where I’m coming from.* (Ann, r3)
LIMITATIONS OF INTERVIEWS

A number of problems appear to confound the use of the interview as a research tool. One of these is that of dependability, at least with regard to pure information transfer and the likelihood of bias. Attempts have been made in this research to minimise this by tape recording the interviews and checking the transcripts with the students. Another way of verifying interview material is to compare it with another criterion that has already been shown to be credible.

A cluster of issues may also surround the person being interviewed. An interviewer has to consider

a) The extent to which a question might influence the respondent to show herself in a good light.

b) The extent to which a question might influence the respondent to be unduly helpful by attempting to anticipate what the interviewer wants to hear.

c) The extent to which a question might be asking for information about a respondent that she is unlikely to know herself.

d) That interviewing procedures are not based on the assumption that the person interviewed has insight into the cause of their behaviour.

(Tuckman, 1972)

While these limitations are acknowledged, the researcher felt, and the data demonstrates, that the use of the interview as a research tool, along with the questionnaire, was critical in determining nursing students' perceptions of their education. The interview provided a means of insight into these perceptions which would not have been evident from the use of the questionnaire alone.

Yeah, I picked up that thing that I was being moulded straight away ... I was aware that they wanted me to become a so-called 'good nurse' ... and they were moulding me to become their vision of that. (Kim, r4)
As Melia (1983:24) states "the understanding of meaning is essential to the explanation of human action; in other words, simply to observe is not enough". In this study, it was felt essential to attempt to gain an understanding of the students' perceptions of their nursing education by asking them directly, not simply relying on a written evaluation in the form of a questionnaire. The interview seemed an appropriate means to determine some understanding of, and insight into, the students' views.

Limitations of the interview also arise in the areas of generalisability and context specific data. As Chinn (1986:188) points out "qualitative reports on a setting pertain only to that point in time. As actors and norms in a setting change over time, the research may not be replicable". However, this does not invalidate the research findings. The issue of transferability rests with anyone wishing to make an application elsewhere (Lincoln & Guba, 1985).

In the words of Mies (1983:29):

the postulate of value free research, of neutrality and indifference towards the research objects, has to be replaced by conscious partiality, which is achieved through partial identification with the research objects.

This was achieved in this study by initial contact with the students who had volunteered to be interviewed and discussing with them the general plan of, and the reasons for the research. The students were aware of the researcher's particular interest in perceptions of nursing education, developed from her personal experiences as a comprehensive nursing student and as a nursing tutor in that course. And as Kemmis (1982:95) points out "cases do not appear through 'pure observation'".
CASE STUDY METHOD AND RATIONALE

As previously indicated, interviews were conducted within this study to gain insight into nursing students' perceptions of their education. While they were not originally designed to be case studies, each interview profile is a synopsis of each student's perceptions of aspects of nursing education. They offer data on two levels - at one level the interviews elicit information on students' perceptions, but on another level they produce critically reflexive dialogue, thus extending the value and meaningfulness of the interview.

Definitions of a case study vary widely, ranging from Denny's (1985:214) formulation that a case is "an intensive or complete examination of a facet, an issue, or perhaps the events of a geographic setting over time", to Guba & Lincoln's (1981) statement that a case is "a snapshot of reality", "a slice of life" or "an episode" (p. 370-371). As stated by Lincoln & Guba (1985:214) the naturalist describes three main purposes for using the case reporting mode:

a) It is ideal for providing the "thick description" thought to be so essential for enabling transferability judgements.

b) The case study is the form most responsive to the axioms of the qualitative paradigm.

c) It provides an ideal vehicle for communicating with the consumer by providing a vicarious experience of the inquiry setting.

Stake (1978:5) points out:

I believe that it is reasonable to conclude that one of the more effective means of adding to understanding for all readers will be by approximating through the words and illustrations of our reports, the natural experience acquired in ordinary personal involvement.
The interviews offer insights into the experiences of the nursing students and as Kemmis (1982:108) suggests "insights reached through case study have the capacity to work reflexively to change the particular situation studied". In the context of this study it was hoped that the students who had the opportunity to reflect on their nursing education would become more aware of that education and use this awareness to critically reflect on possible appropriate changes to the nursing courses, if that is what is required. Kemmis also suggests that the case study is dialectical in that

the dialectic is often intended to be quite explicit in the report of the study. That is, the case study worker will argue the nature of the case and the formation of his interpretation from his observations. (1982:98)

The descriptions of each case study by the researcher is critical to making the dialectic explicit. Within this research, this is achieved by the use of excerpts carefully drawn from the interview transcripts, while remaining true to the body of data from which it is drawn. Stake (1986:95) points out that by presenting data which contains the "richness and ambiguity and conflict which are part of ordinary experience" the readers can experience the realities and complexities of the situation.

LIMITATIONS OF CASE STUDY

The object of a social inquiry is seldom an individual person or enterprise. Unfortunately, it is such single objects that are usually thought of as 'cases'. A case is often thought of as a constituent member of a target population. And since single members poorly represent
whole populations, the case study is often seen as a poor basis for generalisation, at least from the perspective of logical positivism. However, as Stake (1978:7) indicates, case studies provide both examples and analogies so that "as readers recognize essential similarities to cases of interest to them, they establish the basis for naturalistic generalization".

QUESTIONNAIRE METHOD AND RATIONALE

A major advantage of the questionnaire as a research tool is that it can be administered to large numbers of individuals simultaneously. The impersonal nature of a questionnaire - its standardised wording, order of questions and instructions for recording responses - ensures some uniformity from one measurement situation to another. These criteria serve to enhance the replicability of the results, if this is seen as critical. Respondents may have greater confidence in their anonymity, and thus feel freer to express views. Another characteristic of the questionnaire that is sometimes, though not always, desirable is that it may place less pressure on the respondent for an immediate response. When the respondent is given ample time for filling out the questionnaire they can consider each point carefully rather than replying with the first thought that comes to mind, as often happens under the social pressure of interaction in an interview.

In this study, the questionnaire was developed as a means of gaining information from a large number of nursing students completing their comprehensive course. It was seen as a method by which the data gathered in the interview situations could be assessed for its generality across many different nursing courses. The response
rate achieved (83% = 506) and the willingness of students to complete and comment on the questionnaire support the researcher's contention that this type of quantitative research can both reinforce and validate data obtained by qualitative research methods. The quantitative data is backed up by comments written on the questionnaires, such as:

*I think we need more chance to comment on the middle class pakpha bias in nursing education.*
(no.218)

*I do not intend nursing very long ... I would like to continue my education, but in a different field. I find there is a lack of autonomy, self responsibility, opportunity for promotion and the work can be very mundane.*
(no.266)

*Thank you for your interest and concern in this area ... and for asking us, the students.*
(no.255)

I believe that it is critically important to realise that to conduct 'objective' quantitative research, one does not have to be detached and unconcerned about the topic. I regard the fact that I have been both a student within the comprehensive nursing course, and a tutor, as beneficial, providing insights and 'privileged' information that made a meaningful and major contribution to the research design. As outlined in feminist research, experience is revalued as part of social science methodology (Wallston, 1979).

The new definition of experience is that it is interesting (not arbitrary), effective (in the sense that our ideas shape our world and are not simply shaped by it), uniquely human, and contextual. (Reinharz, 1983:72)

In conjunction with this experience is my belief that holding a strong opinion about the subject of research does not necessarily mean that research decisions will be any more biased than if these opinions were not acknowledged.
LIMITATIONS OF QUESTIONNAIRES

The usefulness of a questionnaire is limited to issues on which respondents have rather clearly formulated views. The more or less rigid structure of questionnaires, the inability to explain fully in writing one's feelings and behaviour, and the solemnity and permanent nature of a response that is put on paper in one's own handwriting all work against frank discussion of controversial issues in response to a questionnaire (Cohen & Manion, 1980).

Uniformity of questionnaires may be more apparent than real; however, meaningful uniformity of questions is greatly enhanced by careful pretesting, as was carried out in this research. Superficiality is a medium risk with questionnaires, as respondents have the freedom to 'create' their own answers with minimal supervision on the part of the researcher. However, pretesting the questionnaire will ensure that the questions are appropriate and relevant for the respondents, and comments frequently written by respondents on the questionnaire provide additional insights for the researcher. It is more difficult to establish that the respondents interpreted the questionnaire in the same way as the researcher intended. The greatest risk is that the respondents may lead the researcher by providing socially desirable answers. If possible (as was done in this study), answers should be checked with other measures.

Denzin (1978) argues that the use of multiple methods has definite advantages for the validity of data. This study employed both the questionnaire (with closed and open items) and the interview. It is argued that such an approach produced a database that reflected the reality of the nursing students' perceptions of the nursing education they had received.
ETHICAL CONCERNS

The researcher based this study on the belief that research with human subjects must only be carried out with their informed consent and understanding.

It is important in all informed consent procedures that emphasis be placed on the voluntary nature of participation in social research and, specifically, on the rights of participants to refuse participation or to suspend or terminate their participation at any time during the data collecting process.

The people administering the questionnaire, on behalf of the researcher, were asked to convey to the students the voluntary nature of their participation and their right to terminate completion of the questionnaire at any time. That this information was indeed conveyed was evidenced by a small number of partially completed questionnaires being returned from some of the participating polytechnics and the response rate being less than 100%.

All students volunteering to take part in the interviews were sent a letter outlining the research procedure (refer Appendix 3) and this was then discussed with them. Attempts were made to ensure that adequate information was disclosed regarding the research and that understanding was sufficient to validate consent. Each participant was informed that withdrawal from the study was possible at any time and that they would have the opportunity to review all transcribed material prior to its use in the research report.

As Bower and de Gasparis (1978:64) state:

the ideal model for the conduct of social research investigations ... is one in which subject and investigator are
seen as equal partners in a mutually advantageous effort. It is a model that emphasizes the rights of respondents in decision making before and during the research process, that deemphasizes status differences between researcher and researched, and that accentuates the application of general societal norms of interpersonal relations to the procedures of research.

Every attempt to establish and follow this model was made in this study.

METHOD

GENERAL DESIGN

As already outlined, the design for this study involved the use of a questionnaire and interviews. A questionnaire format allowed the collection of detailed information from a large number of subjects. It also provided the respondents with a chance to freely express views about their nursing education, behind the cloak of anonymity. For example, one student felt able to disclose that:

_I would never go to work in the psychiatric area ... because you can't possibly practice what you have been taught here._

(no.92)

Interviews were carried out with seven of the sample and were seen as the principle means of gathering information with direct bearing on the research objective. The interviews were designed to yield maximum data to allow an explication of nursing education from the point of view of nursing students. As discussed in chapter 1 (refer p. 2), while previous nursing research in New Zealand has touched on this subject, little has been carried out directly with nursing students as they are completing their education. The researcher believes that the students are in an ideal situation, as they finish their nursing course, to critically reflect on that education.
Multiple data sources and methodologies improve validity (Denzin, 1978). The point has been made that the students' interviews might be considered a synopsis of their perceptions of aspects of nursing education. In this way, the interviews offer 'a snapshot' of that education; and while not generalisable they, as suggested earlier, offer descriptions enabling transferability judgements. If this premise is accepted, the interviews can be seen as a dual data source; the study therefore employing methodological triangulation. This may be defined as the use of several methods of data collection in the study of some aspect of human behaviour (Cohen & Manion, 1980). This technique attempts to explain the richness and complexity of human behaviour more fully by studying it from more than one standpoint and, in doing so, by making use of both quantitative and qualitative data. Therefore, in this study, while the interviews (synonymous with case studies) were the source of the material for the organisation of the data into four themes, questionnaire data was utilised to generalise to the wider population and to add substance to the interview data, offering contextual validation.

For example, comments made by the students interviewed on the science components of their curriculum were compared with the results from the questions relating to course content to examine congruence.

The maths ... there was far too much ... it was a real struggle for me which meant that it was probably good that I was doing it, but it's not needed on the job. (Sarah, r12)

Um, some things, particularly in the physics, chemistry, maths ... I think we went into those a lot more than we needed to have done. (Emma, r39)
STUDY SAMPLE

Eight of the fifteen polytechnics in New Zealand offering the basic comprehensive nursing course were initially approached to take part in this study. These polytechnics were selected in order to cover a wide range of geographical areas and to draw on possible differences in demographic representation. Four of these polytechnics are in the North Island, four in the South. Three are situated in major centres and have large student numbers. The Head of the Nursing Studies Department at each of these polytechnics was requested to permit the third year students to complete a questionnaire relating to their nursing education (refer Appendix 1). An affirmative response was obtained from seven of these polytechnics and they continued to take part in the research. At this initial approach anonymity of the results, as they related to particular polytechnics, was assured. The total number of third year students who could have answered the questionnaire was 611 (313 in the North Island; 298 in the South Island); of this total 506 completed questionnaires were received, a return rate of 83%.

INSTRUMENTS

1. Questionnaire Formation

A questionnaire was constructed, using as a guide previous research carried out by Taylor et al (1981) and Perry (1987). The questionnaire was designed to elicit biographic data, previous educational experiences and personal characteristics, as well as students' views on nursing, their opinions of their nursing course and their plans for graduate practice.
Much of the questionnaire consisted of closed questions; some involved only one response, whereas other questions included statements with options of variables on four or five point rating scales, ranging from "A great deal" or "Always" to "Not at all" or "Never". Provision was made in a number of questions for comments from respondents.

The final item in the questionnaire was designed to determine students' interest in the psychiatric and psychopaedic areas of nursing and was deliberately open-ended to allow respondents to comment freely. Specifically, the questionnaire was divided into the following major areas:

Biographic data
Previous educational experiences
Personal characteristics
Opinions on nursing
Opinions on nursing course
Plans for graduate practice

Questions 1 - 4
Questions 5 - 7
Questions 8 - 12
Questions 13 - 15b
Questions 16a - 19
Questions 20a - 23b
(refer Appendix 2)

While it was not planned to make a direct comparison with the previous research by Taylor et al "An Evaluation of Nursing Courses in Technical Institutes" (1981) and Perry "Transition From Student to Graduate:Phase One" (1987) rationale for inclusion of at least some of the material within the questionnaire was based on these research reports. For example, the questions on the concept of an ideal nurse (questions 13/14), and personal satisfaction in nursing (question 19) were both dealt with, either directly or indirectly, in this previous research.

The question on personality (12) was included because of the researcher's interest in why graduates decide to enter certain areas of nursing. It was thought that results might indicate that there is a
"personality type" within particular areas. While results for this question were inconclusive, the responses by the students to that of "desirable qualities in the ideal nurse" were more illuminating.

Questions relating to course content, and nursing competency were seen as a necessary component because of the thesis topic "Nursing Students' Perceptions of Their Education". These areas were explored in some depth within the interviews, and also by Taylor et al (1981).

2. Questionnaire Development

The questionnaire was field tested with eight students who were representative of the sample population. This pilot study was carried out to assess the appropriateness of the questionnaire items for the students. They were first asked to complete the questionnaire (the average time for completion being noted), then the researcher led a discussion about it. Respondents were asked to identify confusing and difficult questions, with particular attention being focused on the instructions. Discussion on the meaning of some answers was also conducted which helped to identify questions that respondents misunderstood or misinterpreted, as well as format or design problems.

Following this pilot study a number of modifications were made to item content and to the format of some questions.

3. Interview Formation

Following a request made by myself to the Head of the Nursing Studies Department in two polytechnics involved in the study, they initially invited student participation in this part of the research. After an indication from several students that they may be willing to take
part, a letter outlining the purposes of the interview was sent to six students, asking them to respond accordingly (refer Appendix 3).

Of these six, four indicated their willingness to be part of the study and became participants. A further three students made indirect contact with the researcher, and after explanation of the study, agreed to take part.

4 Interview Development

The data were collected by the means of focused interviews which were tape recorded. Each interview commenced with a request which amounted to the researcher saying "Please tell me about yourself and what you thought of your nursing education", and proceeded in an informal, conversational style. While the interviews were only partially structured, I did have an agenda delineating the topics I wished to cover within the interview. This list was derived from my formulation of the research question and from an analysis of the situation/experience in which the respondents had participated. This agenda consisted of the following:

... curriculum content
... clinical experience
... tutor/student relationships
... opinions of their nursing education
... concept of a "good nurse"
... professionalism
... socialisation and role acquisition
... autonomy/power structures
... orientation programmes
While this agenda offered a guide, it was not seen as a constraint within the interview situation. This meant that the students introduced topics they felt were relevant, rather than the researcher always dictating the content of the interview. Each interview lasted approximately one and a half hours; items which were seen as appropriate for discussion by the researcher were introduced with open-ended questions and accompanying probes, such as "You've talked about professionalism ... what do you see that term meaning?"

Once an interview was completed the tape was transcribed. The ideas raised in one interview could be tested out in later interviews, both with the same person or with other respondents if the opportunity presented itself or if a point was potentially worth developing.

DATA COLLECTION

As indicated, the qualitative data was collected by the researcher. But, due to a lack of finances, it was not considered feasible for the researcher to personally administer the questionnaire in each of the participating polytechnics. After initial contact was made with these Nursing Studies Departments, the researcher then indicated to the Head of Department a member of the staff known to her and whom she felt would be willing to administer the questionnaire on her behalf. In each instance, this was agreed to.

Timing for administration of the questionnaire was left to each polytechnic - the only requests made were that it follow the students' pre-graduation clinical elective and, if possible, be close to their sitting State Finals.
DATA ANALYSIS

Questionnaire

Due to the survey nature of the quantitative portion of the study, closed questions were analysed in terms of descriptive statistics (frequencies, means, standard deviations, and percentages). Where items were open-ended, responses were converted into analysable data through tabulating the response similarities and differences to establish response categories.

The data from the sections covering the biographic, previous educational experience and personal characteristics were analysed in terms of the frequency of respondents who assented to each coded alternative.

The questions relating to opinions on nursing all used a Likert-type rating scale, ranging from 1 ("A great deal") to 5 ("Not at all"). For example:

13. Many researchers have suggested lists of desirable qualities in the "ideal nurse". For each of the following, please indicate with the appropriate number the extent to which each quality reflects your concept of the "ideal nurse".

A great deal 1 2 3 4 5 Not at all

a) Sincerity
b) Friendliness
c) Cultural sensitivity

The responses to these questions were analysed in terms of the proportion of respondents who marked each alternative and the means and standard deviations of each descriptor.

The section on opinions of the nursing course utilised several question formats. Questions 16a - c employed the semantic differentials
technique to investigate respondents' opinions of their total curricula. Initial analysis of these three questions was done on an institute by institute basis and each polytechnic has received its individual results. For the purposes of ensuring anonymity for each polytechnic only the overall distributions of responses are presented in the result sections of this thesis.

Question 16d requested respondents to indicate, on a scale ranging from 1 ("Always") to 4 ("Never"), how well various aspects of their nursing education were organised. Initial analysis of this question was also carried out for the individual polytechnics; however, again only the overall results have been reported in this thesis. Analysis was in terms of the proportion of respondents who assented to each alternative.

The results for question 17a are a cross-tabulation of the reason for the respondents' choice of clinical elective placement by the practice areas chosen. Questions 17b and 17c elicited information about the students' experiences in these pre-graduation clinical electives. Question 17b queried the extent to which students were able to practice individual nursing care using the nursing process, and 17c used a scale ranging from 1 ("Always") to 4 ("Never") to probe the students' opinions of various facets of the organisation of this clinical elective.

Question 18 asked respondents to rate their perceived ability in various areas of nursing practice, using a four point scale ranging from 1 ("Very competent") to 4 ("Not competent"). Analysis was according to the proportion of respondents who concurred with each alternative.

Question 19 queried the expected importance of various factors in the students' achievement of personal satisfaction from nursing as a
career. Responses on a four point scale ranging from 1 ("Very important") to 4 ("Of little importance"), were analysed in terms of the proportion of students responding with each.

The final section of the questionnaire dealt with plans for graduate practice. The results of questions 20a and b are presented as percentages of respondents indicating each of the coded alternatives. Question 20b is also cross-tabulated with 20d to give an indication of the preferred area of practice by the reasons for that choice.

For questions 21 to 23b the percentage of students indicating each alternative was reported.

INTERVIEWS

Once the tapes were transcribed the researcher read and re-read the transcripts and identified main themes. These themes provided the structure for data analysis and interpretation. Thus, as already indicated, the focus of the analysis was based on a qualitative analysis of the interview data; the questionnaire results were employed to find out if the interpretations derived from the qualitative data were in agreement with the views expressed by the wider sample of students. Analysis was based on the principles of theoretical sensitivity outlined by Glaser (1978). This meant that data analysis was not constrained by the methods used, but developed in accordance with conceptually generated patterns.

OVERVIEW OF THEMES

The purpose of this study was to discover the nature of nursing students' perceptions of their education and the themes which emerged
reflect this purpose. In the following chapters, then, the concepts of curriculum, socialisation, professionalism and power will be addressed.

In Chapter three, there is a theoretical discussion of curriculum, following an examination of the organisation of knowledge in which the focus is on the overt curriculum within nursing education, and students' possible experiences of this, with references made to socialisation, professionalism and power. Leading on from the discussion of the overt curriculum there is an exploration of the less acknowledged covert curriculum and its effects on students' socialisation into nursing. The maintenance of ideological hegemony within the nursing courses is considered, as exemplified by the distortions between theory and practice experienced by the students.

This dichotomy between theory and practice leads into a review of the theme of socialisation, in Chapter four. Its development within the polytechnic nursing courses, and possible influences on the transition from student to graduate is discussed briefly. While the curriculum of the nursing courses espouse autonomy, independence and creative thinking, the students may also experience lack of control and unequal relations of power which reinforce the need for them to 'fit into' existing structural constraints, a further aspect of hegemony (Perry, 1986). A discussion of compliance extends into consideration of personality characteristics considered, until recently, descriptive of nurses, and the possible influence of these characteristics on the process of professional socialisation (Boughn, 1988).

Chapter five consists of discussion and analysis of the remaining two themes - professionalism and power. Within polytechnic nursing courses there is a clear emphasis on 'professional behaviour'. It has
already been suggested (refer chap. 1, p. 7) that there is lack of agreement on the characteristics of a profession. However, the expectation that nursing students will conform to existing practices in polytechnics and clinical agencies suggests that some criteria, such as a level of commitment, are seen as more critical to maintenance of the nursing 'profession' than others. One of the criteria which receives less importance in nursing literature is autonomy (Rosenfeld, 1986) - this might be considered analogous with the feminine role. Accompanying this is a perceived lack of power.

This discussion therefore extends into the final theme - power. Lukes' (1974) three dimensional theory of power is used here since it offers an explanation of the less direct effects of power and the influence that the relations of power have on graduates' socialisation into clinical agencies. This influence is reinforced by the ideology which maintains patriarchy and traditionally espouses the use of power by a dominant class or culture (Smith, 1985). A focus on the need to examine power within nursing circles extends into issues seen as critical in the socialisation of nursing students. The issue of power is a focal point within nursing education. Education should be a learning experience in which students safely and comfortably practice nursing. However, there appears to be the belief, on the part of nursing students, that they must competently demonstrate their knowledge and clinical skills without any margin for error.

Thus the four themes that are the framework of this thesis - curriculum, socialisation, professionalism, power - are seen, by the students who were interviewed in this study, as critical factors influencing students' perceptions of their nursing education. These
themes are not isolated, separate entities, but come together as interrelated concerns. Throughout each is the influence of the dominant ideologies present in the institutions in which these nursing students receive their education.

As already mentioned, each theme is discussed, with accompanying data and analysis, in the following chapters. The interviews are the focus of the data analysis; the questionnaire data is used to relate the theme content to a wider sample, and to establish the generalisability of the interview data. Thus, the qualitative data is the primary focus; the quantitative results substantiate the transferability of the qualitative analysis. The choice of the four themes was made on the basis of their prevalence within the interviews; they appeared to have relative importance for all the students who were interviewed, particularly those of curriculum and socialisation. The other two themes - professionalism and power - were less tangible, but still played a part in the students' discussions.
CHAPTER THREE

Curriculum

The discussion of curriculum begins with a review of the concept, followed by an outline of writers whose ideas about the organisation of knowledge are relevant to nursing curricula. After an examination of the overt curriculum operating in nursing education, consideration is given to the hidden curriculum and ideological hegemony.

Much has been said, and will continue to be said, regarding nursing curricula. The aim of this study was not to point out deficiencies in these, but to see nursing education from the point of view of the consumer - the nursing student. And one primary factor influencing how students perceive that education is the content and processes of their experience of the nursing curriculum.

There are many definitions of curriculum.

A curriculum is an attempt to communicate the essential principles and features of an educational proposal in such a form that it is open to critical scrutiny and capable of effective translation into practice. (Stenhouse, 1975:4)

A curriculum is

all those learning experiences arranged by a formal educational organisation for its students, whether these occur within or outside the premises concerned. (Musgrave, 1974:3)

The concept of curriculum in nursing education appears to be the subject of some confusion. There is a wide spectrum of ideas on what might be included within the concept. They range from Packer's (1979)
general use of the term referring to philosophy, curriculum design, objectives, learning theories, teaching methods, and evaluation to Heidgerken's (1965) use of the term to refer specifically to all planned learning experiences of the school.

Irrespective of what definition one uses, the curriculum is still seen as the means by which knowledge is conveyed to the learner. When one becomes concerned with what counts as knowledge within nursing education, the central focus may well be the curriculum.

There are a number of writers whose ideas about the organisation of knowledge are relevant to a consideration of nursing curricula and their possible effects on students. For example, Bernstein (1970) explicates the need to examine the social assumptions and power relationships "underlying the organisation, distribution, and evaluation of knowledge" (1970:347). Bernstein proposes three "message systems" which are inextricably intertwined with his approach to the organisation of knowledge:

curriculum (which) defines what counts as valid knowledge, pedagogy (which) defines what counts as valid transmission of knowledge, and evaluation (which) defines what counts as a valid realisation of this knowledge on the part of the taught. (1975:85)

Bernstein believes that the social principles which underlie the organisation, distribution and evaluation of knowledge allow one to differentiate between the formal and informal curriculum. To discover these underlying principles of power and control, Bernstein constructed two concepts: classification and framing.

Classification is concerned with the social organisation of knowledge; its focus is on the curriculum, and it refers above all to the "degree of boundary maintenance between contents" (1975:88).
Framing, on the other hand, is about the teacher-student relationship; its emphasis is on classroom interaction and it refers in particular to "the degree of control teacher and pupil possess over the selection, organization, pacing and timing of the knowledge transmitted and received in the pedagogical relationship" (1975:89). Both concepts encompass elements of power and control; these procedures of classification and framing by which what counts as knowledge is organised provide the structure of rules and relationships within which the mental structures of individuals develop.

Bourdieu (1977), although not using the same analytical categories as Bernstein, also argues that the organisation of knowledge, or culture, in the school determines the structure of the culture absorbed by individuals within it.

From these points of view, any curriculum involves a principle whereby of all the possible contents, some contents are accorded differential status and enter into an open or closed relationship to each other. If the contents stand in closed relation to each other, that is if the contents are clearly bounded and insulated from each other, such a curriculum Bernstein calls a collection code. Juxtaposed against this is a curriculum where the various contents do not go their own separate ways, but stand in open relation to each other - an integrated type. A curriculum based on the principle of a collection code will have both strong classification and framing, and evaluation will be both formal and explicit (for example, structured assignments and examinations). A curriculum based on the principle of an integrated code, however, will illustrate a shift from content closure to content openness, from strong to markedly reduced classification, and evaluation less concerned with specific procedures (Bernstein, 1975).
Torres (1974:2 cited in Keane, 1983) defines an integrated curriculum as being a "blending of the nursing content in such a way that parts or specialities are no longer distinguishable". The common relational idea, according to Redman (1978) is towards a more holistic conception of man, in health as well as illness, with broader nursing assessment, intervention strategies and skills.

In light of this definition, the present nursing curricula of the comprehensive courses in New Zealand might be considered to be integrated, with the relational idea, the supracontent concept, being holistic health care (Perry, 1985). The existence of such an idea is essential in order to accomplish any form of integration and it will act selectively on the knowledge within each subject to be transmitted (Bernstein, 1975). The boundaries between subjects tend to become weaker, and the particulars of each subject are likely to have reduced significance. The pedagogy of integrated codes will emphasise ways of knowing, and will focus attention on the deep structure of each subject, rather than its surface structure. Thus integration reduces the authority of the separate contents, with a common pedagogy and common system of evaluation likely. Weak framing allows student participation in decisions; in other words, there is a shift in the balance of power, in the pedagogical relationship between teacher and taught.

However, all this is dependent on the level of integration: whether it is at a deep level, integrating both intellectual and experiential dimensions of knowledge, or at a more superficial level (a focused curriculum) (Bernstein, 1975). It is suggested (Perry, 1985) that nursing curricula are, in fact, integrated at this more superficial level - certainly they have both weaker classification and framing, but evaluation remains both formal and explicit.
It is a debatable point as to whether there is, within the polytechnics, a shift in the balance of power between tutor and student. A definite hierarchical relationship within the system could be demonstrated, at least from the student's viewpoint. Freire (1973a:46) refers to this type of relationship as "anti dialogue"; it is characterised by the "banking" concept. This form of mechanistic education attempts, by controlling thought and action, to adjust students to the world rather than developing their capacities to transform it. When education becomes an act of depositing knowledge, with the students as the depositaries and the teacher as the depositor, communication tends to give way to communiques by the teacher, who makes deposits which the students "receive, file and store".

Freire (1973b) suggests that dialogue is the principle means by which the banking concept can be opposed. Unlike "banking education", that inhibits creativity and domesticates students, a radical pedagogy requires nonauthoritarian social relationships that support dialogue and communication as an indispensable tool for questioning the meaning and nature of knowledge and peeling away the hidden structures of reality. (Giroux, 1979:263)

A horizontal relationship between tutor and student would exemplify a "freeing education", an education aimed at bringing about a level of critical consciousness in students, rather than an education that leads to a continued state of massification (Freire's term referring to the tendency of the education system to conform individuals to the masses, and to encourage acceptance of the present reality as a given). A freeing education prepares one to take on the role of engagement in, and relationship with the world, rather than, as in massification,
depositing information in individuals as prescribed and decided by others, presenting a world in which one must adapt and adjust. A freeing education is, at its roots, characterised by dialogical relations. As such, it is incompatible with actions that prescribe, oppress or exploit individuals, or an education that narrates or alienates. Nursing students should be encouraged to be actively involved in their education, to develop autonomy and the ability to critically reflect on that education.

This viewpoint parallels that of Habermas (1968) who, in his development of critical social theory, exhorts individuals to critically examine the reality about them and expose those relationships and traditions which are unnecessarily constraining and to replace these with something more "freeing". This education enables participants to move to a state of "conscientization" (Freire, 1973a), characterised by the attitude of practising depth in the interpretation of problems and it allows interaction between teacher and student in the review of social constraints. A critical consciousness poses a world that is dialectic in nature; it presents the world holistically and in a process-oriented manner, rather than as a static, definite given.

An important tenet of Habermas' conceptualisation of critical theory is that there are different interests guiding the discovery and development of knowledge. Knowledge is pursued in a technical interest for the desire of prediction and control; knowledge pursued in a practical interest is for the development of self and mutual understanding; and knowledge pursued in an emancipatory interest is for liberation from outmoded relations and structures (Habermas, 1968). All types of knowledge are necessary for the development of the fully human person, and no type is presumed to be superior to another.
Knowledge in nursing is, however, predominantly pursued in a technical interest. The current constraints exercised over the comprehensive nursing courses (such as the requirement of the Nursing Council for 1500 hours theory and the equivalent in practice) and the fact that the courses operate in two structured and bureaucratic institutions ensures 'prediction and control'. The demarcation between students and tutors is maintained and reinforced by the internal course requirements and by official registration procedures.

Nursing curricula are based on an objectives or systems model (Nursing Council of New Zealand, 1977); objectives, content and evaluation express an emphasis on input, process and outcome. This technical approach to curriculum produces a means to an end, that is, student attainment. The objectives model is concerned with control, as it dictates which qualities of nurses are desirable; curriculum content is determined as a means to achieve this end. However, as Stenhouse (1975:97) argues "the objective model appears more suitable in curricular areas which emphasise information and skills". Attempts to determine the adequacy and appropriateness of objectives is limited by this separation of means from the end.

In nursing education, therefore, it would seem that the overt curriculum consists of core skills and information necessary for entry into practice. Transmission of this knowledge is through theoretical instruction and supervised practice. While the Nursing Studies Departments may believe that they are operating within an integrated curriculum, the subjective experiences of the students' suggest that it is more of a collection code. The students see hierarchical structures operating and well defined subject boundaries, as well as being fully
aware of the required hour allocation and the presence of formal evaluation procedures (Perry, 1985; Walton, 1989).

However, as Becker (1961:13) observes "knowledge and skills alone do not make a professional". Interpretation of how students view the environment in which they learn, and are socialised, will indicate on what philosophy their future actions will be based (Pitts, 1985). If they consider that their learning environment places an emphasis on objective reality, to the seclusion of their subjective experience, students tend to learn that, in order to be considered successful, they need to "conform to and ultimately adopt the definition of the nursing role held by those with greater power or authority" (1985:38).

When consideration is given to the curriculum within a school of nursing, it is often the formal curriculum that is being dealt with. But there is also another, covert part of this curriculum that needs to be examined. This is the "hidden curriculum", which Jackson (1968) describes as the unofficial rules, regulations and routines that are learned by students to survive their learning environment. Vallance (1973:7) defines the hidden curriculum as:

those nonacademic but educationally significant consequences of schooling that occur systematically but are not made explicit at any level of the public rationales for education .... It refers broadly to the social control function of schooling.

It is not only the overt content, but also this covert hidden curriculum that conveys messages to students about reality.

Identification of this hidden curriculum cannot occur when consideration is given to objective reality only. The meanings and influences that students derive from the curriculum are not made
explicit. As Pitts (1985:38) states "the obscurity of meaning is evident when the professional student is educated in a technological structure that imposes predetermined objectives onto the learning process". Whatever the aim of the education process might be, the actual experience for the student is "one of control and coercion that is internalised and eventually reproduced" (1985:39). What tends to happen is that the student becomes a 'product' and their ability to be critically reflective of their nursing role is diminished.

That this covert curriculum exists should be indisputable, particularly if one does acknowledge how students subjectively experience their nursing education. Its longterm effects may be far more powerful and influential than nursing educators care to admit. Giroux (1980:284) suggests that

by mediating between society and the student's consciousness through the 'dispositions, structures and modes of knowledge, pedagogic relationships, and the informal culture that make up the daily character of the school itself', settings for socialisation have become sites for controlling the definition of the professional student's reality.

That this reality may well be in conflict with the student's own beliefs and experiences is often not stated.

Giroux goes on to suggest that the concept of hidden curriculum needs to be openly acknowledged as a "pedagogical concern", and that

if the notion of the hidden curriculum is to become meaningful it will have to be used to analyze not only the social relations of the classroom and school, but also the structural 'silences' and ideological messages that shape the form and content of school knowledge. (1983:61)

If nursing education is to produce graduates who will openly challenge
and suggest changes to the system, nursing educators must recognise the presence of the hidden curriculum and seek to determine how it is influencing student learning. Educators must utilise it to indeed analyse their knowledge base, and their ideological precepts. They must focus on the relationship between the school culture and the overt and covert aspects of the curriculum in order to establish a nursing course that will encourage graduates to be reflectively critical of their professional practice.

Giroux states "while school cultures may take complex and heterogeneous forms, the principle that remains constant is that they are situated within a network of power relations from which they cannot escape" (1983:63). This issue of power will be discussed at some length later. One needs to critically analyse where such a culture comes from, whose interests it serves, and how it is sustained in school discourse and social practices. The work of Bourdieu (1977) and Bernstein (1975) clarifies the relation between education and cultural transmission and reproduction. Bourdieu postulates links between the organisation of knowledge and the social organisation of the transmission of this knowledge, between modes of pedagogy and principles of evaluation. The characteristic forms of these linkages imply an inherent logic, a permanence and sense of order.

The concept of this culture is underpinned by the notion of ideological hegemony. This does not simply refer to the content found, for instance, in the formal curriculum. It also refers to the way such knowledge is structured, and to the routines and practices found within different relationships (Giroux, 1983). As Apple (1979:82) states "hegemony is created and recreated by the formal corpus of school knowledge, as well as by the covert teaching that has and does go on". It
can therefore be argued that the nursing courses do not simply "process students", they help create and legitimate forms of consciousness which reinforce the existing hegemonic structures.

Bottorff & D'Cruz point out "in regard to the transmission of aspects of a culture, it is necessary to recognise the importance of the teacher's influence, the educational methods used and the content of the curriculum" (1985:11). Each of these has a critical role in the maintenance of ideological hegemony. This is particularly true if nursing education promotes the transmission of its culture, but does not encourage students to reflect critically on that culture. Students may well see a gap between such stated objectives as self-direction, creativity and autonomous professional practice, on the one hand, and the actual education process that frustrates such behaviours on the other.

Salmon's statement (1974) sums up how these students felt generally about their experiences of the curriculum

Nursing education as I have experienced it, does not socialise the ready, willing and pliable young man or woman into a responsive, involved, knowledgeable and competent, creative and thinking nurse. The young person is failed by the nature of the nursing education which often, albeit tacitly, aims for evaluating its success in the student's ability to pass the qualifying examination, proving safety to practise. (1974:36)

A part of this present study explores the students' perceptions of the curriculum within the comprehensive nursing courses. A review of the literature indicates that the concepts, and concerns regarding curriculum type and content, tutor/student relationships and methods of teaching, the technical approach to the curriculum and formal methods of evaluation, and the existence and effect of a hidden
curriculum are all critical elements. These are the issues that will receive direct attention in the analysis of the data gathered in this study.

PART B

All of the students interviewed discussed their perceptions of the curriculum. The major areas of concern regarding the curriculum, expressed by the students in the interview data, were

... content of the curriculum
... method of teaching
... tutor/student relationship
... evaluation
... hidden curriculum

CONTENT OF CURRICULUM

On the whole, the views expressed in the interviews were supported by the questionnaire data. However, because the students interviewed were able to express opinions on specific subjects the likelihood of opinions that were more negative was greater. But, while several of the students made reference to specific subjects within the social sciences, only one expressed particular dissatisfaction with this area of the course.

In my opinion, subjects like sociology were a waste of time ... we went into it in such detail.
Psych bugged me too ... it's like looking for needles in haystacks ... if you clear away all the garbage then you suddenly think 'Oh, that's ALL they're talking about'.

(Pam, r53/54)
Another student did express some negativity with regard to this area, but felt this opinion changed somewhat later in the course.

1. **You say that you were disappointed in some sessions?**
2. **Yes ... a lot of it was in the nursing studies, holistic health, sociology, etc ... it really didn't mean a lot to us and it just didn't seem to formulate into anything. We hadn't had that necessary nursing experience ... we hadn't been 'out there' and we were trying to relate it to a field situation when we hadn't even been in the field! But it was mainly in the first year that I felt that.**  
   *(Kim, r15)*

Comments expressed within the interviews regarding science subjects were quite negative. But it must be remembered that these students had the chance to comment on specific subjects within the science component of the curriculum, an opportunity not available to those students completing the questionnaire.

From the interview data, it appears that the major areas of concern within the science subjects are maths and chemistry.

**Chemistry ... I don't think that the depth was really required in a nursing course ... organic chemistry, yes, but not a lot of the other. The maths ... there was FAR too much ... all you need to know is how to make perhaps three or four different types of calculations ... there's too much made of it.**  
   *(Sarah, r12)*

**The emphasis on chemistry was quite high ... higher than what needed to be, I think. The maths ... also a heavy emphasis ... I don't think it was warranted. The depth they went into wasn't relevant to the calculations we do on the wards.**  
   *(Kim, r2)*

**Um, some things, particularly in the chemistry, maths ... I think we went into these a lot more than we needed to have done. I feel we haven't utilised much of the knowledge and some people really struggled in these areas.**  
   *(Emma, r39)*

**I felt we covered far too much maths ... because we only need drug calculations and I.V. knowledge really. So the maths is FAR too extensive.**  
   *(Fiona, r9)*
I think the maths is just ... in nursing you need to know how to do about three formulas. The maths just scared so many people ... and it just wasn't needed to that extent. (Ann, r3)

I watched people suffer with maths ... they thought they were going to be thrown out of the course as you had to have a really high pass rate. People really suffered, only to find when they got into second year that they didn't need to know it all anyway. (Amy, r49)

Other subjects received positive comments (biology, microbiology) and this might well suggest why the overall questionnaire ratings were higher than expected, as the questionnaire did not allow for differentiation between subjects.

Microbiology was good ... that was interesting and integral ... very much so. (Pam, r49)

The bio, the micro were all quite relevant. (Kim, r2)

These results compare with those reported by Taylor et al (1981). In that study, respondents were asked to name the subject they found "most and least interesting, most and least useful for nursing, easiest and most difficult, most and least likeable ..." (1981:61). Nursing studies and anatomy and physiology were favourably rated, with physics and chemistry rated as "least interesting, least useful, most difficult, least likeable and most in need of change" (1981:61). Taylor completes his summary of ratings of individual subjects with the statement:

... confirm the impression that, up to 1975 at least, the role and method of teaching of physics and chemistry had yet to be worked out to everyone's satisfaction. Whether this is still the case (in 1981) is not known.
In the section of the questionnaire relating specifically to the curriculum (questions 16a-d) the students were asked to rate the theory portions of the curriculum, clinical experience and course organisation. The theory component (16a-b) was divided into the social sciences (all nursing theory and subjects such as psychology, sociology) and the sciences (such as chemistry, biology). This division was made in order to determine more accurately students' opinions of particular components of their course.

The students were asked to give an overall rating, on seven dimensions, using a five point scale (refer Appendix 2). As can be seen from Figure 3.1 the mean ratings for the social science subjects are generally toward the favourable end of the scale. The students rated these courses positively (a "positive" rating is taken as one falling within the two left-hand categories of the five point scale. Conversely, a "negative" rating is taken as one falling within the two right-hand categories) on two dimensions ("useful/of no use" and
"interesting/boring"). For the remaining categories ("well related to practical/poorly related to practical", "heavy workload/very light workload", "well planned/poorly planned", "easy/difficult", "well taught/badly taught") the majority of the students rated these in the middle.

The overall ratings from the questionnaire for the science component of the course were high, with the majority of students giving positive ratings on all dimensions except "easy/difficult" (refer Figure 3.2). This result is somewhat surprising, given the often expressed criticism that the nursing courses place too heavy an emphasis on the sciences. Individual polytechnic results did show some variation in the mean scores. On a five point scale, there was a range from 1.83 to 3.25 (where 1 equals "heavy" and 5 "very light") with respect to the workload dimension. For the "well/badly taught" dimension there was a range from 1.42 to 2.77, and for "interesting/boring" the range was from 1.67 to 2.94.

**Figure 3.2: Students' ratings of science subjects.**

<table>
<thead>
<tr>
<th>Rating Dimension</th>
<th>Poorly related</th>
<th>Light workload</th>
<th>Of no use</th>
<th>Poorly planned</th>
<th>Difficult</th>
<th>Badly taught</th>
<th>Boring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well related to practice</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>Heavy workload</td>
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<tr>
<td>Useful</td>
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<tr>
<td>Well planned</td>
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<tr>
<td>Easy</td>
<td></td>
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<td></td>
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<tr>
<td>Well taught</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Interesting</td>
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</tbody>
</table>
The other area of curriculum content within the comprehensive nursing courses is clinical experience. Question 16c in the questionnaire related specifically to students' overall ratings of their clinical experience throughout the course. They were asked to rate this component on eleven dimensions, again using a five point scale. A majority of the students rated 7 of the 11 dimensions positively (refer Figure 3.3). The two dimensions rated least positively were "unhurried/hurried" and "not stressful/stressful", with both having a greater proportion of students making negative ratings than positive ones ("unhurried/hurried" = 19.9% to 35.1%; "not stressful/stressful" = 18.1% to 49.1%).

**Figure 3.3: Students' ratings of their clinical experiences.**

Again, these results compare with Taylor et al (1981). In his research students were asked to rate their "practical training and
experience" on a number of seven-point scales. Generally, the ratings were toward the positive ends of the scales (Small et al, 1979:26), but for the components "unhurried/hurried" and "relaxed/tense" the means fell close to the middle category. Thus, when a comparison is made between the two sets of results, the conclusion can be drawn that these two facets of clinical experience continue to concern students.

The final section of question 16 in the questionnaire (16d) referred specifically to course organisation, and the results are applicable to the next three areas of concern within the curriculum, identified at the beginning of this chapter (method of teaching, tutor/student relationship and evaluation). Students were asked to evaluate aspects of their nursing education, on a four point scale, ranging from 1 ("Always") to 4 ("Never"). This evaluation included such areas as programme objectives, relationships between nursing and related subjects, assignments, student evaluation and tutor performance (refer Appendix 2). For 15 of the 20 statements, the majority of the students rated these as reflecting their nursing education either "always" or "most of the time". Despite this favourable response, however, more than 20% of the respondents rated these statements as applying only "sometimes" or "never", except for the statement "the objectives of the programme were made clear". For three of the remaining five statements, over half of the respondents chose the "sometimes" category. These were:

d) Class sessions were interesting and stimulating 51.2%

c) Tutors made it clear how each topic fitted into the total course programme 54.7%

t) Textbooks required for the course were worthwhile 58.6%
For the other two statements, just over half of the students were split between the "sometimes" and "never" categories.

<table>
<thead>
<tr>
<th>Statement</th>
<th>S (%)</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Teaching methods were flexible enough to accommodate individual student differences</td>
<td>46.8%</td>
<td>8.3%</td>
</tr>
<tr>
<td>p) Students' suggestions for change were taken seriously</td>
<td>42.5%</td>
<td>9.9%</td>
</tr>
</tbody>
</table>

Figure 3.4: Students' ratings of course organisation.

The evidence presented suggests that comprehensive nursing students are generally satisfied with most of the theoretical components of their courses. The most contentious subjects are chemistry and maths (a subject not involved in the 1975 survey). While it is acknowledged that the questionnaire did not allow for rating of individual science subjects, and that the views expressed by the students in the interviews...
may be peculiar to their polytechnics, their opinions might well indicate continuing dissatisfaction with particular science subjects and suggest a need for evaluation in this area.

The positive response to clinical experience is encouraging. The correlation between these results and those of Taylor et al (1981) for the two components mentioned earlier (hurried, stress) indicates that nursing educators planning clinical experience should keep these ratings in mind, and give consideration to alternatives such as longer clinical placements (refer Emma, r12 and Sarah, r38 in the discussion of the socialisation data, p. 103).

While students' discussion within the interviews, with regard to curriculum organisation, was not confined to the statements contained in the questionnaire, their comments did reflect some of the areas of concern. The following qualitative data will be discussed under the headings already identified.

METHOD OF TEACHING

Opinions on this area tended to vary somewhat, perhaps reflecting the wide age range (22 to 49) and past experiences of the students' interviewed. There was consensus, however, regarding evaluation of class sessions, giving support to the negative rating within the questionnaire.

Amy described her education as "boring" and a disappointment.

The way the whole course is taught ... even the first year ... is boring. It's not stimulating, it's just dreary. You know ... you get the odd tutor who's fired up and ready to go, and you get the odd unit that really works you hard. But what I found was that some units were SO easy that you slid through them, and didn't feel as though you came away with anything and it was
really hard to know what you'd done. Other units were SO packed ... they really worked you hard and had high expectations ... but you came away feeling extended and that you had really done your thing!! And you really enjoyed it. But then you would get into the next unit and go back to sleep again for the next few weeks!! I found they waste SO MUCH TIME. (Amy, r1)

Within their discussions of teaching methods, students' comments reflect the form of mechanistic education expounded by Freire. The comments graphically illustrate the "banking" concept, discussed in the theory (refer p. 40) - the students saw their nursing education "adjusting them to the world rather than developing their capacities to transform it" (Freire, 1973a).

Oh, EVERYTHING depended on the tutor.... (Amy, r3)

I see my nursing education as being 'spoon fed' ... the whole way. (Kim, r13)

Um ... they spoon fed you at polytech. I mean ... you have to know the stuff and that's fair enough, I guess. But the nursing tutor should just be able to walk in there, say what she has to say and then it's up to you. That's what is going to make or break people ... it will get them sorted out as to whether they want to do it or not ... there is TOO MUCH sitting back. (Ann, r10)

I would have preferred to have more self directed learning ... it takes a lot longer, but I think you get a better knowledge in the area. So it was really frustrating sometimes ... because of this 'hours thing', you went along and listened to a whole lot of babble for two hours, just to fill in that time (it felt like that anyway) when I could have been given the information I had to find out, gone to the library for the two hours ... and learnt more because I would be reading a lot more. (Kim, r13)

Part of the frustration Sarah experienced in the course related to her perception of tutors being unable to incorporate non-nursing subjects into nursing sessions. This is illustrative of defined subject boundaries characteristic of Bernstein's collection code (refer p. 38).
A lot of them couldn't incorporate the information ... often you would ask them something and you just couldn't get a response, or you couldn't understand what you did get!! It was a bit frustrating and annoying to think that they could be out there, teaching you, and getting what seemed an enormous salary to us, and not be able to answer the questions. (Sarah, r14)

These feelings were supported by Pam, who expressed annoyance largely due to her inability to determine the relationship of some topics to the total course structure. Relationships between topics was an area that received a low rating from the majority of the students answering the questionnaire.

There was NO relationship really ... in fact, I can't think of any relationship between sociology and nursing at all ... ever ... that was made, I mean. That's why the first year, in particular, was SO frustrating ... I couldn't see how anything tied in with nursing AT ALL. (Pam, r56)

Comments in the interviews reinforced the hierarchical relationships students saw existing with tutors, for while students did indicate that some individual student differences were recognised and acknowledged (for example, credit for university papers), there was the definite feeling expressed that many of the tutors were unable or unprepared to accommodate student experiences and differences within teaching sessions. This is expanded within the next area of concern.

TUTOR/STUDENT RELATIONSHIPS

As indicated earlier (refer p. 38), this is part of the concept of framing. There is an emphasis on classroom interaction and the control possessed by both teacher and student over "the selection, organisation, pacing and timing of the knowledge transmitted and received in the
pedagogical relationship" (Bernstein, 1975:89). All of the students interviewed expressed views on this relationship; some felt very strongly about their position as students within the overall structure of the nursing course. Pam was able to reflect on the influence of tutors on students' patterns of learning and their ability to think for themselves.

_It varied with tutors. There were some who gave the impression ‘we’re the experts and we’re giving you this information, just accept it’, and there were some who encouraged people to think for themselves, and to go out and find the information._

(Pam, r60)

She went on to note the characteristics of those tutors she had felt more comfortable with; her comments reflect Freire's support of dialogue and communication as tools in a "freeing" education (refer pp. 40-41).

_There were some tutors who were better than others ... those who you felt you were more on an equal footing with ... they were looking at you as a person. We would just sit down and talk about things together, instead of them standing ‘up there’ and lecturing._

(Pam, r16)

Amy commented on how she viewed tutors' response to criticism, something indirectly alluded to in the questionnaire statement (question 16d) "Tutors were open to points of view other than their own" (refer Figure 3.4, p. 54).

_They didn’t take it very well ... they got really defensive, most of them. I guess most people get defensive with criticism, but they’re the tutors and I think they get their role round the wrong way ... I mean, they seem to think that we’re there for them, but they’re actually there for us!! They’re actually working for us, but you wouldn’t always know it!!._

(Amy, r53)

Most of the students expressed the belief that, while there may have been some encouragement to suggest possible course changes,
these suggestions were often not taken seriously (question 16d, o and p - refer figure 3.4, p. 54).

_Evaluations ... well, we had no idea of what came out of them ... no idea at all ... I wouldn't know if anything changed because of them, or what happened._

(Pam, r62)

Pam's comments also reflected her opinion that she, as a student, had little power to change things within the course.

_We've got to sort of accept things. In order to get where you are going you just put up with things ... like polytech being an extension of high school. So you accepted the 'status quo' simply because you knew you had to get through those three years._

(Pam, r16)

These illustrations from the interviews reflect the belief on the part of the students that the power and the ability to make decisions was firmly in the control of their tutors, reinforcing the earlier discussions on Bernstein's and Freire's concepts of how knowledge is organised (refer pp. 37-41). The responses are also indicative of Pitts' notion that students learn to conform in order to be considered successful, and that they "ultimately adopt the definition of the nursing role held by those with power ...."(1985:38).

**EVALUATION**

As discussed earlier (refer p. 39), evaluation within the comprehensive nursing courses appears to be both formal and explicit, even within those curricula based on the principle of an integrated code.
The students interviewed tended to divide evaluation into two areas - evaluation of their work by tutors, and the opportunities available to them to evaluate the course. Within the questionnaire, a statement which received a somewhat lower rating was "ways of evaluating student work were appropriate". Most of the students interviewed seemed well satisfied with the evaluation procedures that were operating within their nursing courses; the one area of expressed concern was the State Final examinations. Five of the seven students were interviewed in the weeks immediately following this examination.

Amy expressed strong views on the examination.

*I don't believe in it. I wouldn't mind a couple of multiple choice papers, because those questions probably test a greater range of knowledge and more technical stuff. I mean ... I am really perturbed that I could fail because I missed out one point and I gave some information that, on my value system, I would assume and hope that someone would give me ... but in the nursing hierarchy they might consider that people have got no right to this information ... so perhaps I've actually broken a 'secret nursing code' that I don't really know anything about!!.*

(Amy, r64)

Emma reflected on the stress she was experiencing, waiting for results.

*... possibly, if I knew my exam results I might be able to say more!! I mean it's that ... they've been saying that we shouldn't base everything on the exam, but for us to be registered, that's our 'ticket for practising', regardless of what's come before. I think that is unfortunate ... at least, that's the way I see it.*

(Emma, r9)

Although the students did not overtly criticise the evaluation requirements of their courses, several did express an awareness of the curriculum being based on an objectives model, discussed earlier
(refer p. 42), with an emphasis placed on student attainment. All were aware of the standards of attainment required within the course, and some talked of the stress these often elicited.

*We had objectives which we should, or could, achieve and they were quite specific to the area we were studying in ... like you might have psych ones, med/surg ones, ones for orthopaedics ... they were all organised and you knew what you had to do to meet them.*

*(Fiona, r46)*

*The work was there, and had to be done. There were certain standards that you had to meet in order to pass ... some didn't find it stressful, but on the whole I think most people did. It's the concentrated effort required ... you see it's a full day ... and then you have assignments and all the other stuff to do on top of that.*

*(Pam, r6)*

The questionnaire did not address the availability of evaluation procedures for students to assess areas of their course. However, this received a good deal of attention in the interviews; on the whole, most expressed some dissatisfaction with these procedures. Remarks were sometimes cynical.

*I don't really feel that they take much notice of our evaluations ... the only ones they do take notice of is if enough people write and say it was an easy unit ... then they change it!!*  

*(Amy, r52)*

*I think evaluation is really important, but the way we have done it ... we evaluate each subject as you complete it and usually that's after an exam and you have the results ... so nobody is particularly concerned about what they're writing ... and sometimes you can't remember what's happened in the previous weeks, and you just want to go home!! So I'm not sure how constructive it is.
And often you had the feeling that all the evaluations were was the tutors saying 'well, we had better give the students the opportunity to evaluate this unit, because evaluation is part of the nursing process!!'.*  

*(Emma, r36/80)*

Emma also lamented the lack of opportunity to evaluate the whole course.
I. You mentioned earlier that you really weren’t given an opportunity to evaluate the whole course?
S. Yes, that’s true. We were talking to one of the tutors after the exam and one of the girls said ‘I thought we would go back into Tech to do some evaluation?’ He said ‘No, if you’ve got any ideas just write them down’. But how often do you do that sort of thing? ... and just after exams, at the end of the course when you are feeling really tired ... which I think is a pity. (Emma, r77)

These comments reflect earlier discussion regarding knowledge in nursing being pursued in a technical interest (refer p. 42). The division between tutors and students is maintained and reinforced by the course and registration requirements.

HIDDEN CURRICULUM

The final area of concern regarding the curriculum addressed previously (refer pp. 43-45) is the hidden curriculum. This did not receive direct attention in the questionnaire; however, most of the students interviewed were very much aware of such a curriculum operating. They reported experiences of being controlled, with no opportunities available to critically reflect on their nursing education.

Kim’s comment graphically illustrated student awareness of a hidden curriculum operating.

*It was very much laid down ... this is the way it’s done, this is the way it’s always been done, this is the way it’s going to be done in the future ... so you do it this way. And it was NOT open to interpretation either.* (Kim, r28)

Sarah entered the comprehensive nursing course as a mature student and at times experienced a good deal of frustration.
I actually found the amount of time wasted at Tech VERY frustrating after having been at Varsity ... knowing that you were going to class and that they were making it last two hours when you could have got that information in one ... and had that other hour, if not at Tech, then for yourself to do work. Yes, I found that really hard. And the whole thing about hours was very frustrating too ... the counting up of hours and always, it seemed to me, spreading things out to make this 3000 hours that you HAD TO HAVE.
A lot of the attitudes ... like treating you like children, not adults ... they were all the time saying 'we're treating you as adults, you ARE adults' ... but it wasn't really happening which was VERY frustrating! (Sarah, r4/14)

Kim's feelings reinforced Sarah's.

Tech is very much like a school situation ... you've got your times, you have to be there, be on the roll type of thing ... you've got to comply. (Kim, r4)

Amy saw the polytechnic operating as a hierarchy and discussed the influence this had on students.

Polytech is a system ... very much so. It's sort of ... it works down. Your first port of call is with the person with whom you have the problem, and if you can't sort it out there then you move on to the next one, and then the next one, then the next one. They get quite annoyed if you just jump straight to the top ... even if you say 'well it's a bottleneck' ... they just don't like it. (Amy, r10)

Fiona, while she viewed tutor/student relationships as being quite satisfactory, was aware of "things operating within the institute".

Of course, there were things operating in the institute that were there because it is that type of place. Like counting student hours ... that was VERY strict ... and some tutors more strict than others. (Fiona, r40)

Emma placed an emphasis on feelings of being controlled and a
hierarchical structure.

We were told 'you are adults and to be treated as adults', but then there were many times that you felt very much in the student role and they were THE TUTORS ... and to meet criteria or whatever, you MUST comply.  
(Emma, r18)

Feelings reported by Kim, Sarah and Amy summarised the general tenure of the students' statements on this area of the curriculum. They saw a dichotomy existing between the philosophical orientations the courses espoused - autonomy, accountability, professionalism - and the messages students were given on expected performance and behaviour.

In the first year, tutors made you think a little more laterally and tried to make you more autonomous ... but in the second and third years when you were out in the clinical setting, it was very much laid down the line what was expected of you ... and that sort of confidence, assertiveness and autonomy just seemed to go out the back door.  
(Kim, r2)

I. Did you ever challenge the tutors about what seemed to you a waste of time?
S. Oh, constantly. But we never really got very satisfactory answers. They would just say 'well, this is the way it is and this is what we have to do'. Some tutors were good ... if you finished your class early then they would say 'go home and the hours will not be docked'. But others just kept you till the bitter end! That's one thing I found really annoying ... it was like being treated as school children ... with the rolls being marked all the time.  
(Sarah, r5)

We used to complain and complain about the waste of time, etc ... but would more or less be told 'well, this is how it is; you've signed up for the course and that's that' ... if you complained it was as if 'well, YOU have a problem with coping with the course and you'd better come and see us so we can discuss how YOU can deal with YOUR problem' ... so you tend to think 'this is ridiculous' and you can't be bothered anymore.  
(Amy, r5)
While there is some lack of consensus among the students who were interviewed regarding the areas of concern identified in the curriculum (content of curriculum, method of teaching, tutor/student relationship, evaluation and hidden curriculum), there does appear to be a general degree of dissatisfaction with certain teaching methods. General opinions are also held regarding students' status and power within the total course structure. The overall experiences reported in the interviews reflect inconsistency between the stated aims and objectives of the nursing courses and the day to day course organisation and expectations. The students realised these inconsistencies, but on the whole felt powerless to effect change, which ensured maintenance of the dominant ideology. It is interesting to note that Taylor et al (1981) reported criticism levelled at the siting of the nursing courses within technical institutes (Wynne-Jones, 1972) because of their "petty discipline". Taylor goes on to state:

this cannot be completely dismissed as a possible problem, since a few students had made informal comments along these lines, and one of the third-year students in the 1975 survey mentioned the 'regimented school atmosphere' as being among the main disadvantages of the technical institutes as places in which to locate nursing courses. On the other hand, there is no indication that this was seen as a general problem (1981:166).

The final part of this statement might be questioned in light of the information reported in the current study.
CHAPTER FOUR

Socialisation

This discussion of socialisation begins with a review of the concept; an examination of professional socialisation, its definition and possible development follows. The polytechnic nursing course philosophies are discussed, then the role transition from student to graduate is outlined. Possible outcomes of this transition and suggested changes are addressed. Consideration is then given to personality characteristics, and how these might influence the socialisation process; a summary of the concept of socialisation as it is manifested in nursing completes the discussion.

The process by which individuals who aspire to become members of a particular occupational group develop a self-image which includes the values and beliefs of that group is termed socialisation. Simpson & Back (1979:226) state "socialisation is commonly conceived as learning the behaviours, skills and outlooks that prepare one to perform in a role". For the purposes of this discussion socialisation may be defined as changes in the behavioural or conceptual state of the person that follow from an environmental condition and lead to the greater ability of the person to participate in a social system. (Biddle, 1979:282)

Socialisation into nursing has often begun prior to entry into the education programme, through parental influence, images portrayed by the media and personal experiences. But it is within the basic educational nursing course that the student learns what constitutes
professional nursing. As Perry (1986:7) states

educational preparation for professional practice entails more than just acquiring a theoretical and experiential knowledge base for nursing practice. Students are also exposed to a socialisation process which inducts them into a professional culture and institutional structures.

However, consideration needs to be given to whether the nursing student plays an active or passive role within this socialisation process. This involves questions about who controls this process, on whose concept of the profession the socialisation process is based, the balance between idealism and reality presented in the nursing course, and the extent to which each of these influences the ultimate socialisation of the nursing student into the profession.

Cohen (1981:14) defines professional socialisation as the complex process by which a person acquires the knowledge, skills and sense of occupational identity that are characteristic of a member of that profession. It involves the internalization of the values and norms of the group into the person's own behaviour and self-conception.

A nursing education course can influence the extent and pattern of development of students' conceptions of nursing, through its attempt to control the acquisition of knowledge and the opportunity to practice nursing. Thus, consideration of professional socialisation and the development of attitudes and values must be seen within the context of nursing education (Perry, 1985). In the process of nursing education the students' rudimentary concept of nursing is developed and expanded; this ultimately becomes the ideal role concept of the new graduate. The course imparts to the student new images, expectations,
skills and norms which influence how the person then defines him or herself and others' perceptions of that self. The nursing school, with its anticipations and expectations, becomes a reference group for the nursing student. The school determines criteria which are seen as measures of successful assimilation into nursing culture. These criteria tend to encourage comparisons with peers and with the school's overall philosophies. By and large, students know what is expected of them by reference to written course objectives, feedback in the form of formal and informal assessment and grades, and frequent evaluations. Thus, nursing educators often "serve as a 'yardstick' by which the student evaluates performance and acquisition of attributes of the professional group" (Betz, 1985:302).

Many views of socialisation see it as a process where the individual learns a role and internalises a set of rules which then regulate professional behaviour. They suggest that, while the individual may experience conflict and difficulty during the socialisation period, a successful outcome is dependent on the individual's ability to assimilate the shared norms and expectations of the profession, and to pattern behaviour accordingly.

The basis of this view of socialisation is that of role acquisition. Nursing uses the concept of role model frequently during the education and professional socialisation of nurses (Hamilton, 1981; Betz, 1985). Historically, conceptions of the nurse role have developed within at least two main dimensions, which suggest value systems - the PROFESSIONAL ROLE conception and the BUREAUCRATIC ROLE conception. The first of these roles suggests primary loyalty to the nursing profession, rather than a specific employment agency. It is
associated with professional principles and standards and emphasises commitment to knowledge and continued learning. In contrast to this role, the bureaucratic one suggests primary loyalty to the work place, rather than the nursing profession as such. It is associated with rules and regulations of nursing care delivery within the employing organisation.

Inherent within this concept is the necessity of role clarification (Meleis, 1975). During the socialisation process into a professional role the person must become aware of what the role means in relation to expected attitudes and patterns of behaviour, as well as other factors which shape the role in a negative or positive way. In order to achieve role clarification, Meleis considers it necessary that role modelling, role repetition and interactions with a professional reference group should occur.

Within the educational setting, the professional role conception tends to receive greater emphasis. Each individual entering a nursing education course comes with personal values which reflect their cultural background and may well have influenced their choice of nursing as a career. It is within the educational course that these values are clarified and internalised via development of the professional role. The reality of nursing education is often far different from a student's lay image of it (Sobol, 1978; Policinski & Davidhizar, 1985). Students' perspectives of nursing may vary from those of graduates' in several ways. In today's nursing courses students are often encouraged, on the one hand, to be independent, innovative and questioning, but also expected to be compliant and co-operative on the other. It might be suggested that when the new graduate is
confronted with the bureaucratic principles which operate within an institution like the hospital, that conflict may well be experienced if the graduate views these principles as diametrically opposed to the professional ideals she may consider fundamental to nursing practice. Within a bureaucratic organisation individuals are expected to adjust to well-established policies; they tend to lose sight of the aims of the total organisation, and rules often constrain individuality and independence. Thus, the disparity that may occur between the nursing school and nursing practice could, in part, be grounded in the primary allegiance of each institution to either professional or bureaucratic principles. This view of professional socialisation is from a functional perspective - a paradigm in which the socialisation of nursing students and new graduates is considered in terms of role change.

The term socialisation can be used to refer to "those learning processes that lead to a greater ability of the person to participate within a social system - either through understanding it or by conforming to it inadvertently" (Biddle, 1979:282). The notion of socialisation includes that of learning, with the person (learner) being seen as a recipient. This is particularly true if one is considering socialisation from the view point of role acquisition. While nursing programmes often espouse independence, autonomy and self-directed learning, the student role is still governed by the nursing educators who set and enforce standards. They sanction behaviour which conforms to the norms of the professional group. Nursing education can be seen as responsible for the socialisation of the nursing student into the values of the profession (Watson, 1981). This nursing education often stresses the ideal, with little experience grounded in practice. This may mean that the student internalises a role conception based on
a false 'ideal' role model with little foundation in nursing practice settings.

This does not suggest, however, that nursing students are completely unaware of the concept of the bureaucratic role, nor its influence in the work environment they are likely to enter. But they do tend to see themselves as separate from this environment, even when participating in clinical experience. Students may well be aware of the disparity which exists between the idealised, individual, patient centred care they are encouraged to give and the bureaucratic, hierarchical environment in which they practise this care. But as students they may see themselves as insulated from its effects. Therefore, role taking, or 'anticipatory socialisation', remains incomplete - the potential conflict between professional and bureaucratic roles may only be realised when the nursing student graduates. Anticipatory socialisation has been defined as "the preservice role-learning involving the process of being indoctrinated in what is important to the job" (Dobbs, 1988:168). If this process is incomplete, the student often maintains a limited understanding of the total demands and expectations of the nursing role. This will be likely to result in role conflict and confusion; the nurse commonly frustrated by the difference between her image of 'real' nursing and the functions she must assume in actual work situations.

Thus role theory is based on the process of adaptation and suggests that there is agreement about the content of roles. It seems to imply that one must conform to a set of role expectations, and that within the profession there is agreement as to which beliefs, norms and behaviour graduates must exhibit in order to become accepted and functioning members of the nursing profession (Perry, 1985).
But one needs to consider if there is indeed agreement within nursing circles as to which attitudes, norms and values should be incorporated within the professional self-concept, if role clarification is to be achieved. While nurses writing about professional socialisation do suggest that there is such an agreement (Miller, 1979; Watson, 1981) this conclusion can be questioned. The literature reveals that there is often a marked discrepancy advocated by theorists and practitioners regarding the values and attitudes which a professional nurse should have. As Perry (1985b:33) suggests "there is also little correspondence between the kinds of attitudes and values propounded in the classroom and those that the student experiences in practice situations". And Williamson (1976:102) points out

nursing schools and employing organisations represent two different subcultures of the nursing world. The norms, values, and behaviour expectations differ more between school and work than they do between two different work settings. It is therefore quite possible for a person to be congruently socialised into one subculture but not into another.

If this is indeed the case, role theory offers only a limited explanation of professional socialisation. It connotes a method of induction into the nursing profession that remains outside the student's understanding and control and fails to recognise the subjective experiences of the student. It also does not give recognition to the active component of the socialisation process and how students may well rationalise it. Socialisation of the nursing student is not a passive process. Other explanations should be explored.

Bucher & Stelling (1977) suggest that at least two sets of social variables must be given credence in order to explain the socialisation
process. The first is structural variables, which include "concepts pertinent to the nature and organisation of professions, and to the social structure of the formal organisations which 'process' succeeding generations of professionals". The second set, known as situational variables, "refers to social situations which are a function of the larger structural variables" (1977:21). Within these two sets of variables, questions are raised regarding the position of the educators within the profession and how they influence the development of professional socialisation. The students' views of the nursing profession are based on their experiences within their education - the learning institution, the philosophies of the nursing educators, programme organisation, the types of experiences made available - all set the stage for socialisation to occur. Bucher & Stelling (1977:264) state:

it appears that it is the way a training programme is organised and the consequent nature of the trainee experience that determines the nature of the outcomes. In other words, there is evidence of a programming effect; structural and situational variables combine to mould the professional identity and commitment developed by trainees, and to delimit their career options.

Examination of the polytechnic nursing course philosophies shows an emphasis on professional nursing. Descriptions of the nursing role demonstrate valuing of individualised, comprehensive, direct care of patients. The nurse in the courses' stated objectives has an holistic view of patients, a feeling of direct responsibility to them, and an individualised therapeutic relationship with each. Thus the aim of the nursing courses within the polytechnics is clear. But, given the fact that a great deal of the students' nursing experience occurs within the hospital and polytechnic bureaucracies, one might suggest that this
aim may not be possible to uphold. Perry (1985:35) states "ideology is created and sustained through definite practices of communication, decision making and productive work which creates meanings for people as they relate to one another in these practices". In this way, the nursing students come to believe and accept that the goal for the nursing care they are being encouraged to practice is not, in fact, possible to achieve in the existing health care structures.

The curricula of the nursing courses are structured to develop the students' knowledge and skills and to integrate these with the professional nursing orientation of holistic, individualised patient care. Within the curriculum an emphasis is also given to the teaching of specific techniques and skills and the associated knowledge base, especially in the clinical area. However, this tends to reinforce for the student the division between specialties, and while it might be intended that nursing students are being educated to give comprehensive care, it appears from the comments made in the interviews that they may well be continuing to view nursing very much in the light of these specialties. This may reflect some degree of anticipatory socialisation on the part of students, who adjust their role expectations according to experiences within specific clinical areas. It may also occur because of the nature of the knowledge conveyed to students during their education. There does appear to be a real effort on the part of educators to integrate knowledge and to apply it to different nursing contexts. However, when attempting to avoid the medical orientation, with its bias toward diseases of body or mind, nurses are utilising both physiological and psychological aspects of care in each setting, which tends to result in highlighting the division of knowledge further. Hence, as Litchfield
(1986:19) points out "knowledge, then, is comprehensive in that it draws from the range of sciences and disciplines, but it is additive rather than integrated".

When the changes in nursing education in New Zealand were introduced in the early 1970s, it was envisioned that there would be a corresponding change in nursing practice. It was hoped that the establishment of nursing education within a tertiary institution would produce graduates who would practise comprehensive, autonomous nursing care. But on the whole, this has not eventuated. And the fault may lie, as Perry (1986:7) suggests, in the fact that these early assumptions may not have taken into account the socialisation processes that students and new graduates go through. We may not have taken into account the structure and constraints which underpin professional nursing thought and action.

The contrast between the nursing care taught in school and that operating in practice appears as strong as ever. The gap between nursing education and nursing practice has been identified, explored, and analysed (Blanchard, 1983; James, 1984; Litchfield, 1986). Yet, the role transition from student to graduate continues to be a traumatic experience for the neophyte nurse. Some authors (Kramer, 1974; Farabaugh, 1984) suggest this may be so because nursing students do not see their future nursing role in the light of what happens in practice. Nursing educators often do not encourage their students to acknowledge the possible differences; instead, students are encouraged to assimilate high standards and to believe they will be able to build their future nursing practice on them. In school, the emphasis is on creativity and cognitive knowledge. Students are reinforced for elaborate care plans,
intervention to provide for emotional needs and comprehension of one or two patients' health histories. However, while these ideals may be regarded favourably within the work setting, they are often not practised because of the workplace, time constraints, etc. Thus, problems may well arise when these nursing students graduate because it is often not possible for them to maintain the standards they have learned in school; the demands of the job force them into compromise. Emphasis must be on delivery of physical nursing care first, with the emotional and educational nursing interventions of less priority.

Although the student is likely to realise the dichotomy that exists between school and practice expectations and values, the new graduate's response may still be frustration, fear and anger and she may suffer what Kramer (1974) termed "reality shock". The new graduate is often doubtful about her ability to meet this criteria for a 'successful' nurse. What may follow is a cycle where fear and anxiety inhibit work performance and learning and compound her feelings of inadequacy. Critical reflection is prevented by the hegemonic nature of the institution. Kramer proposed that nurses leave the profession largely because of the antithetical nature of the professional and bureaucratic roles.

However, although research does indeed suggest that there is a dichotomy between the type of nursing propounded by nursing educators and the situation found within nursing practice, explanations still seem to simplify the socialisation process that does occur and students reactions to it. It is apparent that students tend to receive conflicting messages during their nursing course (Perry, 1985; Hickson, 1988). On the one hand, they are taking part in an educational process that espouses autonomy, independence, and creative thinking;
on the other hand, experiences within their education (such as roll marking, hour allocation) give them the message that their behaviour needs to comply with the expectations of nursing tutors' if they are to develop a professional self-concept acceptable to the nursing profession.

It therefore seems feasible to conclude, as Perry (1986:10) suggests, that "perhaps we socialise students to readily accept the institutional constraints placed on professional practice". While many new graduates undoubtedly experience some degree of reality shock, as postulated by Kramer (1974), it may well be that their education has prepared them to alter their expectations and behaviour so they 'fit in' with the existing practices and rules of their employing agency. For example, while initially new graduates may be aware that the nursing care practised in their workplace contradicts the principles learned during their education, they may well see it as the only option available to them and adjust their principles accordingly. Nursing care is often linked to a time frame, and because the total organisation of the hospital tends to support this orientation, it is seen as the natural and most realistic means of providing nursing care (Perry, 1986).

These organisational practices serve to socialise the new graduate into existing hierarchical structures and can be considered an aspect of hegemony. In this sense, hegemony can be defined as an 'organising principle' that is permeated by an agency of ideological control and socialisation (the hospital) into its total organisation and practices (Boggs, 1976). As Perry (1986:10) expounds "the hegemonic influences which define the nature of nursing, the limits and status of nursing knowledge and practice, act to reinforce the status quo. Hegemony is therefore a form of social control ...".
So, when nursing students encounter control, in the form of hierarchical structures and constraints which govern their educational experiences, there is not any reason to be surprised that, on entry to hospital practice, they seem to adjust to the existing structures and constraints. While nursing students may be taught that their education will equip them with the ability to become change agents, it does seem that their experiences within that education might well negate that possibility. They appear to learn that compliance, and 'fitting into the system' is the best policy.

However, while compliance may well be advisable when they are nursing students, it may ultimately be a hinderance to their future enactment of professional nursing. Rendon (1988:176) asks the question "are these students, who experience enjoyment, involvement, and satisfaction in the student role, best equipped to enact autonomous independent practice in their future?" She goes on to suggest "since the professional nursing role incorporates independence, critical thinking, autonomy, and action, should not the requirements of the student role allow for these qualities to assure compatibility with desired outcomes?"

This discussion of compliance of nursing students leads one into consideration of personality characteristics; how these might influence the choice of nursing as a career and have a determining effect on the process of socialisation for the individual nursing student. There has been a great deal of research concerning personality characteristics of nurses. The most frequently used instrument to assess these personality characteristics is the Edwards Personal Preference Schedule (EPPS). Until recently, the characteristics that typically described the nursing student were high levels of succourance, nurturance, abasement and
low level needs for dominance, autonomy and achievement. Thus, these findings generally depicted nursing students as being submissive and fitting well into the culturally stereotyped 'feminine' category. A predominant theme in the research on nurses' personality structures is their concern for the general welfare of mankind and the desire to help others. Most studies of motivation for nursing have found the concern for humanity to be a strong, underlying force (Lewis & Cooper, 1976).

Because of the degree of nurturance connoted in the nursing role, it is possible that persons with a predominantly compliant character are more attracted to the profession. Boughn (1988) suggests that a central issue is whether the lack of autonomy nurses are attributed with is in any way a result of specific characteristics of those individuals who select nursing as a career. Her literature review reveals that nursing students have not possessed characteristics that reflect an autonomous nature. Boughn (1988:151) then states "this raises the question that if a profession is developing from a non-autonomous student population, how could the outcome possibly be an autonomous professional?"

Rendon (1988) suggests that as the nursing profession changes in the direction of greater autonomy and independence, it will be important to observe whether the personality characteristics of nurses change accordingly. Kahn's (1980) findings have already indicated a change away from the submissive-dependent image of the nursing student.

Within this context of a changing profession questions about conflict between personality and present and future role congruence are raised. This is particularly true if one believes that nursing students' personality profiles are affected by the educational process.
While the nursing profession is striving for autonomy, it seems appropriate that examination of the nursing student's psychological characteristics be carried out, to clarify the type of individual attracted to the profession. Boughn (1988) suggests that the professional socialisation process that occurs during nursing education could be better designed to promote desired autonomous behaviours.

In the present study, one section of the questionnaire related specifically to personality, while another reflected the concept of the "ideal nurse". The results, while somewhat inconclusive, do suggest that further research might profitably offer nursing educators guidelines as to what effect the socialisation process has on the self-concept and personality of the nursing student, and what influence this might have on their future nursing role.

Thus, two types of socialisation need to be considered within nursing education. There is the process which involves moving students from one point to another, the end product being a person who has both the technical competencies and the internalised values and attitudes demanded by the profession and society. But there is also the process which presents the student with the ideal, as judged by the nursing educator, but which often has little basis in practice. It is the combination of both of these processes which has such a profound influence on the students' ultimate view of, and commitment to, nursing. Nursing educators play a vital role in the socialisation of nursing students into the profession and at the same time the development of their image of a nurse.

There are a number of issues raised in this section which will be explored within the data analysis. The students' views of the socialisation process are interpreted, along with their anticipation of
the transition from nursing student to graduate. Possible reasons for choice of practice area and the relationship between personality and the socialisation process are also addressed.

PART B

The second of the major themes identified in the interviews related to the students' experience of socialisation into nursing.

The students' prime areas of focus regarding socialisation identified in the interviews were

... impact of course
... clinical experience
... competency
... choice of area for graduate practice
... personality characteristics

Within the interviews, it appeared that the students' perceptions of their nursing education were influenced, at least to some extent, by their age. Three of the students were in their early to mid twenties (Ann, Emma, Fiona), the other four were aged between 30 and 49. The division of opinions between these two groups is not categorical, but within some areas there are definite correlations with age. The following discussion concerning socialisation will therefore, where applicable, relate to age. While it is acknowledged that the ages of the students who were interviewed do not represent the distribution of ages within the nursing courses of the participating polytechnics (refer Figure 4.1, p. 82), some of the perceptions reported by the older students
do offer suggestions that might be given consideration if the courses hope to continue to attract a wide range of applicants.

IMPACT OF COURSE

When it was first proposed to move nursing education from the hospitals to polytechnics it was hoped that this would allow for improvements in recruiting (Taylor et al, 1981), with particular regard to attracting more applicants, possibly more men and people from minority ethnic groups.

In 1973 the proportion of students aged 18 or over entering comprehensive nursing courses was 75%. In this study, 91.8% of students were aged 20 or over on EXIT from the course, their age at entry thus being over 18. This indicates, therefore, that the proportion of students aged 18 years and over entering polytechnic nursing courses has markedly increased, as Perry (1987) also noted.

Figure 4.1: Age of respondents.
Taylor et al (1981) compared the number of male entrants to polytechnic nursing courses and hospital general programmes and found evidence that the new courses were attracting more male entrants. However, if hospital psychiatric and psychopaedic programmes were included along with the general programme, the reverse became true. In this study 93.1% (471) of students were female and 6.9% (35) were male, compared with 94.9% female and 5.1% male in Perry's study (1987).

With the phasing out of the hospital training programmes, it must be of some concern that the number of males entering the polytechnic courses is only increasing very slowly. If one looks at where these male students would like to practise, results indicate that, while the top four areas do reflect the overall choices, males would choose to work in only 8 of the 19 areas (accident and emergency, intensive care, medical, paediatric, psychiatric, surgical, other(hospital), public health), with a much higher proportion wanting to practise in the psychiatric field - males 20.0% (7) compared with 5.5% (26) females. This bears further investigation.

Students were asked to identify their ethnic origin. One respondent identified herself of European/African descent; the rest fell
into the following three categories:

**Figure 4.2: Ethnic backgrounds of nursing students in 1979, 1986, and 1988.**

1979 (Taylor, et al., 1981)

1986 (Perry, 1987)

1988 (Forbes)

As the results indicate, 5.0% identified themselves as Maori/Pacific Islanders, a slight increase from Perry's figures (1987) of 3.9%, and a good deal higher than that found by Taylor et al (1981) of 1.7%.

As previously indicated (refer chap. 2, p. 28), the interviews commenced with a request "Please tell me about yourself and what you thought of your nursing education". In response to this, the students began by reflecting on why they chose to enter nursing education. While all felt that it would offer them a worthwhile and interesting
career, it appeared that there was some difference in opinions about the course depending on age. Three of the older students expressed that they had always had an interest in nursing, but for various reasons, had been unable to commence earlier.

_‘I’ve almost always been interested in nursing, and became really keen while working for IHIC ... but had other commitments, and I felt I wasn’t stable enough or financial enough to do the course before this._ (Kim, r1)

In contrast, however, a comment made by Fiona reflected the results of the questionnaire, indicating that many of those entering at a younger age are likely to have made the decision at secondary school.

_My sister is a nurse, but it wasn’t until my sixth form year that I even started to think about my career options ... and decided that nursing was a ‘safe’ career to take ... that there would be jobs at the end and I also enjoy looking after people and working in the health sector._ (Fiona, r2)

Question 6 within the questionnaire asked the students to state when they made the decision to enter nursing. It is very possible that many students who consider becoming a nurse do not eventually do so, either because of the social status of nursing or for other personal reasons, and equally certain that some enter nursing without even having wished to do so. Therefore, what is of most importance is not the age of first considering nursing but the age at which the final decision is reached.
Figure 4.3: Time when respondents decided on nursing as a career.

From this figure we find two clear concentrations - "always interested" (33.5% = 169) and "secondary school" (34.5% = 174). The next highest category is "after leaving school" (19.0% = 96). However, if these last two are combined we find that 53.5% (270) of the students completing the questionnaire made their decision to enter nursing either at secondary school or after.

If the results for question 6 are cross tabulated with age, the following picture emerges.
These results show that for ages 20 - 24 and 25 - 29, over half made their decision to enter nursing at secondary school, or after leaving, and a further third have always been interested. The pattern is almost reversed for the 30 plus group, with just over half having always been interested, and another third deciding at secondary school or after.

What is of most interest from these results is whether the combination of age and the time of making the decision to enter nursing education has an influence on the students' perceptions of their nursing course. Comments made within the interviews would suggest that such an influence does exist. The older students who indicated they had always had an interest in nursing certainly expressed more dissatisfaction and frustration with the course.

*It's been a disappointment, the whole course in some ways. There's no real extension and no real making people think or reason....*  
(Amy, r1)
At least two of the younger students seemed to accept the formal educational context operating within the polytechnic almost unconditionally. Fiona appeared to experience little difficulty in 'fitting in' to the system and saw the formal constraints and requirements as necessary and just (refer p. 78).

_There were things operating within the institute that were there because it is that type of place ... but I thought that was okay ... some people used to kick up about it, but I was keen to be at every lecture so it didn't worry me. I guess it was very much like going to school, in some ways._ (Fiona, r40)

Emma talked about her place in the nursing education course.

_I've just gone along to the classes, or whatever. In the theory you take down what you're given ... I sort of feel that I don't know enough to realise if I have a need in a particular area ..., so I just accepted what we were told._ (Emma, r64)

While the younger students did report feelings of lack of control (for example, Emma, r18 chap. 3, p. 64), there tended to be a contrast between their responses and those of the older students, in that the younger students appeared to accept this control as not only necessary, but also as just.

As previously indicated (refer chap. 3, p. 62), Kim's comments reflected insight into this control. Kim had talked about being 'moulded' into a system, and when questioned about this reasoned

_Possibly, as a mature student, I saw this more than some of the younger students ... because those coming straight from school have been moulded anyway ... they're used to a school situation ... where I had been out in the workforce and I was expecting it to be a little different ... I was probably expecting it to be more of a university type setting ... but it wasn't._ (Kim, r4)
Within the interviews, there were several comments made regarding past experience which was seen as relevant to nursing.

I. Do you think other experiences can be beneficial to students entering the nursing course?
S. Yes ... I would recommend a year's nurse aiding ... perhaps even a compulsory year before anyone came into the course ... just to get that experience. But it does depend on the person too ... what situation they are in and their maturity level. (Fiona, r65)

Question 11 requested the students to indicate any previous qualifications/experience they saw as relevant to nursing.

Table 4.1: Previous qualifications/experience

<table>
<thead>
<tr>
<th>AREA</th>
<th>NUMBER</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Aid</td>
<td>185</td>
<td>36.6%</td>
</tr>
<tr>
<td>Child Care</td>
<td>158</td>
<td>31.2%</td>
</tr>
<tr>
<td>University</td>
<td>55</td>
<td>10.9%</td>
</tr>
<tr>
<td>Enrolled Nurse</td>
<td>50</td>
<td>9.9%</td>
</tr>
<tr>
<td>Parenting</td>
<td>49</td>
<td>9.7%</td>
</tr>
<tr>
<td>Teaching</td>
<td>11</td>
<td>2.2%</td>
</tr>
<tr>
<td>Social Work</td>
<td>8</td>
<td>1.6%</td>
</tr>
<tr>
<td>Occ. Therapy</td>
<td>4</td>
<td>0.8%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>3</td>
<td>0.6%</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>1</td>
<td>0.2%</td>
</tr>
<tr>
<td>Other</td>
<td>95</td>
<td>18.8%</td>
</tr>
</tbody>
</table>

Results indicate that those seen as most relevant by the students (apart from the "other" category) were nurse aiding (36.6% = 185), child care (31.2% = 158), university (10.9% = 55) and enrolled nursing (9.9% = 50). Of the 18.8% (95) who placed a tick in the "other" category, the most frequent response was other employment - 6.9% (35), including hospital work, with small numbers indicating St John's, counselling and previous nursing training.
In her interviews, Emma talked about her work experience prior to entering the course, and how, on reflection, she realised its benefits.

I’m Emma ... I’m 22 years old, and I’ve always wanted to do nursing. I’m really not sure why ... I have got relatives who are nurses ... I don’t know whether the glamorous side appealed ... but I certainly found the reality to be quite different. Um ... at the end of the sixth form I had had enough of study and couldn’t see myself going on to university straight away, so I thought a year working would benefit me. I had worked it out that I would work for a year and then go nursing, but I wasn’t accepted the first time round ... so ended up working two years at Social Welfare doing clerical work, ... which I now think was good for me. Um ... I don’t know whether I would have felt equipped to handle nursing straight from school. I came from a fairly middle class family and school, so working at Social Welfare was quite an eye opener.  

(Emma, r1)

Emma also demonstrated an awareness of the stresses the course presented, but discussed how her home circumstances helped to minimise these.

I think living at home has been a great help. A lot of the students have been coping with weekend jobs or working part time and studying ... I don’t think I could have coped with that ... and I’ve been lucky enough to get vacation work when I wanted it, so financially I haven’t had the same strain they’ve been coping with.  

(Emma, r2)

Several of the students remarked on the strain of trying to progress through the course at the same time as ‘managing’ other roles, such as parenting. While a few of the students interviewed identified university as previous experience that could be relevant to nursing, their responses also indicated the dichotomy they saw between the two educational institutions (university and polytech) and the frustration this engendered. Ann experienced difficulty in adjusting her expectations of what the course would be like with the actual requirements she experienced.
In lots of ways our nursing education was just an extension of high school ... there is SUCH a contrast between polytech and varsity ... I just wish the tutors would walk in and say ‘we’re going to do this’ or say what we really need to know ... I mean, sometimes there is just TOO MUCH orientation around hours ... if you’re finished something you’re finished it.  

(Ann, r34)

Most, if not all, of the students were aware of a socialisation process occurring. Several made direct reference to this process, and alluded to the accompanying influence of the 'systems' within which their nursing education had taken place - the polytech and the hospital/s.

We’re very much moulded into the hospital system.  

(Kim, r3)

I see myself as coming from one system (polytech) into another one (hospital).  

(Emma, r70)

Emma went on to say

Tutors did tend to acknowledge that we were working within a system ... although more that we would be moving into working in a system ... not so much that polytech was a system! So they were quite open about the fact that they saw hospitals as systems, but perhaps didn’t openly acknowledge that the education we were going through was really the same sort of thing.  

(Emma, r72)

Amy talked about polytech and the hospital as 'systems', and students learning to 'play those systems' in order to survive. Her remarks parallel the suggestion made earlier (refer p. 77) that students are socialised to readily accept institutional constraints.

During the second year, once you get out into clinical, you learn that you have to adapt to the system to get along ... and you do so, VERY quickly!  

(Amy, r45)

She also remarked on possible rebellion against this.
I see polytech as a system ... like the hospital ... very much so. I don't think they view 'bucking the system' very kindly ... they don't want the hassles. So I never did so ... I just tried to live through it!! (Amy, r50)

These results reflect the trends in recruitment to the comprehensive nursing courses over the past fifteen years. However, comments expressed within the interviews suggest that the courses are likely to have a varying impact on students, dependent on a number of factors, including age. It would therefore be appropriate for future research to investigate the response of students to the course according to their age, particularly as the courses are designed to attract a wide range of ages.

There is clear evidence in this study that the students were well aware of a socialisation process occurring. While it is probable that most nurse educators would acknowledge this process, it is less likely that they would do so with regard to the effect it has on students. The 'persuasion to conform' that occurs within nursing courses is not openly acknowledged, but it is a critical factor within socialisation and ensured students became part of an ideological consensus and ensured conformity without coercion. The following two quotes illustrate the adjustment of students' to existing structures and constraints, and the process of compliance, both discussed earlier (refer pp. 77-78).

You could see the socialisation going on ... I've had the experience of working in wards where comprehensive nurses have been working for a year ... and the socialisation is complete. It just seems as though they fitted in. (Sarah, r9)

I. Do you think graduates from the Tech programme can make changes within the hospitals?
S. Well, I suppose they could ... but you've got to survive!! and the way to survive is to be socialised 'real quick'. You can't even make changes to the Tech system ... so you come out being a survivor ... because you
have to be a survivor to get through. And so you go into another 'system' and you've got this inbuilt survival instinct ... that you just 'slot in' and try to not make too many waves.  

(Amy, r33)

CLINICAL EXPERIENCE

Many of the students' comments within the interviews were concerned with their experiences in the clinical areas. There was an awareness on the part of students of a dichotomy between the individualised, comprehensive nursing care espoused by the nursing courses' stated objectives and the expectations often found in clinical. It became clear that the students realised they were expected to "readily accept the institutional constraints placed on professional practice" (Perry, 1986:10). Ann's comment graphically portrayed the messages she received regarding 'acceptable nursing behaviour' and how they were diametrically opposed to the nursing care she would like to practice.

I remember in one ward ... I was looking after the patients in a five bed unit ... and I knew one of the guys played cards (Bridge I think it was). They were all sitting round really bored ... so I said to him 'would you like me to go and get a pack of cards?'. So I went to the office and said to the Charge Nurse 'Have you got a pack of cards here?'. After a lot of questioning I was given them ... I got the guys playing this game and they had a ball ... they wanted me to play too, but I thought under the circumstances that it wouldn't be a good idea. But I would have loved to ... there was no other work really going on, so I was available to play. And I still think it would have been perfectly alright for me to do so as I think it is important to find things that will make the patients happy. Anyway, I went away for morning tea, and when I got back it was all packed up!! And the guys were all standing round with their hands in their pockets!!  

(Ann, r47)

Third year comprehensive students have an extended clinical placement in one or more areas prior to the State Finals in November. Several of the students remarked on this clinical elective period and, on
the whole, found it a positive and useful experience. One of the two students who had commenced working as a Staff Nurse at the time of her interview reflected on how the transition from student to registered nurse had been made easier for her by that elective.

I. Now that you have started working as a Staff Nurse, do you find you are managing?

S. Oh, yes, because of our electives ... they were really the time that we were like Staff Nurses ... we had no tutor there ... so I didn't find the transition too difficult ... and we are giving total patient care where I am working. (Fiona, r16)

Question 17 in the questionnaire (refer Appendix 2) related to this pre-graduation clinical elective. Section 17a asked the students to indicate which area(s) they went to for the elective and the main reason for that choice.

In the following table, the number and percentage of students going to each area during that pre-graduation clinical elective is given.

**Table 4.2: Number of students to each clinical elective area**

<table>
<thead>
<tr>
<th>AREA</th>
<th>NUMBER</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical</td>
<td>212</td>
<td>28.8%</td>
</tr>
<tr>
<td>Medical</td>
<td>120</td>
<td>16.3%</td>
</tr>
<tr>
<td>Other(Hosp.)</td>
<td>71</td>
<td>9.7%</td>
</tr>
<tr>
<td>Paediatric</td>
<td>56</td>
<td>7.6%</td>
</tr>
<tr>
<td>Obstetric</td>
<td>53</td>
<td>7.2%</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>49</td>
<td>6.7%</td>
</tr>
<tr>
<td>Acc.&amp; Emerg.</td>
<td>29</td>
<td>3.9%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>21</td>
<td>2.9%</td>
</tr>
<tr>
<td>Specialist Dept.</td>
<td>19</td>
<td>2.6%</td>
</tr>
<tr>
<td>District Nurse</td>
<td>19</td>
<td>2.6%</td>
</tr>
<tr>
<td>Geriatric</td>
<td>17</td>
<td>2.3%</td>
</tr>
<tr>
<td>Coronary Care</td>
<td>15</td>
<td>2.0%</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>13</td>
<td>1.8%</td>
</tr>
<tr>
<td>Practice Nurse</td>
<td>13</td>
<td>1.8%</td>
</tr>
<tr>
<td>Operating Theatre</td>
<td>12</td>
<td>1.6%</td>
</tr>
<tr>
<td>Other (Comm.)</td>
<td>12</td>
<td>1.6%</td>
</tr>
<tr>
<td>Psychopaedic</td>
<td>4</td>
<td>0.5%</td>
</tr>
</tbody>
</table>
This table shows clear areas of preference, and also reflects the choices students make for area of practice following graduation. Those results (refer Table 4.4, p. 109) suggest that the students make their decision on where they wish to nurse following graduation for particular reasons and that this decision is likely to have been made before the pre-graduation clinical elective(s). The results are very similar to those of Perry (1987), the top five choices being the same.

Figure 4.5 combines this information with the main reason the students gave for going to the area. Since some students went to more than one area during their pre-graduation clinical elective, the total number of responses is 735, not 506. It is encouraging to note that, in times of reported difficulty in obtaining sufficient clinical placements for students' experience, the high percentage of "own choice" reasons reported.

**Figure 4.5: Reasons for choice of clinical elective by area chosen.**

- **Area**
  - Psychopaedic
  - Other (Comm.)
  - Theatre
  - Practice Nurse
  - Intensive Care
  - Coronary Care
  - Geriatric
  - District Nurse
  - Spec't Dep't
  - Gynaecology
  - A & E
  - Psychiatric
  - Obstetric
  - Paediatric
  - Other (Hosp.)
  - Medical
  - Surgical

- **Percent**

- Own choice
- Educational
- Tutor's choice
- Only place available
A large part of the clinical experience within the comprehensive nursing course focuses on the organisation of nursing care. Section 17b in the questionnaire asked the students to indicate, on a four point scale ranging from "always" to "not applicable", the extent to which the statements described their nursing care during their pre-graduation clinical elective(s). (Students from one of the polytechnics responding to the questionnaire did not answer this section, nor 17c, as they had not completed their clinical elective).

Figure 4.6 demonstrates that the students' experience for each of these statements is to the favourable end of the scale.

The only statement to be rated slightly lower was "writing care plans", with 10.8% (41) indicating that they "never" had the opportunity to do this during their pre-graduation clinical elective, and a further 9.2% (35) indicating this was "not applicable" for the area they were in. Further analysis of this response on an individual polytechnic basis showed that two of these had a much lower proportion of students who chose this alternative. This result may suggest that the choice
of clinical areas by these polytechnics for the students' pre-graduation clinical elective is more appropriate with regard to the type of nursing care tutors wish students to practice or it demonstrates how clinical areas are functioning in particular regions of the country. It is pertinent to note that Perry (1987) also reported a higher percentage indicating they had "never" had the opportunity to write a nursing care plan during their pre-graduation clinical elective, although her figure of 23.6% is higher than these results indicated.

This result must engender concern as to what the students will do when practising as registered nurses, if the areas where they are working do not make use of the nursing process. One student spoke directly about this; her comment again suggests that the students learn compliance and 'fitting in' is the best policy, as previously discussed (refer p. 78).

*Unfortunately, I think I'll probably fit into their type of nursing ... for example, I found that there was something about the electives that meant you just 'slotted in' to using the type of care that they provided.*

*(Emma, r5)*

In question 17c students indicated, on a four point scale ranging from "always" to "never", how their clinical elective experience met 21 objectives. The majority of students rated 18 of the 21 objectives positively (for five of these - numbers 13, 14, 15, 17 and 18 - this meant a choice of the "sometimes" or "never" category) (refer Appendix 2). For the remaining three statements, over half of the students chose the "sometimes" or "never" categories. These are:

h) I had effective contact with a tutor while working in the clinical area(s). 63.1%
t) I received positive comments about my comprehensive education. 50.5%

u) I was given on-going evaluation about my progress in the clinical area. 51.5%

It must be remembered that as a matter of policy a number of the polytechnics do not closely supervise their students during this pre-graduation clinical elective, a factor which is likely to have influenced two of these objectives - (h) and (u). However, it is interesting to note that all of the students interviewed discussed their experiences and feelings regarding tutor coverage during their nursing education and some reported the dramatic difference between that coverage and the pre-graduation clinical elective.

Well, the big thing in the electives, when we didn't have a tutor around was that the students would say 'isn't this great, no tutors, I feel like I'm really operating well and doing things a lot better; I feel a lot more responsible'. So the students have expressed that they feel good about less tutor supervision. (Kim, r50)

The students indicated that their relationship with tutors was important in clinical experience; of prime importance was the amount of supervision provided by the tutors. Several students reinforced the feelings expounded by Kim, expressing the wish to develop independence and reporting frustration with continued 'monitoring' by tutors.

While Emma reported feeling generally comfortable with tutor supervision, she did demonstrate an awareness that the presence of a tutor influenced student/staff interaction. This reinforces earlier discussion (refer p. 71) regarding students seeing themselves as separate from the clinical environment, even when participating in
clinical experience. It also parallels further comments of Emma's (refer r34, p. 100).

_Tutors were generally very supportive and helpful ... and most of them seemed to know when you needed more support such as in the second year. But I found in the electives that because you didn't have a tutor with you all the time and you were more answerable to the ward staff, that you were more accepted as part of their team ... you weren't THE POLYTECHS._

_(Emma, r13)_

The interviews offered an opportunity to better understand clinical experience from the nursing student's point of view. The students' comments were much broader and open than would have been the case in a more focused questionnaire situation. Several of the students remarked on their nursing education and its preparation for graduate practice.

Kim described his nursing education as

_I see my nursing education only as a grounding ... it's like getting your driving licence ... you don't become a good driver until you're out driving ... I see my nursing as much the same. I've got the basic skills for whatever area I move into, but that's where I build up to become a 'better nurse'._

_(Kim, r10)_

Pam discussed the concepts of the nursing role she felt the nursing educators portrayed.

_It was very idealistic ... um, almost impossible. They had WONDERFUL ideas of what a nurse should be ... and ideally I suppose they should be ... but it's pretty impossible to do. My idea of a nurse is that there is a lot more involved ... not just perfection ... although of course it would be very nice if we could all reach those high ideals._

_(Pam, r41/42)_
Ann talked about her clinical experience and whether it had been a realistic preparation for graduate practice.

Well, in some ways it has ... it has tended to drive home the safety things which are most important. And knowing what nursing's about ... that's a priority. But the course is very 'rounded', so I believe that when we go out there it is going to be totally different ... I mean, I've only been a student and when I go out there again I will be a Staff Nurse ... you can't really compare the two. (Ann, r16)

Emma expanded on these concerns.

Things that worry me ... I wonder about the responsibility, cause you have 'that badge' and even though you are coming out after three years as a student, you are expected to be able to take on the nursing role. I know we are trained so that we are given the principles and can supposedly adjust wherever ... but I feel we miss absorbing a lot of the little things that go on because we're not in the hospitals all the time. (Emma, r25)

Three of the students made reference to feelings of a 'them and us' situation. Emma reflected on the socialisation process she saw occurring, and the importance to students of feeling part of the health team.

In our elective units WE were referring to the second year students as THE POLYTECHS ... I mean, who are we? we're still polytech students as well ... but because I felt (and one or two others have said the same) that we were relating and working with the ward staff more and were a part of THEIR team we didn't feel quite as separate. (Emma, r34)

Clinical experience has also been discussed in the section on content of curriculum (refer chap. 3, p. 52), and results indicate that students were, on the whole, satisfied with their clinical placements. However, when the students were asked to analysis this issue in more specific terms within the interviews, some comments reflected
dissatisfaction and concern. The main areas of contention appeared to be the amount of tutor supervision, a feeling of 'isolation', and the idealistic concepts portrayed of the nursing role. It is interesting to note that, in the research conducted by Taylor et al (1981), over a third of the students thought that they had too little responsibility. While section 17c in the questionnaire did refer to student responsibility during clinical electives, the questionnaire did not determine what the students felt regarding the responsibility expected of them during the nursing course. However, it is pertinent to note that in the interviews students did mention this issue (refer Emma, r25 p. 100), along with tutor supervision, expressing the wish that supervision be reduced, thereby giving the students more responsibility. These concerns are also reflected in the following section.

COMPETENCY

Within the students' discussion of their clinical experiences, many placed an emphasis on competency. The remarks reflect the importance they assigned to its attainment and its influence on confidence and belief in their abilities.

Pam expressed concern regarding preparation for the responsibilities of being a registered nurse.

*The course does its best ... as it is ... but I still feel there is not enough practical clinical experience ... because at least with the old training you were in the wards all the time and at the end of the three years you could run the ward standing on your head ... but we can't, and that concerns me.*

(Pam, r28)

Question 18 in the questionnaire (refer Appendix 2) asked students to indicate, on a four point scale, ranging from "very competent" to "not
"competent", the extent to which they felt their nursing education had made them competent, thus reflecting both theoretical and clinical experience.

Figure 4.7: Extent to which students felt their education made them competent as nurses.

For nine of the objectives, a large majority (approximately 90%) rated themselves either "competent" or "very competent". For a further five of the objectives, although the majority of the students still saw themselves as "very competent" or "competent", 15 - 25% rated themselves as "partly" or "not competent". For the remaining three objectives, over half of the students placed themselves in the "partly competent" or "not competent" categories. These are:

m) Supervise and guide the work of others 50.2%
o) Promote and participate in nursing research 50.8%
q) Become involved in professional nursing concerns 50.8%
The views expressed by the students within the interviews regarding their clinical experience and competency were much broader and wide ranging than the questionnaire allowed for. However, many of their responses reinforce the validity of the quantitative results.

Emma expressed feelings of stress.

_The stress was quite high at times ... being placed in different environments with different staff who sometimes weren't at all that accepting of the polytech system of training._

(Sarah, r12)

Sarah also commented on the number of clinical placements, a factor she saw as detrimental to building confidence.

_One thing that I felt was continually breaking down confidence was always being moved around ... you were just in a place for a short time and just building up your confidence, then you were off to the next place ... it was a little like having the rug pulled out from under you. Um... that's the nature of the course ... moving round a lot and having a wide variety of experiences. But I think that the course could be structured differently so that, while you would get the wide experience, you would at least spend a couple of long patches in wards._

(Sarah, r38)

Amy had some worries regarding her ability to function as a registered nurse, with particular concerns being patient workload, and a lack of experience in many areas of nursing practice.

_I can't conceive of looking after six patients in a day. Because we have only had say three patients on a shift, we probably haven't got the idea of prioritising and knowing exactly what to leave as the totally unimportant things. And I think there are things that we miss out on going through the polytech system ... like practical, hands on experience ... things like catheterisation, nasogastric tubes ... that sort of thing. I mean my horror is that someone is going to hand me a catheter one day and say 'go do it!'. _

(Amy, r24/21)
Emma also voiced similar concerns, along with the lack of opportunity to develop organisational skills.

_The workload pattern concerns me ... we have had a maximum of four patients and the reality of six or eight ... depending on where you are working ... is horrendous! And the organisational things ... dealing with doctors, supervisors, etc ... we haven't really had much to do with them as we would see our tutor or a staff nurse. The procedures or channels of communication ... what you do and who you contact in certain situations ... that also concerns me._

(Emma, r26)

At least two of the students addressed the issue of being accepted as a member of the health team. Amy saw this as being partly influenced by the tutor-supervision students had during their clinical experience, an issue explored earlier (refer pp. 98-99).

_Well, I felt that the tutors acted as a buffer ... so you don't really get to feel what it's like working as part of the ward because they're there between us and the staff._

(Amy, r2)

Emma made several references to the relationships she observed between the comprehensive nursing students and hospital staff. Her comments may well give an indication of why at least some of the students completing the questionnaire rated themselves as only "partly competent" in this area.

_At a ward level it's sort of been 'we are THE POLYTECHS' ... and sometimes we haven't related to staff other than asking questions, such as how they go about something or where to find certain equipment._

(Emma, r32)

Within the interviews, only one student made specific reference to her ability to supervise and guide the work of others. She had just commenced employment as a Staff Nurse in a rehabilitation ward, and
suggested ways in which the new graduate's ability to carry out this objective might be enhanced.

_I am finding it quite different working with staff of various levels... Enrolled Nurses, for example. It wasn't until my orientation programme that I found out what they are allowed to do as far as procedures go. It would probably be a good idea to give us that type of information right at the end of the course._ (Fiona, r33)

While none of the students specifically addressed the issue of promoting and participating in nursing research, mention was made of adverse reaction to specific subjects which may influence students' views of this area.

_We had a class called 'nursing perspectives' which the younger students hated and I don't think could see the relevance of... I suppose I could when talking about such things as autonomy, accountability and professionalism... but it was a bit dry and one of those things that I think could have been delivered in some stimulating, hour long lectures rather than having it every week and dragging it out._ (Sarah, r12)

Several of the students mentioned the New Zealand Nurses Association (NZNA) and their views on its place within nursing. Kim's statement appears to sum up students' views.

_Students simply didn't see it had any relevance... all they wanted to do was their education, get their registration and go out nursing... and not have any sort of input into any professional issues. They can't see that to change the system they need to be involved... and, anyway, a lot of them aren't prepared to be change agents at all._ (Kim, r76)

What must be given consideration, and it bears further investigation, is whether the students' experiences within their nursing education negate the possibility of them becoming change agents, as suggested earlier (refer p. 78).
As already discussed, the interviews gave the students the opportunity to express particular concerns regarding content and their experience of the curriculum. The main issue raised by the students concerning their clinical experience, which was not directly addressed within the questionnaire, was the dichotomy they saw between the nursing care they were practising as students and the nursing care they believed they would be required to practice following graduation. To a certain degree this discrepancy influenced their feelings regarding the level of competency they could hope to achieve in their nursing course.

Positive feelings about the type of nursing care they were taught were voiced. Ann made a very interesting and reflective observation about this care.

1. Do you think you have had the experience that you need to function as a Staff Nurse?
2. No, I don’t ... but that is not what the course is about ... it’s about quality nursing. Realistically, we are going out to the ‘meat factory’, but what is important about our course is that we find out what quality nursing is ... how nursing should be done. (Ann, r40)

However, while the students saw aspects of their clinical experience as positive, several also expressed some negativity regarding the nursing care they were taught.

Um ... I think it is good that we are educated to work anywhere instead of just within a certain hospital, and I think that it’s good that we look at all sorts of nursing areas. Possibly they do have to aim for the ideal, but sometimes you feel ‘oh, what’s the point ... it’s just NOT like that out there’. (Emma, r29)

It could be VERY frustrating ... you’re told a certain way to do nursing care...whereas often in reality you can’t do that care and therefore you have to make compromises. I had problems with that. (Kim, r35)
While Taylor et al (1981) did discuss the clinical performance of technical institute graduates, from the viewpoint of supervisors and the graduates themselves, the students were not asked to rate their competency before commencing graduate practice, as requested in this study, in question 18 of the questionnaire. Taylor does however, make the comment that, according to ratings established in his research "... their (the graduates) ability to organise and supervise the work of others and to take responsibility ... appeared to be less well developed until they had spent some time in their first jobs" (1981:158). Perry (1987) did request students to rate their own level of competency and, although using a five point scale, her results are comparable with this study, with particular regard to participation in nursing research. The lower ratings for some of the objectives may well indicate, as Sarah, r12 and Kim, r76 suggest (refer p. 105), that the students did not see the relevance of particular courses or aspects of nursing ... instead their aim was to simply "get their registration and go out nursing" (Kim, r76).

CHOICE OF AREA FOR GRADUATE PRACTICE

Within the theoretical discussion of socialisation it was suggested that many comprehensive nursing students continue to view nursing in the light of specialities (refer p. 74). This view was reinforced by comments made in the interviews.

Within the questionnaire, question 20 was concerned with areas of nursing and plans for graduate practice (refer Appendix 2). In question 20a, 5.7% (29) of the students indicated that they did not intend to work as a registered nurse. The main reason given was not getting their choice of job (2.0% = 10).
Question 20b requested the students who intend to practice as a registered comprehensive nurse to indicate their first practice area preference.

<table>
<thead>
<tr>
<th>AREA</th>
<th>NUMBER</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical</td>
<td>194</td>
<td>38.3%</td>
</tr>
<tr>
<td>Medical</td>
<td>76</td>
<td>15.0%</td>
</tr>
<tr>
<td>Paediatric</td>
<td>63</td>
<td>12.5%</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>33</td>
<td>6.5%</td>
</tr>
<tr>
<td>Other (Hosp.)</td>
<td>30</td>
<td>5.9%</td>
</tr>
<tr>
<td>Acc.&amp; Emerg.</td>
<td>26</td>
<td>5.1%</td>
</tr>
<tr>
<td>Obstetric</td>
<td>21</td>
<td>4.2%</td>
</tr>
<tr>
<td>Public Health Nurse</td>
<td>9</td>
<td>1.8%</td>
</tr>
<tr>
<td>Operating Theatre</td>
<td>8</td>
<td>1.6%</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>7</td>
<td>1.4%</td>
</tr>
<tr>
<td>Geriatric</td>
<td>6</td>
<td>1.2%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>6</td>
<td>1.2%</td>
</tr>
<tr>
<td>Other (Comm.)</td>
<td>4</td>
<td>0.8%</td>
</tr>
<tr>
<td>Specialist Dept.</td>
<td>3</td>
<td>0.6%</td>
</tr>
<tr>
<td>Coronary Care</td>
<td>2</td>
<td>0.4%</td>
</tr>
<tr>
<td>Psychopaedic</td>
<td>1</td>
<td>0.2%</td>
</tr>
<tr>
<td>Practice Nurse</td>
<td>1</td>
<td>0.2%</td>
</tr>
<tr>
<td>Psych.Domicil.Nurse</td>
<td>1</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

As the results indicate, there are definite areas of preference. Surgical tops the list (38.3% = 194), followed by medical (15.0% = 76) and paediatric (12.5% = 63). These results compare with Perry (1987) - within her survey, the students' top three choices matched those above, with 45.7% indicating surgical as their first choice, 15.8% medical and 9.5% paediatric. The main area of choice, in this study, for those who indicated the "other" category (within the hospital) was orthopaedics, with 50% (15) noting this area.
These results reflect the areas the students went to for their pre-graduation clinical elective (refer Table 4.2, p. 94), supporting the contention that students are likely to have made their choice of area for graduate practice prior to this elective. Question 20d was designed to ascertain the main reasons for the students' choice of practice area.

Table 4.4: Main reasons for choice of practice area

<table>
<thead>
<tr>
<th>REASON</th>
<th>NUMBER</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offers broad experience</td>
<td>304</td>
<td>20.8%</td>
</tr>
<tr>
<td>Enjoyed clinical experience</td>
<td>299</td>
<td>20.5%</td>
</tr>
<tr>
<td>Offers a challenge</td>
<td>265</td>
<td>18.2%</td>
</tr>
<tr>
<td>Always been area of interest</td>
<td>169</td>
<td>11.6%</td>
</tr>
<tr>
<td>Consolidation of experience</td>
<td>153</td>
<td>10.5%</td>
</tr>
<tr>
<td>Offers a chance to specialise</td>
<td>117</td>
<td>8.0%</td>
</tr>
<tr>
<td>Prior knowledge of area</td>
<td>55</td>
<td>3.8%</td>
</tr>
<tr>
<td>Theory component most interesting</td>
<td>35</td>
<td>2.4%</td>
</tr>
<tr>
<td>Other</td>
<td>31</td>
<td>2.1%</td>
</tr>
<tr>
<td>Area of most recent clinical experience</td>
<td>22</td>
<td>1.5%</td>
</tr>
<tr>
<td>Influence of individual tutor</td>
<td>5</td>
<td>0.3%</td>
</tr>
<tr>
<td>Received information from employer</td>
<td>4</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

Examination of the reasons for choosing an area may give some indication of why students continue to show a preference for particular areas for graduate practice.
These pie charts show that, for the three main areas of preference for graduate practice, the students have based their decision on three main criteria - it offers broad experience, they have enjoyed clinical experience, and it offers a challenge. For paediatrics a large proportion of the students also indicated that they have always been interested in this area. Consolidation of experience featured in the surgical and medical choices.

The nursing courses within the polytechnics were designed to replace the individual training programmes for general, psychiatric and psychopaedic nursing. There has been concern expressed that graduates from the comprehensive courses are reluctant to practice in the psychiatric and psychopaedic areas (Review of the Preparation and Initial Employment of Nurses, 1986). Questions 23a and 23b were
included in the questionnaire (refer Appendix 2) to assess this claim.

Table 4.5: Work in psychiatric/psychopaedic areas

<table>
<thead>
<tr>
<th>Psychiatric</th>
<th>NUMBER</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>240</td>
<td>47.4%</td>
</tr>
<tr>
<td>No</td>
<td>266</td>
<td>52.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychopaedic</th>
<th>NUMBER</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>99</td>
<td>20.0%</td>
</tr>
<tr>
<td>No</td>
<td>407</td>
<td>80.0%</td>
</tr>
</tbody>
</table>

These results suggest that psychopaedic nursing, in particular, continues to have little appeal for comprehensive graduates. This is supported by the position it has on Table 4.3 (preferred area of practice - p. 108), and Table 4.2 (number of students to each clinical elective area - p. 94). While the question was specific to the next five years, the results must engender concern. There were definite regional patterns within the responses, and individual polytechnics have been given their results. This issue will receive further attention in the discussion of the implications arising from this study.

Amy was one student who made a specific comment regarding psychopaedics.

*I see the term comprehensive meaning that you can work in all areas of nursing ... BUT we only have two weeks in psychopaedics and you CAN'T be a qualified psychopaedic nurse with only two weeks clinical experience. And anyway, with only that much how can you know whether you like the area? You know ... most people who end up in psychopaedics do so by elimination ... they can't get a job anywhere else ... and is that good enough? I mean, shouldn't people get to choose, and the people they're nursing should have people who chose to go there, not ones who are only nursing them because they're forced to go there.*

(Amy, r60)
Four of the students interviewed made direct comments regarding particular nursing areas, several making reference to the reasons influencing their choice of area for initial practice as a registered nurse.

The majority of my class plan to go into general nursing, particularly surgery. It's just a thing about nursing ... that it's surgical; people go in to 'have surgery'. It's a whole social issue. (Ann, r61)

Pam's comments reflected her area of preference, and her reasons for not being as interested in other practice specialities.

I quite like surgery ... because I love to see people getting better and going home ... and it fascinates me.
I don't really want to do psych nursing ... um, I quite enjoyed it, but I don't feel I'm 'doing anything' ... you sit about and talk a lot and I can't be bothered with that! (Pam, r25/26)

Kim also spoke of differences between areas of nursing.

The surgical wards are task orientated ... you're doing dressings, taking out redivates, etc. (Kim, r48)

Kim then proceeded to remark on reasons for students' choice of practice area, making some most interesting observations.

There are some students in our class who have expressed that they don't want to go into a psych area. They are mainly the younger ones who are not feeling confident about the setting, the type of patients they would have and they would not be 'ruling the roost' type of thing. A nurse in a medical or surgical situation has quite a lot of power, and they probably feel more confident in that type of ward where they know the system, they know what has to be done ... giving out the drugs, doing the dressings, etc. Whereas in a psych area the patients walk about freely, they discuss things and sometimes you can't tell them from staff members ... and I think the young students don't feel confident in that type of situation. (Kim, r57)
Fiona is another student who made a direct comparison between the medical/surgical and psychiatric areas.

*Most of our class have decided to go into medical or surgical areas ... I think it is looked on as being more glamorous and psychiatric nursing is something you *PERHAPS* get into after a med/surg ward.* (Fiona, r60)

Ann also reinforced the previous remarks, but is one young student who wished to practise in the psychiatric field.

*I really like psychiatric nursing because it's laid back and you haven't got the 'hen pecking order' as much and you work as a team which is really important. In general hospitals it's just hard slog.* (Ann, r13)

Later on in the interview, Ann made some very thought provoking and pertinent remarks regarding socialisation and psychiatric nursing.

*Students are coming into the course already socialised into what they think nursing is about. They have this belief that if you get into psychiatric nursing, you may never get out again and you go like the patients!! It's really bad ... and they believe you're not a 'real nurse' until you've been working in the general system.* (Ann, 61/62)

Her remarks suggest that societal views and values have a strong socialising influence in this area, and that students' decisions about where they wish and plan to practice following graduation may well be determined prior to entry to the nursing course. It might also be suggested that the much higher numbers of males wishing to work in the psychiatric area is also, at least in part, due to these societal views.

The term 'comprehensive' was defined by a number of the students and their comments tend to also reflect speciality areas.
To me, the term comprehensive means being taught in general, obstetric and psychiatric nursing. *(Fiona, r25)*

Ann stated

Being a registered comprehensive nurse will mean that I can go psychiatric, general and psychopaedic nursing ... I don't think it really opens the door for obstetrics, unless I go and do something further. *(Ann, r22)*

The questionnaire and interview data reported here must be given serious consideration, as they reinforce previous study data. Taylor et al (1981) reported on the distribution of technical institute graduates in clinical areas at the time of the 1978 survey. While he indicates that there was a broader distribution over the different clinical areas than had been anticipated, Taylor's results still illustrate that the majority of comprehensive graduates were working in surgical and medical areas, with smaller numbers in psychiatry, obstetrics/gynaecology and intensive care.

As reported, this study found that surgical, medical and paediatric areas were clearly preferred. For the two main choices, the principle reason for the students indicating that choice was "it offers broad experience". This may well indicate the concern students expressed regarding perceived lack of experience (refer Amy, r24/21 p. 103) during their nursing course; their choices therefore reflecting the belief that they will have the opportunity to rectify this situation in these particular areas.

The Review of the Preparation and Initial Employment of Nurses in 1986 addressed the issue of recruitment of new graduates into specific nursing areas. It suggested that possible reasons for psychiatric and
psychopaedic hospitals recruiting few comprehensive graduates are:

... a desire to consolidate medical/surgical skills

... that these areas are seen as being less glamorous and a myth is perpetuated about what is "real nursing" (1986:24).

The results in this study, from both the questionnaire and interviews, support these contentions. It is therefore crucial that recommendation 35, in this report, be actioned ... "that research be undertaken in the area of recruitment and retention in specific areas" (1986:65), with particular regard to psychiatric and psychopaedic nursing. The specific proposed research topics which appear to have particular relevance and urgency are:

(ii) whether the preparation provided is relevant to the product required

(iii) the reasons why those who commence courses are not attracted to the psychiatric/psychopaedic base hospital areas


PERSONALITY CHARACTERISTICS

In the theoretical discussion of socialisation, the issue of personality characteristics was raised; how these might influence the choice of nursing as a career and have an effect on the process of socialisation. It has been suggested that those attracted to nursing may have a predominantly compliant character and that a lack of qualities, such as autonomy, that nurses are often attributed with, may well be a result of specific personality characteristics of these individuals (refer pp. 78-79).

In the questionnaire, question 12 asked the students to choose,
from a list of 22 characteristics, those they felt best described their personality (refer Appendix 2).

Table 4.6: Description of personality

<table>
<thead>
<tr>
<th>CHARACTERISTIC</th>
<th>PERCENT</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sense of humour</td>
<td>85.2%</td>
<td>431</td>
</tr>
<tr>
<td>Capable</td>
<td>80.8%</td>
<td>409</td>
</tr>
<tr>
<td>Dependable</td>
<td>80.4%</td>
<td>407</td>
</tr>
<tr>
<td>Sensitive</td>
<td>80.4%</td>
<td>407</td>
</tr>
<tr>
<td>Warm</td>
<td>80.2%</td>
<td>406</td>
</tr>
<tr>
<td>Independent</td>
<td>73.9%</td>
<td>374</td>
</tr>
<tr>
<td>Cheerful</td>
<td>73.1%</td>
<td>370</td>
</tr>
<tr>
<td>Sociable</td>
<td>67.4%</td>
<td>341</td>
</tr>
<tr>
<td>Confident</td>
<td>52.4%</td>
<td>265</td>
</tr>
<tr>
<td>Outgoing</td>
<td>49.8%</td>
<td>252</td>
</tr>
<tr>
<td>Intellect. Curious</td>
<td>46.8%</td>
<td>237</td>
</tr>
<tr>
<td>Emotional</td>
<td>44.9%</td>
<td>227</td>
</tr>
<tr>
<td>Optimistic</td>
<td>43.1%</td>
<td>218</td>
</tr>
<tr>
<td>Autonomous</td>
<td>38.7%</td>
<td>196</td>
</tr>
<tr>
<td>Objective</td>
<td>36.8%</td>
<td>186</td>
</tr>
<tr>
<td>Achievement Oriented</td>
<td>36.6%</td>
<td>185</td>
</tr>
<tr>
<td>Cautious</td>
<td>31.0%</td>
<td>157</td>
</tr>
<tr>
<td>Quiet</td>
<td>30.0%</td>
<td>152</td>
</tr>
<tr>
<td>Shy</td>
<td>12.1%</td>
<td>61</td>
</tr>
<tr>
<td>Extroverted</td>
<td>10.7%</td>
<td>54</td>
</tr>
<tr>
<td>Dominant</td>
<td>10.5%</td>
<td>53</td>
</tr>
<tr>
<td>Introverted</td>
<td>2.6%</td>
<td>13</td>
</tr>
</tbody>
</table>

These results indicate that there are some characteristics the majority of the students believed described their personality. "Sense of humour" (85.2% = 431) heads the list, with "capable" (80.8% = 409) next, "dependable" and "sensitive" (80.4% = 407) third equal, with "warmth" (80.2% = 406) a close fifth.

However, a slightly different picture emerges if the personality characteristics are cross-tabulated with age. Then the following become more critical for the older age groups - autonomous, optimistic,
achievement oriented, emotional, cautious, independent and intellectually curious.

Kim made a specific comment regarding personality.

_The type that goes into nursing ... someone who is not an A type personality ... who is caring and willing to sit down and listen to someone, wanting to make them feel better. Quite often someone who is passive ... they'd rather follow, than be leaders or change agents ... this is a generalisation, of course, but I think that type of person._ (Kim, r56)

These results can be correlated with questions 13 and 14, to give a more accurate picture of the qualities the students saw as important to nursing. Question 13 related to the students' concept of the "ideal nurse", and 14 to those qualities they believed reflect the "ideal nurse" concept of nursing educators. Using a five point scale, ranging from "a great deal" to "not at all", students were asked to rate 20 qualities.

**Figure 4.9: Students' "ideal nurse", and their view of their tutors' "ideal nurse".**

<table>
<thead>
<tr>
<th>Mastery of material</th>
<th>Technical procedures</th>
<th>Clean/neat appearance</th>
<th>Intelligence</th>
<th>Dedication</th>
<th>Change agent</th>
<th>Efficiency</th>
<th>Ability to impart knowledge</th>
<th>Cultural sensitivity</th>
<th>Ability to make decisions</th>
<th>Integrity</th>
<th>Communication skills</th>
<th>Empathy</th>
<th>Desire to help others</th>
<th>Tolerance</th>
<th>Patience</th>
<th>Sincerity</th>
<th>Liking for people</th>
<th>Friendliness</th>
<th>Sense of humour</th>
</tr>
</thead>
</table>

- Students
- Tutors

Point at which students thought the "quality" was more important to their "ideal" than to their tutors' "ideal".
Results indicated that "sense of humour" reflects the students' concept of the ideal nurse much more than they believe it would the nurse educators' concept. Qualities like mastery of material, technical procedures, clean and neat appearance, intelligence, dedication, change agent and efficiency were rated as more important to nursing educators' concept of the ideal nurse than that of students'. These results suggest a correlation with the technical approach to curriculum, discussed within the theme of curriculum (refer chap. 3, p. 42).

Many of the students interviewed commented on their idea of a "good nurse". Although their remarks were often general, they do tend to reflect a number of the qualities enumerated in the questions just discussed.

_I would say someone who makes a good nurse is one who has a strong idea of who they are and obviously the needs of other people and their rights. Someone who has an understanding of the way society works, and that not everyone has the same chances in life ... therefore one needs to be non judgemental. Obviously someone who communicates well, with a certain amount of confidence and who will strive toward perfection._  

(Sarah, r35)

_A person who is efficient, caring and can look at the patient as a total person ... not just looking after their physical needs, but their emotional and spiritual needs as well ... someone who can interrelate with others and accept people for what they are._  

(Fiona, r23)

Emma's comments supported the previous quotes and she went on to talk about what she believed is the educator's concept of an "ideal nurse". Her remarks support the results of questions 13 and 14, mentioned above.

_I think they place quite a high priority on personal skills, but also have an emphasis on theoretical knowledge and organisational skills ... and competence in a technical sense._  

(Emma, r60)
Some students mentioned personality characteristics they consider desirable in tutors, such as honesty, warmth and encouragement as well as demonstration of professional behaviour, including respect and supportiveness.

*Those who I found 'good tutors' were the friendly ones ... ones who were on your level, sort of ... they weren't threatening.*  
*(Ann, r28)*

*When things happen, and students are having difficulties, you really want to have a tutor there who is going to help you sort it out, get in behind you and support you ... and you don't always get that.*  
*(Sarah, r46)*

Amy was one student who expressed disappointment at some tutor behaviour.

*Even the tutors don't challenge the way the ward is run, they just run their own little part of it how they want it to run ... but they never speak up. At least I've never seen them do so, even to a Staff Nurse who has been one of their students. I've had them say to me 'Oh, that's not very good, is it?', but they never said to her 'You know, we actually taught you better than this and it upsets me to see you doing it that way ... which would make people think. But instead they let it go ... it's not THEIR problem anymore.*  
*(Amy, r33)*

While these results are somewhat inconclusive, it can be suggested that the older students interviewed demonstrated many of the perceived characteristics determined as critical for their age groups - for example being autonomous, achievement oriented, and independent. They certainly displayed awareness of the dichotomies within the nursing courses, as previously discussed (refer p. 76).
Thus, the interviews and questionnaires offer extensive material for this theme. There is an interrelationship between the areas of focus identified - impact of course, clinical experience, competency, choice of area, and personality characteristics - and also some linkage with the other three themes. The data reported raises issues that will be explored further in the implications chapter. In the following chapter, the other two themes - professionalism and power - will be discussed.
CHAPTER FIVE

Professionalism and Power

Education has well established functions. These include the preservation and transmission of knowledge (the teaching and learning functions); the extension of knowledge (the research function); and the training in the skills needed by society. Professional education has an important and specific purpose: the preparation of individuals for the competent fulfilment of professional responsibilities. Within a discussion of nursing education the extent to which education promotes the functions of education in general, and of professional education in particular, need to be considered.

A discussion of professionalism profitably begins with a definition of the concept, along with an outline of the specific criteria generally accepted as characteristic of it. An examination of whether or not nursing possesses these characteristics follows. A discussion of the relationship of feminism and nursing is then developed, with an expose of oppressed groups. Strategies for enhancing professionalism in nursing complete the discussion.

Although much has been written on the subject, it remains very difficult to establish a succinct definition of the term 'profession'. Carr-Saunders & Wilson (1964:4), after an extensive study of various professions, were unable to produce a definition, but concluded

The term profession ... clearly stands for something. That something is a complex of characteristics.
Numerous people from a variety of academic disciplines have attempted to define this complex of characteristics, producing many and varied ideas about what constitutes a profession. While there is, at times, varying degrees of incongruence regarding these characteristics, the most common of these are:

... has a professional organisation
... provides a needed service to society
... has a code of ethics
... improves technique and education by use of scientific methods
... intellectual knowledge over manual skill
... laymen cannot judge the professional performance
... practices a full-time occupation

(Flexner, 1915; Bixler & Bixler, 1945; Cogan, 1953; Greenwood, 1972)

There are a number of writers who have outlined the criteria which they see characterising a profession and how these might relate to nursing (Etzioni, 1969; Chapman, 1977; Roberts, 1980; Tiffany, 1982; Crowder, 1985; Speedy, 1987). Again, there are varying opinions on which criteria might best characterise nursing, but for the purposes of this discussion they will be:

... a long and disciplined educational process
... a unique body of knowledge and skill
... discretionary authority and judgement (autonomy)
... a level of commitment
... an active and cohesive professional organisation
... acknowledged social worth

When one considers this list, analysis needs to be within a framework of definition, agreement among theorists, and whether nursing fits that definition.

EDUCATIONAL PROCESS

A prolonged period of education in which the specialised knowledge of the profession is transferred to its members is essential to a profession. While there is some discrepancy among writers on the specifics of the educational process deemed appropriate to a profession, many agree that it should be conducted within a tertiary institution, usually a university (Blixer & Blixer, 1945; Greenwood, 1972). Writers have pointed out the positive correlation between increased length of training, increased formality of training, the proximity of that training to a university and its position in the labour hierarchy (Freidson, 1970).

In the initial stages of the establishment of formal nursing education programmes the training schools were established in the hospital setting. The fact that hospitals were, and are, service institutions greatly influenced nursing. Education, at best, was secondary to service needs of the hospital (Roberts, 1980; Crowder, 1985). While nursing leaders advocated placement of educational preparation in universities from the early twentieth century, this did not start to become widespread (in the United States) until the mid 1950's.
Many writers suggest that this 'new' approach to the educational preparation of nurses greatly enhanced nursing's move toward true professionalism (Crowder, 1985). However, as others point out (Rosenfeld, 1986), nursing in many countries has yet to unify or standardise its education requirements. There is also continuing debate regarding where this educational preparation should occur if nursing is to fit this criterion of professionalism; that is, whether any tertiary institution is suitable, or must the educational programmes be conducted in a university (Roberts, 1980).

There is no doubt that the progression in the type of nursing education offered during this century has and is continuing to enhance nursing's claim to professionalism. The development of postgraduate courses and continuing education experiences for nurses are in the best interests of ensuring the development of professionalism (Crowder, 1985).

**BODY OF KNOWLEDGE AND SKILLS**

Within this educational process there must be transfer of specialised knowledge to those being educated if the occupation is to be deemed professional. There is considerable agreement on the type of knowledge which must characterise this criterion of professionalism. The knowledge which a profession possesses should be able to be abstracted and organised into a body of principles, but also be applicable to the problems of everyday life. The knowledge should have an intellectual and theoretical base (Cogan, 1953; Greenwood, 1972); encourage improvement in technique and education by the use of scientific methods (Flexner, 1915; Bixler & Bixler, 1945; Greenwood, 1972); and provide the members of the occupation with the skills
and competence to solve problems within their area of expertise (Bixler & Bixler, 1945; Cogan, 1953).

Along with these requirements, there is a responsibility for the creation, transmission and organisation of the knowledge (Bixler & Bixler, 1945; Greenwood, 1972). A further characteristic is that professional knowledge and skills are often imbued with mystery (Cogan, 1953; Greenwood, 1972).

Butterfield (1985:101) states "one means of fostering the intellectual aspect of the art of nursing is to be found in the development and identification of a substantial organized body of theoretical knowledge fundamental to nursing". And, as Buckenham & McGrath (1983) indicate, continuing development of nursing theory must occur from within the profession.

If a body of theory exists, and the profession adopts a rational, critical attitude toward it, perpetually examining the validity of its abstract propositions, then the profession will demand, and support, a strong core of researchers and theoreticians whose activities will result in theoretical controversy. Discussion of these controversial issues will, in itself, provide a stimulus for the continued development of the profession's fund of knowledge.

At the present time, nursing would not fit this definition of professionalism. Until recently, nursing has lacked a validated core of knowledge exclusive to nursing; its knowledge base has mainly been derived from other disciplines such as psychology, sociology and medicine (Roberts, 1980; Benner, 1984). A lack of research in nursing practice has been instrumental in the delay to build a nursing knowledge base.

In recent years, however, there have been definite advances in
the development of nursing knowledge. Rosenfeld states

acquiring expertise through extended education depends on formulating theoretical knowledge based on empirical research. Nursing has only begun to develop a body of abstract knowledge, and therefore, the profession lacks a source for scientific expertise. (1986:485)

A profession is able to establish and maintain jurisdiction over an area of service because of its systematised knowledge. As Christman & Johnson (1981:11) express:

a specific knowledge base enables the members of a profession to provide a service to the public that cannot be obtained from someone without that particular knowledge base. Possession of specialised knowledge that enables service also allows the profession to maintain a certain degree of autonomy.

They go on to say:

thus, a profession's knowledge base becomes the pivotal factor that enables it to meet its primary goal, service to the public. The profession's sphere of knowledge also forms the basis from which the group maintains its professional autonomy, its authority and freedom in self-regulation and function within its area of knowledge based competence.

AUTONOMY

A further criterion that has been identified as a tenet of professionalism is possession of discretionary authority and judgement or autonomy. This power to define and control the sphere of work rests on society's recognition that the professional group has the authority, responsibility, and right to control that area.

Many people consider self regulation and autonomy as the cornerstone of professionalism (Greenwood, 1972). Etzioni sees
professional autonomy as a "derivative trait (which is) based on both
the mastery of a knowledge field and commitment to the ideal of
service" (1969:291). Autonomy requires knowledge to inform
judgement. Etzioni goes on to state that "autonomy cannot be granted
without trust ... and members of the society will not grant autonomy
unless it is persuaded that the occupation MUST be trusted if it is to do its
work properly" (1969:292).

Theorists within the field of nursing generally agree that nursing
lacks autonomy. This conclusion is based on the need for public
sanction of nurses' skill and knowledge and their work to be seen as
distinct from that of physicians (Dachelet, 1978; Roberts, 1980;
Rosenfeld, 1986).

Roberts suggests

one reason nursing ... has less autonomy than true
professions is that society does not accept that the service and
level of expertise justifies the amount of autonomy given to
the other professions. (1980:35)

She goes on to state that full autonomy carries with it responsibility for
accountability. While there is increasing acceptance of the concept of
accountability within nursing, by which the individual nurse accepts
responsibility for meeting an individual patient's needs, Tiffany
suggests it is debatable how personally accountable nurses are prepared
to be for their actions (1982).

LEVEL OF COMMITMENT

This is a further criterion of professionalism, although it does not
receive as much attention in the literature as many of the other criteria
considered crucial. A literature review suggests that this criterion lacks an accurate or specific definition. Several theorists suggest that level of commitment to a profession can be judged by the fact that its members are practising fulltime (Flexner, 1915; Bixler & Bixler, 1945; Goode, 1972). Others postulate that the strength of a profession's sense of identity offers a measure of the level of commitment (Storey, 1958; Goode, 1972). The continuing expansion of its body of knowledge based on empirical research might also be indicative of the level of commitment present within a profession (Bixler & Bixler, 1945; Greenwood, 1972).

Research indicates that, historically, nursing has been perceived as just a job, a means to an end (Crowder, 1985). Consequently, lack of a lifetime commitment to nursing has tended to erode the foundation of its claim of being a profession. Roberts (1980) outlines the fact that nursing is an occupation in which many members work part-time. For many nurses, their work may not be their main source of income and they may be torn between their role as a nurse and that of being a wife and parent. Roberts suggests that "until the social custom of women who work doing two jobs is changed, this situation is unlikely to improve" (1980:51).

Schlotfeldt (1974) questions whether or not nursing care rendered by nurses is considered by them to be of value and worthy of continuous development and refinement. With regard to a level of commitment Tiffany postulates that this may be diminished by the fact that nursing has created an administrative rather than a professional elite.

Nursing practice has become the Cinderella of our profession, a development resulting in an apparently subordinant role for the clinical nurse; a situation that is characterized by the routinization of work at ward level rather than personalized, dynamic, innovative nursing practice. (1982:44)
However, there is evidence to suggest that the level of commitment by nurses to their occupation may be increasing. Certainly nurses are remaining within nursing for much longer periods of time. As Crowder (1985) outlines, there are several reasons for this. The acceptance by society of women working is increasing, many women are continuing to work or are re-entering the workforce because of economic necessity and many women are choosing to work because of the personal rewards it offers them.

Crowder goes on to suggest that:

when a person knows she will be a working member of a profession or organization for an extended period of time ... she will be less inclined to accept unquestioningly forces that impinge on that profession or job. Therefore, the current practice of women remaining in the workforce for longer or extended periods is serving to improve the status of nurses and nursing, and enabling them to achieve professional status. (1985:188)

ACTIVE AND COHESIVE PROFESSIONAL ORGANISATION

Another feature that has been identified as a criterion of a profession is a cohesive professional organisation. This is one of the criterion that has received the most support from writers. Professional organisations have their roots in the Guilds of the Middle Ages; they offered strength gained from unity. That strength gave them the power to control the education of its practitioners and control those who entered into the guilds. Flexner (1915), Bixler & Bixler (1945), Cogan (1953), Storey (1958) and Greenwood (1972) all define a professional organisation as mandatory within a profession.

Nursing theorists agree that this criterion is essential to a profession (Roberts, 1980; Crowder, 1985; Rosenfeld, 1986). As Crowder points out
ideally the professional organization should be able to contribute significantly to the profession as a whole. It is the professional organization that should represent every practitioner of that profession, speak as a unified voice for the profession and be recognized by the population at large as the voice of the profession. (1985:189)

However, in order to have the ability to have an impact both politically, and on society, the professional organisation requires universal support of the nursing practitioners. While historically this has not been the case in New Zealand, membership of professional organisations is increasing.

ACKNOWLEDGED SOCIAL WORTH

The final criterion considered a feature of a profession, as it might relate to nursing, is its acknowledged social worth, measured in terms of the service orientation it possesses. Along with the presence of a professional organisation, this criterion has received the most support from authors defining professionalism. Of ten definitions, five (Flexner, 1915; Bixler & Bixler, 1945; Cogan, 1953; Storey, 1958; Glaser, 1966) include the criterion "provides a needed service to society" within their definitions; a further two, (Goode, 1972 and Rueschemeyer, 1972) state that a criterion of a profession is "community sanction".

In terms of the service it offers, a profession is expected to make such an activity available to all who require it, but to not seek out clients or advertise. The service is based on mutual trust, with professional objectivity deciding the needs of the client. Personal involvement with the client is seen as undesirable.

Many authors would agree that on the grounds of service orientation, nursing presents a stronger case for being a profession
(Roberts, 1980). However, as has been indicated, a profession's social worth has to be acknowledged by society at large. It has been suggested that while professionalism would imply that nurses have a special area of their own related to, but different from, the foci of other professional groups when caring for the same patient, this is often not recognised by society (Rosenfeld, 1986).

Theorists external to nursing have concluded that nursing has not yet achieved full professional status (Etzioni, 1969; Friedson, 1970). The major reasons for this conclusion, according to Speedy, are:

a strong level of commitment is not in evidence as so many nurses work in part-time positions; nursing does not have a unique body of knowledge and skill; nurses do not have discretionary authority or the ability to make autonomous judgements, nor are they legitimated as a profession by community sanction.

(1987:22)

While utilising slightly different criteria than previously discussed, Chapman's (1977) conclusion that nursing cannot be defined as a profession was based on an examination of nursing using the criteria of authority for action, control and development of a professional sub-culture, community sanction and unique knowledge. Roberts (1980) supports Chapman's conclusion; her contention that nursing cannot be termed a profession is based on the premise that it is lacking the two main qualities which constitute the essence of professionalism, namely autonomy and service orientation. Before professionalisation can be achieved in nursing, Roberts suggests that its knowledge base must continue to develop and that there must be a greater commitment by its members.

Etzioni (1969) defined a category of occupations which he termed "semi-professions"; these occupations shared some but not all of the
characteristics of the true professions and remained outside of this circle. Etzioni described the semi-professions thus:

> their training is shorter, their status is less legitimated, their right to privileged communication less established, there is less of a specialised body of knowledge, and they have less autonomy from supervision or societal control than 'THE' professions. (1969:v)

Recent analysis suggests that the nursing profession may be in an 'emergent' stage. Roberts postulates that while "nursing falls short of a true profession, it fits the category of semi-profession" (1980:33). She goes on to analyse nursing in terms of its knowledge base, autonomy, education, service orientation, objectivity, involvement and commitment, professional organisations and code of ethics.

Tiffany (1982) reviews the factors that he sees as the major areas of concern regarding nursing as a profession, including the creation of an administrative rather than a professional elite, nursing by proxy, and career advancement in nursing being synonymous with an exit from clinical practice. Tiffany's main contention is that while nursing potentially has all the ingredients necessary to hold claim to being a profession ... what is far from certain is to what degree those who enter the profession are individually professional and whether or not the organizational methods employed in our health care systems enable or encourage the professional development of nursing. (1982:43)

However, Tiffany goes on to suggest that a number of developments within nursing, such as the use of the nursing process and the move to patient allocation and primary nursing, indicate that nursing is evolving towards a professional model and that individual nurses are increasingly searching for a professional orientation in their working environment. (1982:44)
But there are some theorists, such as Melosh (1982) who believe that professionalism in nursing cannot eventuate, since nursing's autonomy is constrained by medicine's professional dominance. That is, nursing cannot become a profession because most nurses are women and women are subservient to men and doctors.

If this is indeed the case, it seems appropriate to examine the possible conflict between professional and feminine roles and the impact of feminism on nursing. Initially, there needs to be an acknowledgement that having to function within the two roles of 'woman' and 'professional' produces a conflict because there is a contradiction between the characteristics and behaviours associated with the female sex role and those required for success in a professional role. Many authors have cited the direct relationship between the status of the nursing profession and the female image of the profession (Heide, 1973; Meleis & Dagenais, 1980; Matejski, 1981; Chinn & Wheeler, 1985).

The status of the nursing profession has been profoundly influenced by both the history of nursing and the feminine nature associated with the profession. (Meleis & Dagenais, 1980:163)

It has been suggested that nursing has to be structured differently to create greater compatibility between feminine and professional roles (Speedy, 1987).

While this relationship may well have been documented, the one between nursing and feminism has remained obscure within reviews on these topics. With few exceptions literature has not incorporated a feminist analysis within nursing. However, it would seem that nursing,
traditionally a woman's occupation, could benefit from this viewpoint. Feminism can be defined as

a world view that values women and that confronts systematic injustices based on gender. (Chinn & Wheeler, 1985:74)

It is suggested that nursing could profit from a better understanding of feminist theory as it would provide a frame of reference for examining nursing from a historical, political, and personal point of view (Chinn & Wheeler, 1985).

Some authors have suggested that nurses are an oppressed group (Roberts, 1983; Chinn & Wheeler, 1985; Speedy, 1987) and a feminist analysis of nursing is based on this premise. The view that nurses are oppressed is supported by evidence that nurses lack autonomy, accountability and control within nursing (Freidson, 1970). As Chinn & Wheeler state "a major contribution of feminist thinking in relation to nursing is the basic tenet of feminist theory - that women are oppressed" (1985:76).

Freire's (1973b) theory of oppressed groups can be adapted to provide such an analysis of nursing. Freire has pointed out that

the major characteristics of oppressed behaviour stem from the ability of dominant groups to identify their norms and values as the 'right' ones in the society and from their initial power to enforce them. (1973:31)

This is apparent in nursing, where the domination by physicians and administrators occurred early in nursing history and has continued to this day. Reviews of the history of women healers (the predecessors of nurses) indicate that prior to industrialisation these women were an
autonomous and primary healing force for society ( Ehrenreich & English, 1973). It is noted that early nursing education was originally autonomous, but increasingly became controlled by physicians in the late nineteenth century (Torres, 1981). It can therefore be determined that nurses were once an autonomous group but domination by physicians and powerful societal forces has led to nursing exhibiting the characteristics of other oppressed groups.

Thus, nurses tend to exhibit personal characteristics similar to those of other oppressed groups. For example, many nurses lack self-esteem, they denigrate their position in the health care system and characteristics often associated with nursing, such as nurturance, sensitivity and caring are often devalued when compared with those characteristics of the dominant male culture, such as intelligence, objectivity and decisiveness. As Roberts (1983) and Speedy (1987) explain, these attributes combine to create the feeling for nurses that they are indeed second class citizens and the belief that there are no alternatives. Therefore, this attribution of values contributes to the maintenance of the status quo.

As Freire (1973b) outlines, the perpetuation of the dominant-submissive relationship is based on the premise that the characteristics of the powerful (for instance, doctors) are perceived as being the best that can be obtained. For many nurses, this view of nursing as an oppressed group may be difficult to accept because nurses become acculturated to the existing structure.

The way nurses think, the way they come to know their world and themselves, has been shaped by inquiry and exposition from a male point of view. (Greenleaf, 1980:24)
This offers a further illustration of hegemony - the nurse's thinking is defined, via the process of professional socialisation, by the dominant groups within the health system, namely the doctors and administrators.

Torres (1981) has noted that in academic settings nurses have been rewarded for being marginal and taking on the characteristics of the dominant group. To promote coping with, and adjustment to, the hospital culture after being educated in a nursing culture, there has been encouragement for nurses to become "bicultural" (Kramer & Schmalenberg, 1978); that is, by becoming marginal it is suggested that nurses will promote their acceptance and reward by the dominant culture.

The lack of cohesiveness and the divisiveness that exist within nursing are further characteristics of an oppressed group. Lack of awareness or denial of a group's own culture is another trait of oppressed groups (Chinn & Wheeler, 1985). Lack of participation in professional organisations can be viewed as evidence of a lack of pride in the group and a desire not to be associated with it; that is, avoidance of alignment with powerless others. These attributes combine to create the submissive-aggression syndrome, which occurs when the oppressed person is unable to directly express the aggression felt for the oppressor. As Roberts (1983:23) states

> although there may be much complaining within the oppressed group, self-hatred and low self-esteem create submissiveness when confronted with the powerful figure.

What occurs instead is that this aggression is released within the oppressed group, resulting in self-criticism and infighting known as "horizontal violence".
It is apparent that nurses, like other oppressed groups, have been forced to be dependent and submissive in order to deal with the domination of a powerful group. Education, as has been noted in other oppressed groups, has been important in maintaining the status quo. By control of the environment in which nurses have been educated, the means for the maintenance of dominant norms are continued. Even an analysis of nursing textbooks, resource materials and conceptual frameworks illustrates a further means of oppression. As Heide (1982:260) states "sexist language is both consequence and cause of continual male-centredness and domination". Nursing theory, until very recently, used 'man' as a generic concept. As Chinn & Wheeler point out "nursing theories embody many underlying patriarchal assumptions about human experience" (1985:75).

Lynaugh (1980) suggests that the conflict which arose about moving nursing education from the hospital (the domain of the physician) to tertiary institutions (with increased control by nurses) was a social issue. Nurses, like other women, were not viewed as needing tertiary education for their work (nurturance and caring). Viewing this reality through the oppressed model, controlling the environment in which nurses are educated had benefits for the maintenance of the dominant norms. However, it is debatable whether moving nursing education has done much to break this cycle of oppression. Many believe that the structure of the educational system has done little to change this situation. This has been discussed in some detail within the theme of socialisation.

While an analysis of nursing does illustrate characteristics that are typical of oppressed groups, these may or may not be recognised by nurses as undesirable. Even if this recognition is present, there is often
a feeling of powerlessness to effect any change. Chinn & Wheeler (1985) list low involvement in professional nursing organisations, divisiveness, and a lack of effective leadership among the traits that are recognised by nurses as undesirable. Chinn & Wheeler point out, however, that while recognition of these traits may cause concern, they are often not seen as being a result of an oppressive system. Even more damaging to the nursing profession are those characteristics that are viewed as desirable by nurses, as there is no realisation that these actually serve to perpetuate that oppression. This situation occurs because, as Freire (1973b) delineates, these traits are considered optimal. Nurses often strive to emulate physicians believing, for example, that acquisition of such traits will give nursing more power and increased status. However, as Chinn & Wheeler suggest

too often, the assumption that emulating the medical power model is desirable results in failure to question the fundamental moral and ethical basis of the model and promotes assimilation within a self-perpetuating, oppressive patriarchal system.

Other theorists, such as Maresh (1986), offer alternative paradigms as an explanation of constraints on women and nurses. However, these paradigms can still be considered within the framework of oppression. Maresh believes that the barriers to professionalisation for nurses are: learned helplessness (arises from powerlessness), patriarchal dominance, hierarchical structures (power is retained by males) and feminization (systematic socialisation into feminine traits). These beliefs are endorsed by Chinn & Wheeler when they state

nursing practice typically occurs in the oppressive, reductionistic milieu of the patriarchal order - the hospital -
which does not foster, tolerate, endorse, nor approve nursing practice based on nursing’s own theories and values.

(1985:76)

If it is accepted that a feminist analysis of nursing provides insight into the causes, and consequences, of oppression of women and in nursing, strategies for dealing with and rejecting this oppression can be used. Speedy (1987:25) states

the only conclusion one can reach from a feminist analysis of nursing is that it is not and never can be, while presently structured and ideologically governed, a profession.

It is therefore clear that if this oppression is not dealt with, then barriers to the true professionalisation of nursing will continue. Within nursing’s attempts to increase its status there must be considerable emphasis placed on defining its unique role and developing a description of the areas of knowledge, skill and expertise that would be nursing’s prerogative and responsibility. Nursing will never achieve true professional status (if this is what it in fact desires) until society perceives it as a profession and until nurses internalise the attitudes and behaviours of professionals.

But this may well be where nursing’s main difficulty lies. As Butterfield states so succinctly

nursing needs to clarify its stance on professionalism, since both the preparation of nurses and the methods of delivering nursing care are dependent to a large degree on where nursing sees itself in relation to this issue.

(1985:99)

Parsons (1986:270) suggests "it is time for nurses to examine critically their acceptance of certain tenets of professionalism". Styles (1982) proposes that nurses should create a model that reflects the unique
'professionhood' of nursing, instead of persisting with their attempts to fit into existing descriptions.

Parsons' admonishment that nursing seek new models to define professionalism is based on the premise that the widely accepted criteria for professions are "historically and sociologically unacceptable for women" (1986:273). She goes on to outline how nurses might achieve this objective, by working in four areas: identification of nursing history, the acknowledgement and acceptance of the concept of deviance as a determinant of nurses' behaviour, the place of work in women's lives, and analysis of the work place.

The first step, the identification of nursing history, is critical if nurses are to establish their own position in the health care system. Today's social and political climate is very different from the 19th and early 20th centuries; nurses must re-evaluate past traditions in order to move ahead. Secondly, examination of the relationships of power within the health services (which will be discussed later within the theme of "power") will help nurses to identify the perception society may well have of their position in this system; and as Parsons iterates "in the process, nurses will be able to focus on role definitions that are more congruent with the ideology of the profession" (1986:274). As a third step toward the development of new models of professionalism, nurses need to determine the role of work in women's lives. If 'ideal professionals' are committed to work primarily, and devote most of their day to their careers, the ideal is clearly masculine. The female cultural mandate directly opposes the professional ideal and this issue must be addressed. Finally, there needs to be an examination of the places where professionals work. Parsons suggests
if nurses are to create new standards that complement rather than conflict with their own views of what is acceptable professional practice, they must confront norms of employing institutions that block the attainment of professional goals. (1986:275)

Nursing needs to determine the ideology of professionalism it wishes to embrace and then establish goals for its attainment. For there is no doubt that the issue of professionalism is more than a question of semantics. Unless nurses can clearly define their own professional role, then others will define it for them.

This leads into a discussion of the fourth concept identified in this study - power. In the classical sense, power is conceived of as

a Machiavellian control of the masses, whereby the individual in power exerts a masterful grip over others who are less intelligent and skillful. (Maraldo, 1985:64)

However, power is not an elusive phenomenon; it is present in all human relationships and is part of even the most fundamental interpersonal situations.

Power must be seen as a force that works both on people and through them. Power is not static; it is a process that is always in play. In many studies, the concept of power has a behavioural focus, with consideration given to control and authority. These studies tend to ignore or diminish the effects of power with regard to coercion and force.

Lukes' (1974) three dimensional theory of power does, however, direct attention to the more subtle uses and less direct effects of power. Lukes identifies the first dimension of power as the pluralist view. This view adheres to the belief that no single group in society has complete domination over the decision making process; instead, this process tends
to be a diverse one, with decisions occurring because various groups exert pressure at different levels of the system. The pluralist methodology makes explicit that researchers need to look closely at who initiates or vetoes policies within a particular area. However, the weakness of this view is that it locates power among the actors, rather than in institutional ideology and structures.

Lukes sees this weakness being redressed, to some extent, by the second dimension of power which also gives consideration to the area of non-decision making, that is, the limitation of decision making to 'safe' issues by manipulating the dominant community values, myths, and political institutions. The process of non-decision making is defined as:

... a means by which demands for change in the existing allocation of benefits and privileges ... can be suffocated before they are even voiced; or kept covert; or killed before they gain access to the relevant decision-making arena; or, failing all these things, maimed or destroyed in the decision-implementing stage of the policy process.

(Bachrach & Baratz, 1970:44)

Such a view implies that the structure of organisations is unbalanced in favour of a minority, and that organisations function to channel and to discriminate among conflicts, with the outcomes not entirely to the benefit of all members. Bachrach & Baratz (1970:44) see this as:

a set of predominant values, beliefs, rituals and institutional procedures ('rules of the game') that operate systematically and consistently to the benefit of certain persons and groups at the expense of others. Those who benefit are placed in a preferred position to defend and promote their vested interests. More often than not, the 'status-quo defenders' are a minority group within the population in question.

While this two dimensional view of power does elicit some of the
less visible ways in which a pluralist system may be biased in favour of a certain group. Lukes argues that both views of power are too narrowly conceived. He believes this is because they both still focus on actual observable conflict, whether it be overt or covert, and they presuppose that power is only apparent or exercised when actual conflict occurs. Lukes suggests that to adhere to either of the two views is to "ignore the crucial point that the most effective and insidious use of power is to prevent ... conflict from arising in the first place" (1974:23).

Thus, Lukes' third dimension of power focuses on the aspects of power which result from the influencing and shaping of individual preferences and perceptions of social issues. He views this as "the supreme and most insidious exercise of power" (1974:24). Lukes iterates that consideration must be given to potential conflict which may occur because of the discrepancy between the interests of those exercising power and the 'real interests' of those they exclude. Lukes suggests that this conflict is potential because of the likelihood of conflict occurring should "those subject to power become aware of their interests" (1974:25). He bases his concept of power on the premise that people's 'real interests' are sublimated by socialisation into a system.

Lukes' view allows consideration of the potential issues which are kept out through the operation of social forces and institutional practices. His third dimension of power suggests the necessity for a study in greater depth of bias within the system. This analysis would examine how institutions make an impression on, and socialise individuals into, a perception of social reality; it would make clear how this perception may have both intended and unintended consequences in how individuals exercise power.
Use of this concept of power is appropriate within the context of this study. If one examines nursing graduates' socialisation into hospitals, it becomes apparent that the organisational practices and procedures operating within this system often prevent them from utilising the knowledge and beliefs established within their nursing education. Thus, the prevailing ideology of the hospital system serves to suppress the 'real interests' of these graduates. Although they may be, at least initially, cognizant of the dichotomy existing between their educational principles and their nursing practice, graduates' behaviour is defined and constructed via the socialisation process which confronts them on entering the hospital setting (Perry, 1985).

This analysis is compounded by the predominant ideology within society that maintains patriarchy and therefore advances a particular view of women. Although individuals may be unaware of how this ideology of patriarchy might determine and exercise control of bias within systems, the taken-for-granted views they hold about women may well influence the conscious decisions they make. Likewise, women (for instance, nurses) may not be aware of its influence and their lack of participation and inertness may well allow maintenance of the bias.

An understanding of nursing power (or lack of it) is critical to the advancement of nursing interests and goals, its effect on the change process and how nurses respond to change when it occurs. Literature suggests that nursing has experienced a lack of power and that this is intertwined with political and feminist issues, and the need for a clear role definition (Ashley, 1980; Bell, 1983).

Traditionally, the use of power has been associated with men. As Smith (1985) points out, it connotes active behaviour, whereas women
have been associated with passivity. Historically, the myth has persisted that women who openly seek power engage in unfeminine behaviour and that there is an element of social unacceptability in this act. For women, there appears to be an ambivalence about acquiring power.

Kalisch & Kalisch (1982) define the illusory essence of power which they see rooted in its very human and transient nature. They believe that power is an inevitable part of all forms of human interaction and denial of this fact will only disadvantage the individual attempting to achieve change.

Nurses are said to have little power in the health care system. Maraldo (1985) suggests that if one considers this statement from the power-is-illusion viewpoint, and believes it to be true, then it is because of a lack of self-confidence and a perception of having no power. This contention is supported by the fact that while great power potential exists within nursing (such as the need for nursing expertise and the sheer number of nurses in the health care system), nurses remain reluctant to exercise that power.

There is a need within nursing to begin to examine power-potential or actual - and the existing conflicts regarding it. Ferguson (1985:9) states

nursing’s power base is constrained as long as nurses fail to reach agreement on the educational base required for the practice of nursing and the credential(s) denoting its achievement.

Because of nursing’s important role in health care, nurses should be educated to be powerful and effective people. Many nurses either seem to feel powerless or believe that any power they do have is unimportant.
Historically, nursing education appears to have done little to alter this opinion. The first attribute of power within oneself is self-confidence, which nurses tend to lack (Roberts, 1983; Speedy, 1987). Self assertiveness, autonomy, aggression and competition - all attributes rewarded by society and which lead to power and the ability to create and promote changes in society - have not been encouraged enough in nursing education. Most authors suggest that in order to be successful in using power, one must have a sense of power and that personal strength is the most important element in any power base (Korda, 1975; Claus & Bailey, 1977). This sense of power seems to be lacking within nursing circles.

Lerner (1985) believes that part of the difficulty with nursing's perceived lack of power rests on its long history of control of its education by hospitals. Because of nurses inability to set their own standards of practice, they were unable to perceive themselves as having power in relationship to other professionals within the health care system. She suggests "nursing education should be aware of this history and the influence it has upon the issues of rights and power" (1985:91). Students may well experience a sense of powerlessness during their nursing education. This may be reflected in a lack of mutually established learning goals, since the instructors define the learning objectives and student expectations. Most students learn to acquiesce to their instructor's covert expectations to survive in the system. (Griffith & Bakanauskas, 1983:105)

Lerner (1985) outlines several issues that she believes are involved in socialising nursing students to see themselves as persons with power. The first of these is NURSING IMAGE - how nursing is practised and how
the lay image of nursing will influence career choice. If this image is derived from television for example, students who enter nursing may already have assimilated a negative stereotype of nursing. As Lerner explains:

nursing cannot have high prestige as a career if it is consistently devalued in the media. It is also difficult for nurses to command respect as knowledgeable professionals if the public is constantly exposed to a negative image of nursing. (1985:91)

Nursing needs to direct its attention to this issue - it must ensure that nursing is portrayed as a serious career choice if it is to assume more power.

The second issue Lerner believes is involved in socialising nursing students to see themselves as persons with power is that of EDUCATION, involving recognition by the students of the value of autonomy in nursing. Educators need to help students to realise the very real contribution nursing can make to both care and cure. This knowledge will give nurses power over situations and may well change outcomes for patients.

The third issue is that of UNITY - the gap between nursing education and practice requires bridging. A focus on commendable nursing actions and positive role models would promote unity. More effective power is exerted by a unified group.

KNOWLEDGE is the fourth issue, and Lerner believes that there needs to be a realisation by students that knowledge is power. Nursing educators can assist students to understand that nursing is an intellectual discipline as well as a practical one. Nursing students must have the opportunity to develop self-confidence by taking part in
nursing care experiences that allow them to take responsibility for their own actions. Stress experienced by nursing students is a significant deterrent to success.

Evidence suggests that allowing students to have feelings of power and control enhances learning and self-confidence (Policinski & Davidhizar, 1985; Windsor, 1987). Power can be increased through positive rather than negative reinforcement and a reminder that lack of technical skills does not mean inadequacy. Nursing students enter nursing with little idea of the demands that will be made on them. In the hospital setting they often feel awkward and intrusive, because they are there as 'outsiders' and cannot lay claim to the territory. Davidhizar (1982) views the nursing educator within the clinical area as a supportive facilitator, enabling students to decide on their own course of action. Knowledge and self-confidence will produce nurses with the ability to use power appropriately to enhance the wellbeing of their clients.

Many nurses express feelings of powerlessness, but one must consider whether they in fact lack power, or if it is that the power they do have is misused or misdirected. Ashley (1980) believes that the maintenance of a close and long standing relationship with medicine and many other male-dominated areas in the health field has severely damaged nursing's potential for power. She sees those nurses accepting the patriarchal structure of their profession as having the illusion of power, but at the cost of separation from women's experiences. By accepting the structure, Ashley believes that nurses negate the validity of their own experiences, thereby losing the power they might have by identifying with the needs and concerns of all women. (1980:20)
Often, because of the ambivalence associated with power seeking and its acquisition, nurses choose inappropriate arenas for pursuing power, such as conflict with patients.

It can be suggested that the desire for power on the part of individuals and groups within the health care systems has been a factor in determining nursing's traditional role and power in the health field. The power of any group is relative and must be understood within the context of the group's proximity to others who have power. Power relationships involve elements of dependency and nursing has lived with the myth that it is, and always has been, the dependent group in relation to medicine. Historically, however, it has been shown that physicians recognised their own increasing dependency on nurses early on and came to believe that nurses had to be intellectually and socially controlled, as discussed earlier in the theme of professionalism (refer p. 135).

Early manifestations of power in nursing produced the traditional and ongoing arguments regarding whether nursing meets the criteria of a profession. The basic issue within this argument is really one of power. Recognition of expertise and a more 'professional' aura portray the concept of more power and more authority. One result of limitations on the use of nursing power has been that the public does not tend to recognise nursing care as separate from medical treatment. This lack of distinction can be directly ascribed to those beliefs and values that underpin the health care systems. This is based on economic factors and class ideology. Physicians view themselves as a ruling class and medical ideology is paramount. Medical ideology and all the ideologies of the traditional health professions are masculine and, as such, they negate the very existence of nursing as a separate and valid profession.
with much of value to offer society. Nurses may well represent a majority in the health field, but that majority is a silent one - its power is imprisoned and hidden from view.

Recognition of one's position within a group, the status of that group, its reputation for achievement or influence enhances one's own stature, the esteem in which the group is held enhances one's own self-esteem. But the relationship is two-way; since a group is made up of individuals, the impact of those individuals influences the way in which the group is seen. Until nurses begin to care for other nurses, the profession will lack the power necessary to control its practice.

Nurses confront and deal with situations involving power on a daily basis and therefore need to gain a better understanding of it in order to be more effective. Many nurses have failed to acknowledge and examine the ways in which nurses have used their power - usually to maintain the system that has oppressed them. Students and graduates learn that co-operative and collaborative use of their power is necessary, and expected of them, to keep the system functioning. They learn less about the methods of using power to change that system. Yet the fact that nurses are the major productive group in the health care system could be used as a powerful force to bring about needed change.

The specific characteristics of a profession and the issues relating to power and powerlessness identified in previous discussion are used to analyse the relative data gathered in this study. These themes did not receive as much attention within the interviews as the previous two (curriculum and socialisation), which is reflective of the often hidden nature of these issues. In part B, therefore, the data relating to professionalism and power is interpreted and discussed.
PART B

While the theme "professionalism" was one of the topics included within the original agenda for the interviews (refer chap. 2, p. 28), it was one that did not appear to have a high profile for the students. In the opinion of the interviewer, this reflects the different, and often hidden nature of this issue in comparison with more overt concerns such as the curriculum and socialisation. While only one of the students interviewed addressed the issue of professionalism directly, several others did express their views in a less overt manner. The students' responses can be analysed according to the criteria determined within the previous discussion on professionalism (refer pp. 123-131) - however, because of overlap of students' comments some of these will be amalgamated.

The theme of professionalism was one that was not directly focused on within the questionnaire. However, questions 15a and 15b, which deal with the students' decision to enter nursing education and opinions on disadvantages of nursing as a career are applicable. Question 19 focuses on achievement of personal satisfaction in nursing, another facet which can be discussed within the concept of professionalism. Questions 21 and 22 are concerned with continuing education and are appropriate to this discussion.

EDUCATIONAL PROCESS/BODY OF KNOWLEDGE

Within the questionnaire (refer Appendix 2) students were asked to indicate whether they intended to continue their nursing education.
Question 21 gave a choice within a time frame, and question 22 requested an indication of what course they would be most interested in taking.

**Table 5.1: Continuation of nursing education**

<table>
<thead>
<tr>
<th>TIME</th>
<th>NUMBER</th>
<th>PERCENT</th>
<th>PERRY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>112</td>
<td>22.1%</td>
<td>24.0%</td>
</tr>
<tr>
<td>1990</td>
<td>91</td>
<td>18.0%</td>
<td>21.1%</td>
</tr>
<tr>
<td>In 3-5 yrs</td>
<td>123</td>
<td>24.3%</td>
<td>21.0%</td>
</tr>
<tr>
<td>Sometime</td>
<td>163</td>
<td>32.2%</td>
<td>29.7%</td>
</tr>
<tr>
<td>Never</td>
<td>17</td>
<td>2.8%</td>
<td>3.6%</td>
</tr>
<tr>
<td>No response</td>
<td>3</td>
<td>0.6%</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

As can be seen, all but 3.4% indicated that they would consider further nursing education. The results compare with those of Perry (1987), with the slightly lower figures in the first two categories in this study, suggesting a reticence on the part of the students to commit themselves to definite future education within two years of graduation.

**Table 5.2: Proposed course of study**

<table>
<thead>
<tr>
<th>COURSE</th>
<th>NUMBER</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Dip.</td>
<td>92</td>
<td>18.2%</td>
</tr>
<tr>
<td>Dip. Nursing</td>
<td>47</td>
<td>9.3%</td>
</tr>
<tr>
<td>B.A.</td>
<td>98</td>
<td>19.4%</td>
</tr>
<tr>
<td>Masters</td>
<td>7</td>
<td>1.4%</td>
</tr>
<tr>
<td>Short Courses</td>
<td>170</td>
<td>33.6%</td>
</tr>
<tr>
<td>Other</td>
<td>68</td>
<td>13.4%</td>
</tr>
<tr>
<td>No Response</td>
<td>24</td>
<td>4.7%</td>
</tr>
</tbody>
</table>

These results indicate a number of options are being given consideration by these graduates. The main response within the "other"
category was midwifery, and while some of these did stipulate a course overseas (for example, in Scotland), many of them were referring to study here in New Zealand. As midwifery is currently part of the Advanced Diploma course, these results seem to suggest one of two things - either that students are unaware of this situation, which seems unlikely, or they are expressing the wish for the midwifery course to be separate from the Advanced Diploma. These results support those found by Perry (1987), with the greatest number (25.1%) of students in her research indicating that they would prefer to undertake short courses. Similar support was given in her study to the Advanced Diploma and B.A. results.

Within the interviews, only one student spoke directly about further nursing education. But it must be remembered that they were awaiting State Final results and were perhaps reluctant to contemplate further nursing education at that particular time.

*I plan to carry on with my nursing education. I'm not sure if I'll do Massey ... I might do an education paper. I'm going to wait a few years as I've had enough of learning just at the moment, but I do plan to do something within the next five years.*

(Kim, r27)

Another student did express a desire to continue her education, but not within nursing.

*I keep thinking that I might break away from nursing because it is just ... I really love nursing, but I just feel it is not going anywhere. I am just sick of 'female orientation' ... absolutely. As I said, I have done two Varsity papers this year and that is really more interesting at the moment.*

(Ann, r73/74)

Comments made by several of the students reflected their views on the 'new' approach to the educational preparation of nurses, discussed
previously (refer chap. 1, p. 1 and p. 124).

In today's course there is a broader education ... you're not thrown in at the deep end and left to your own devices.  
(Sarah, r3)

Pam's comment reflected how she saw this educational process enhancing nursing's claim to professional status.

Nursing is a profession because of the training and education involved and the amount of knowledge that we use.  
(Pam, r43)

Some of the students also made reference to a 'body of knowledge'. Sarah believed that this knowledge increased her ability to function comprehensively, although her comments reflect the lack of a perceived nursing knowledge base.

I see myself having a broader grounding in the sciences, sociology and psychology, communication skills ... that sort of thing ... and they will all help.  
(Sarah, r8)

Emma's definition of a profession summed up this criteria of professionalism.

A profession is when the people do some sort of training and course of study ... and they prove their competence in that area, however that's assessed. And they have a responsibility and accountability for what they do. And I see bringing a science into the art of nursing will help it to be recognised as a profession.  
(Emma, r53)

The results of questions 15a and 15b, and 19 are applicable to the other criteria of professionalism identified earlier (refer pp. 126-131).

In question 15a, students were asked to indicate, on a five point scale ranging from "a great deal" to "not at all", the extent to which
certain factors influenced their decision to enter nursing education. These factors included such areas as prospects for career advancement, improving one's own education, prestige and standing in the community (refer Appendix 2). It is useful to understand the motives which have influenced students to choose the nursing profession as a career and whether they view nursing's professional status as a salient factor in that choice.

Results indicate that, for this group of students, the factors having the greatest influence on their decision to enter nursing education were "personal satisfaction" and "to be dealing with people rather than things". For these two factors, 80% or more of the students chose the "a great deal" or second category. Perhaps somewhat surprising is the high rating given to "opportunity for travel", although this result may
reflect the current job prospects in New Zealand, plus the belief and hope that greater opportunities are available overseas. Over half of the students placed another seven factors in the top two categories. The factors which appear to have had little, or no influence on the students' decision are "family member a nurse", "family pressure", "career advisor's suggestion", and "could not get into another training programme".

Question 15b determined what factors might be seen by students as disadvantages of nursing as a career. The same five point scale was utilised and results indicate that students viewed the tertiary grants as the greatest disadvantage, from the factors listed - 76.4% (386). Length of the nursing course was the factor seen as the least disadvantageous. These results would suggest that, to the students, personal and immediate needs are paramount, that is the ability to complete the course under the threat of financial hardship.

**Figure 5.2: The students' ratings of various factors as disadvantages of nursing as a career.**

Using a four point scale, from "very important" to "of little importance", Question 19 requested students to indicate how important
certain factors were, to them, in the achievement of personal satisfaction in nursing. Included were the acquisition of knowledge, professional status, opportunities for ongoing education and control over nursing care - all these can be related to professionalism, and in particular, the criteria discussed earlier.

Figure 5.3: The importance of various factors in achieving satisfaction in nursing.

The majority of students rated 14 of the 15 factors in this question as either "important" or "very important" to their achievement of personal satisfaction in nursing. For nine of these, the percentage of students responding in this manner was 90% or more. The one factor to be given only "some importance" or "little importance" by a majority of the students was "hospital perks" - 63.9% (323). While the factors included in this question were not identical to those of Perry (1987), the results do reinforce her findings, particularly for the nine highest ratings.
Students' discussion within the interviews, while more generalised, did reinforce questionnaire results. The following qualitative data will be discussed with reference to the remaining criteria of professionalism identified in the theoretical discussion (refer pp. 126-131).

AUTONOMY

In general, students' comments reflected an acknowledgement that autonomy is both necessary and desirable within nursing.

Sarah saw herself as a professional because

... of the training we've done, and the position we work in ... the fact that we are working in a capacity that has a code of ethics, we have a great deal of responsibility to make decisions and to be accountable for them. (Sarah, r24)

However, Emma held the opposing view.

I don't really see nursing functioning as a profession at the moment ... to me, we're not level with professions such as doctors and lawyers. (Emma, r54)

Kim, while realising the importance of autonomy within nursing, expressed the view that the comprehensive nursing course was not encouraging its development.

1. So are the tutors encouraging you to be autonomous?
   S. Not in the second and third years ... no. But, in theory, that's what we have to become once we graduate. (Kim, r43)

Students also mentioned the need for confidence and for nurses to become more assertive. The importance of patient advocacy was seen as
critical, but more than one student voiced the realisation that this may be a difficult goal to uphold.

A nurse needs to be someone who has a strong idea of who they are, and obviously the needs of other people and their rights. (Sarah, r35)

I feel very strongly that nurses should be client advocates. I would hope that I would speak up on a client's behalf. But I also realise that it is not an easy thing to do. (Ann, r52)

Nurses need to be a lot more assertive and have good communication skills ... as long as you're not 'attacking' ... but be assertive. (Kim, r104)

While Amy espoused the function of the nurse as a patient advocate, she had some serious doubts as to nurses' ability to carry this out diligently.

We're meant to be patient advocates ... and the whole course should make us aware of this. But I think it's very tricky ... if you challenge someone, there may well be a backlash, although we're told 'nursing is a professional qualification and you've got as much right to stand up there' ... and theoretically I agree. But we're operating in a system where everything counts ... people write reports on you, and it goes down for ever in your records! So there's always that feeling that whatever you do could 'pop up' when you least expect it. So no-one wants to rock the boat, and they certainly don't want the boat to tip over!! (Amy, r38)

Emma reflected on nursing's relationship to medicine and its influence on nursing autonomy. Her comments relate to the views expounded by Ashley (1980) on power which were outlined in the theoretical discussion earlier (refer p. 148), and those discussed within the theme of professionalism (refer pp. 134-138).

It's the history that we've had ... we need to get away from the idea of 'we do what we are told by the medical staff' ... we need to get more responsibility to
initiate nursing actions, and have greater input and equality in patient care
... a more multidisciplinary approach, rather than being told what we are to
do, or simply running round after doctors. (Emma, r55)

Kim's statement sums up the general feelings of the students who
were interviewed, with regard to autonomy.

_I think that nursing education is going to HAVE TO make nurses feel more
autonomous. I've probably expressed this before ... but we need to be more
autonomous, more assertive ... and nursing itself has to get away from that
subservient type situation and nurses need to become more supportive of
each other._ (Kim, r114)

LEVEL OF COMMITMENT

Although this issue was addressed directly by only one of the
students, many of their interview comments reflected concern with a
perceived lack of direction and available support in nursing, which
may well influence nurses' level of commitment.

_Commitment to nursing is something I feel. I think probably because I felt
I wanted to nurse before I started, I don't know that the education I
received made much difference to that._ (Emma, r82)

But Emma then went on to express her concern about the direction she
sees nursing taking and the frustration this may well engender.

_I think with regard to staffing and financial cutbacks we seem to be going
back instead of forwards ... and in our type of care. And sometimes I have
felt that we are educated at a higher level ... we have more knowledge than we
get to use in the practical setting. I think that can be VERY frustrating ...
you sort of feel 'well, why bother ... why spend all this time if I'm not going
to get the opportunity to use it?_' (Emma, r83)

Pam saw certain behaviour as critical if professional standards
are to be maintained.

_We have certain standards to achieve. I think your behaviour and your appearance and your competency should be of an extremely high standard._

_(Pam, r44)_

Kim reflected on the importance of being informed of where nursing is heading and saw this as an individual responsibility.

_You have to know the direction nursing is taking in order to start to make any sort of commitment. Involvement in associations like NZNA has given me a better perspective on industrial and professional matters._

_(Kim, r74)_

Sarah's views on professionalism and the apparent lack of commitment within nursing were influenced by her opinions on young women in general.

_Speaking generally, I think that young women just don't have very strong views of who they are and what their rights are ... if they don't have that for themselves then they can't have it for other people._

_(Sarah, r28)_

She believed that a major difficulty within nursing education is an apparent lack of support and cohesiveness.

_Standing back and looking in, it seemed to me that the whole thing wasn't very cohesive ... there wasn't a lot of support and people seemed to be doing their own thing a lot._

_(Sarah, r18)_

Amy and Ann focused on what happens to nurses when they are placed in stressful situations, without that support.

1. How do you think you're going to deal with that psychologically ... if you come off at the end of a shift only having been able to carry out tasks?
S. Well ... I'll probably start to think 'why am I doing this job? whatever possessed me to do this?' You know the sort of thing ... come home feeling so tired, and not getting anything back because I'm not even doing the job right ... all I am is tired!. (Amy, r25)

After commenting further on specific situations, Amy went on to remark

Nursing's incredible ... if you make too many waves people don't like you ... they get real anti if you start challenging. You do see the odd one who challenges, but it is very rare ... so things stay the same. (Amy, r33)

Ann saw at least part of nursing's difficulties occurring because it is largely a female workforce.

It's a sad sort of situation really ... because it's female orientated work ... and women tend to be apathetic about what to do about things, and nurses tend to be against striking and action like that. (Ann, r14)

These remarks support the contentions made within the theoretical discussion of professionalism, with reference to the relationship between the status of nursing and the feminine nature of the profession (refer p. 133).

Ann discussed the current situation within hospitals - she described it as a 'meat factory', with nurses unable to spend time with patients. Ann then went on to speak about nurses' response to this situation; her remarks relate to the submissive-aggression syndrome, explored earlier (refer p. 136) - the result of such aggression within an oppressed group being self-criticism and infighting.

They get burnout ... pretty tired and stressed. And nurses tend to blame themselves if they don't manage to complete their work ... you don't hear many nurses saying 'we've got to do something about this, and let's get together and try'. (Ann, r42)
PROFESSIONAL ORGANISATION

The lack of attention given to this criterion by the students may be indicative of a general disinterest in such organisations and a lack of understanding of their purpose.

Sarah's comments may reflect many nursing students' views of organisations such as NZNA.

Well ... I don't know a lot about them, but one of the theories that I have about them is that up until now they have not been effective for nurses and ... um ... I was a bit hesitant about joining them. And we've got this strike coming up and you can only strike if you are a member. It seems to me that this time they have got their act together a lot more than in previous years, and I certainly support the strike. It's a pity that it has to come to that, but I don't have any qualms about it ... I think that has been one of the problems in the past that nurses have had ... and I don't think that the union has been strong enough in helping nurses to realise who they are and what they're worth. But it has changed a little in the past few years ... possibly because there have been enough people who have been dissatisfied with it. (Sarah, r26)

Ann alluded to professional organisations when she discussed what nurses should do about the current situation within hospitals.

1. What can nurses do then?
2. Get together as a group. It's public awareness, isn't it? Do things like getting onto the Health Minister ... you just have to ... well, that's what I think anyway. I just don't think the politicians are aware, I assume they have been told, but I'm sure they're not really aware. (Ann, r43)

Kim expressed VERY strong views on students' apparent apathy toward professional organisations.

Nursing students, I found, are very much 'sit back, let it happen and don't make too many waves'. We tried to form an NZNA unit within the polytech ... and had about three people turning up during the whole three years! Sure, there was the quite heavy workload to deal with, but they just seem to moan amongst themselves, but when it comes to facing up to things
they don’t do it very well. It seems as though they would rather follow, than change or be leaders. 

A lot of students didn’t even know what was going on politically with student grants. There was a small group that was aware of the different reports and what NZNA was about ... but some students didn’t even know what NZNA was!! I’d say 50%, no make that 75%, didn’t know what the associations did and what they were for ... they just tended to let things happen.  

(Kim, r54/67)

After outlining how such organisations were introduced within the course to the students, Kim commented further on student responsibilities.

A lot of the nursing tutors were quite active in NZNA and those ones did reinforce it. But I think it is up to students to do something about it as well ... the opportunity was there for a student unit, which can be quite a valid body if students want changes or have a grievance ... but they just didn’t make use of it.  

(Kim, r71)

SOCIAL WORTH

This criterion of professionalism received the least attention from the students in the interviews. Although they did not comment directly, the tenure of their discussions suggested that they saw the health cutbacks and current nursing situation as denigrating nursing’s social worth even further.

Sarah stated

It is very difficult to fight against rejection or someone disagreeing with you, or things like that. I think we all seem to be conditioned to not respond well when we’re in a negative situation ... which is a pity ... and that goes particularly for women.  

(Sarah, r47)

Emma commented at some length on nurses’ disillusionment and
how this might be addressed

*Things like bringing down the staffing/client ratio, working harder to have nursing recognised as a profession, and allowing nurses to make more decisions and have greater input into care. Possibly getting the education that is now available recognised as being okay ... perhaps what is needed there is trying to create a greater understanding of the course and what it's hoping to achieve ... its strengths and weaknesses.*

(Emma, r84)

A comment from Kim, also reflecting the aggression syndrome within oppressed groups, clearly illustrated the position these particular students saw nursing being in.

*I think there is a hell of a lot of 'horizontal aggression' in nursing. It amazed me in the wards I worked on that the nurses worked together in a manner of speaking, but they never went out, they never really communicated well together ... they just did their jobs and then left!!*

(Kim, r108)

Therefore, while many of the students did not comment specifically on the issue of professionalism within the interviews, their discussion and comments do suggest concerns regarding the particular criteria identified previously. All the students expressed the desire for nursing to be autonomous, but felt that it was either not being developed within their nursing courses (refer Kim, r 43 p. 158) or it was not possible in the current hierarchy operating in the health sector (refer Emma, r55 pp. 159-160). They were also very much aware of nursing's position in the health sector hierarchy and their comments support the contention that a feminist analysis may have much to offer nursing.
The final theme determined in this study relating to nursing students' perceptions of their education is that of power. It is one that was not addressed directly, either within the interviews or in the questionnaire. As with professionalism, this may be because it is an issue that is not often openly acknowledged within nursing circles, nor society at large. However, responses to particular areas of certain questions in the questionnaire do indicate an awareness that issues of power and control were part of the course. For example, in question 16, part (d), on course organisation, students were asked whether "students suggestions for change are taken seriously". Over half of the students (52.4%) responded with either the "sometimes" or "never" category.

The main issue relating to this theme within the interviews was the students' perception of their lack of power in the student role. Although this belief was not universal among these students, the majority did express strong feelings of 'being controlled' and the belief that they were unable to alter this situation. The following statements illustrate the students' sense of powerlessness, discussed earlier, both within the theme of power (refer p. 146) and curriculum (refer chap. 3, p. 40).

As Amy stated

*It's pretty much you have to do everything their way, or else they don't feel it is valid.*

(Amy, r1)

Emma remarked on an aura of being controlled

*We were told that 'if you don't want to be here you can leave' ... but that was kind of a 'don't you dare leave' sort of statement. And another example of this control is an authority thing ... being told to do something by a Charge Nurse for example ... and the tutors expected us to do
it, even if we didn’t want to. Um ... they said ‘well, if you’re told to do it by someone senior then you do it, and you can question afterwards’. So there was a definite power structure within the course. (Emma, r38/17)

The students expressed feelings of frustration, but a general acceptance of the ‘status quo’.

When you tried to make some constructive criticism about what was happening, that was quite frustrating because you didn’t seem to get anywhere. (Sarah, r15)

If you complained, it was ‘well, YOU have a problem coping with the course’ ... and you start to think ‘this is ridiculous’ and you can’t be bothered. And then, by the third year, you just want to get through and get out ... you do think about all the poor people who are coming behind you, but you start to think ‘well, they’ll just have to slide through the best they can’ ... because they (tutors) won’t change. (Amy, r5)

Emma expressed student acceptance of the ‘status quo’ very simply.

‘We just accepted that’ was the system.... (Emma, r44)

These comments reinforce earlier discussion - the elements of power and control within the curriculum (refer chap. 3, p. 40); the issues of compliance and ideological dominance expounded in the theme of socialisation (refer chap. 4, pp. 77-78) and the importance of education in maintaining the status quo explored within the theme of professionalism (refer p. 137).

Several of the students were well aware of ‘power games’ operating, both within the polytech and the hospitals.

1. Did you see that power structure operating within the polytech?

S. Oh yes. It was quite subtle, but for example ... some of the tutors would disagree with something ... they would go to meetings, discuss
it and try to get it changed ... but, NO, that was the way it was going
to be. There seemed to be a lot of pettiness ... power games ... going on
between some of the tutors.

(Emma, r38)

Emma and Fiona commented

There's a hierarchy at polytech ... with certain channels of communication
and that kind of thing ... and sometimes you didn't seem to get very far.

(Emma, r69)

There is a power structure operating in the hospital where I am working ...
very much so.

(Fiona, r42)

Kim expressed strong opinions on this 'hospital hierarchy'.

There's that certain hierarchy and power still in the hospital system and
communication isn't that good ... so if you say something detrimental you
can get picked on by the other nurses and made to feel pretty bad about it.

(Kim, r32)

Kim then proceeded to talk some more about "horizontal violence",
discussed within the theme of professionalism (refer p. 136) and
mentioned earlier (refer Ann, r42 p. 162 and Kim, r108 p. 165).

I think that it's very important, because of that 'horizontal aggression' that
seems to be in nursing, that you sort of suss out the situation before you
jump in and try to make changes.

(Kim, r32)

Pam reflected on the concept of the 'power hierarchy' and her
feelings regarding it.

I. Would you talk more about the hierarchy you mentioned earlier.
S. Well, it's operating EVERYWHERE and I can't stand it! I don't
feel I have respect for titles ... they mean absolutely nothing to me,
and if people are going to start being very authoritative and pulling
rank, etc, I'm not going to 'yes mamam, no mamam' ... at all.

(Pam, r27)
Two of the students spoke directly about doctor/nurse relationships and the exercising of power within this relationship. These remarks support the contentions made by Ashley (1980) in the theoretical discussion of power (refer p. 148) and the views of Freire (1973b) on oppressed groups (refer p. 134).

In some areas, doctor/nurse relationships were really poor ... the nursing staff ran after them, and the doctors always seemed as though they were in a bad temper the whole time ... the staff were fearful of them ... things like saying 'don't do it like that, 'cause the doctor will come around and blow his stack' ... that sort of thing ... CRAZY.  

(Kim, r101)

Ann commented on patient advocacy and its relationship to power.

I. Do you think you would speak up on behalf of a patient?
S. I would hope so. I know it is happening a lot more now ... I was in a surgical ward and the Charge Nurse flew off at one of the doctors because he wasn't using a sterile technique. And I have heard a nurse refuse to do something with an I.V. But it's not an easy thing to do when you are placed in that position, although I do feel that the attitudes of most doctors to nurses is changing.  

(Ann, r53)

Kim summed up views on nurses' response to power and how their behaviour often reflects the belief that they lack any power of their own.

A lot just seemed to accept the way it was ... they accepted the status quo ... it's a real shame. One example ... a nurse was helping a doctor deal with a patient with a pneumothorax ... and there wasn't something on the trolley and he went off his head!! And she (the nurse) went running, RUNNING down the ward to get it, and then came running back again.  

(Kim, r102)

The other issue within power, given some emphasis by the students, is the assistance that might be given to nurses to assist them to exercise more power. While some students felt that the course had tried
to encourage assertiveness and patient advocacy, they did remark that
this is still under tutor control.

_there is more likelihood now (at end of course) that students would speak.
up. Mind you, there is the other thing too ... as students you are encouraged
 to be assertive on the one hand, but on the other, if you say too much you
get landed._

(Pam, r35)

Pam went on to reflect on the effect of this 'control' on students.

_I think to a great degree a lot of students don't say anything because they
just want to get through, get a good report and come out on top._

(Pam, r35)

Kim remarked

_Assertiveness and confidence seem to get knocked out of you in the second
and third years ... but that could be altered by reinforcing that change is
necessary and having continued assertiveness training ... not just touching on
 it in the first year ... and continuing communication skills and those sorts of
things._

(Kim, r83)

Kim then went on to expand on ideas of how nurses might try to change
the power structure they see operating within the hospitals,
particularly in regard to the doctor/nurse relationships mentioned
earlier (refer Kim, r101 and 102 p. 169).

_... not be so apathetic, and state, in an appropriate manner, your objections.
Just be a lot more assertive and have good communication skills ... as long as
you're not 'attacking' ... but be assertive and show the doctors that you are
not there as their servant, but that you've got a different role than they
have._

(Kim, r104)

Ann also expressed views on assertiveness
1. Do you think the course could do more to encourage students to be more assertive?

S. No, not really. It's just one of those things ... and I would hate a whole pack of nurses to be assertive ... you would get nowhere ... and everyone's an individual. But if someone feels really strongly about something I would hope they would say something ... to the right people. Hopefully those who can't be assertive have other strategies and ways of coping. (Ann, r32)

As with professionalism, while the students did not generally offer specific comments on the issue of power within the interviews, their discussions did indicate an awareness of its presence and influence. Responses demonstrated a belief that they lacked power (as students); the discussion also illustrated a kind of unquestioning acceptance of this position. As with the professionalism data, the remarks reported here from the interviews do offer support for the theoretical views explored earlier. Lukes theory of power and the necessity for a study of bias within systems (refer pp. 141-143) is appropriate, along with an examination of the ideology of patriarchy and its effect on nursing. The data illustrate the need for an understanding of nursing power as a critical factor in the advancement of nursing interests.
CHAPTER SIX

The Integration of Major Themes

This chapter presents a synopsis of chapters three, four and five, drawing together the four themes and the theoretical issues. Outlines of these theoretical concepts and their relationship to the data gathered in the study are reviewed. Further examples from the interview data are given in an effort to draw previous illustrations together.

While each of these themes has been considered individually in the preceding chapters, they are not separate entities but interrelated concerns. This connection between themes is derived from the nature of the institutions as they presently exist. While this thesis eludes to hierarchical structures and constraints within institutions and their power relationships, it does not attempt an in-depth analysis of why such relationships exist, nor changes that might be made. In order to fully understand these connections, one must examine the structure of institutions in their present form and their operation. However, this thesis is not an investigation of these issues, but how and why the identified themes became evident in the students' perceptions of their nursing education.

Intertwining of the themes remains important. For example, the issue of power cannot be divorced from that of curriculum, socialisation and professionalism. Power is evident in curricular organisation - nurse educators define a predetermined level of knowledge to be attained and traditional evaluation procedures ensure control is firmly in their hands. Such procedures also presume that the development of
the student's conceptual abilities is accurately 'measured and evaluated'. Demarcation between students and tutors is maintained and reinforced by these internal course requirements and by official registration procedures.

Nursing curricula based on an objectives or systems model place an emphasis on input, process and outcome. This model asserts a consensus on the part of educators as to which qualities are desirable in nurses and defines the curriculum content required to achieve this goal. Student dependency on the authority of the educator is fostered and this may well perpetuate a reluctance on the part of many students to assume self-direction. Responsibility for personal learning will be minimised, as will accountability for performance in practice.

In turn, power influences the process of professional socialisation and the development of professional behaviour. While autonomy, independence and responsibility may be espoused within course objectives, the structure and constraints which underpin professional nursing are paramount. Students receive clear messages that their behaviour needs to comply with tutors' expectations if their professional self-concept is to develop to a degree acceptable to the nursing profession. Therefore, the student's concept of herself as a professional is constructed within the organisational practices of the institutions - the polytechnic and the hospital - in which her education takes place. This construction is influenced by the established power relationships of these institutions.

The objectives or systems model is concerned with control, a factor characteristic of the education and health institutions in which nursing education takes place. While the present nursing curricula
might be considered to be integrated, at least at a descriptive level, an examination of the nursing courses using Bernstein's (1975) social principles which determine the selection, transmission and evaluation of knowledge (curriculum, pedagogy and evaluation), indicates that all three are confined and influenced by the institution's organisation, internal constraints and evaluation procedures.

While nursing educators may espouse a horizontal relationship between tutors and students, in practice the students experience a loss of personal control, because of institutional constraints such as hierarchical relationships. Many students interviewed in this study understood that they were being 'spoon fed' and 'moulded' in their nursing education (refer Kim, r13 and Ann, r10 chap. 3, p. 56). The students explained that they considered their education to be under tutor control; their experiences illustrated the unequal relations of power characteristic of bureaucratic institutions. Comments demonstrated an education differing from that which gives support to students' active involvement and which considers them as autonomous individuals with the ability to critically reflect on their education. The students recalled many examples which demonstrated for them an inability to influence, or effect any change in the educational process (refer chap. 3 Pam, r62 p. 59 and Sarah, r5 p. 64). They seemed very aware that procedures operating within the polytech and clinical agencies, such as course requirements, roll marking, and hierarchical tutor/student relationships, mitigated any action toward change they might attempt. For example, Emma reported

There were some tutors who I felt were not really functioning effectively as educators ... but I really felt powerless to do anything about that.

(Emma, r76)
While Sarah did recall a situation in which the students felt their grievances had been heard, the excerpt illustrates the difficulties experienced.

_We did have one instance where we did get satisfaction after complaining about a tutor ... but we really had to push VERY hard. But it was through another Department ... we couldn’t seem to get anything done in Nursing Studies._ (Sarah, r17)

Thus, curriculum design, structural constraints such as those just mentioned and tutor/student relationships are all powerful forces within the nursing courses. This analysis is not designed to expound a belief that autonomy necessarily requires a 'non-structured' type of education system; nor is it stating that failure to develop autonomy within the nursing course will automatically ensure its failure to develop in the graduate. Instead, it is outlining the students' experiences and perceptions of their nursing education and their concerns regarding autonomy, a factor critical to professionalism (refer chapter five), and it is an attempt to suggest areas within nursing education that would benefit from closer examination.

The students who were interviewed were very much aware of the power held by tutors and nurses in clinical practice, a factor which diminished their sense of personal accountability and level of confidence (refer Amy, r50 chap. 4, p. 92 and Emma, r38/17 chap. 5, pp. 166-167). While students reported an awareness of this form of mechanistic education postulated by Freire(1973a) (refer chap. 3, p. 40), they also acknowledged a lack of choice, a feeling of passivity, and manipulation by educators. In this way, opportunities for students to develop their capacities to transform their nursing world were limited.
Amy's discussion clarifies this notion very clearly

S. One student in our class is still finishing the course ... she was different and they hit her SO hard. Like they did with anything that was different in the course.
I. Why did they hit her hard?
S. Because she challenged ... she is really vocal and doesn't conform ... I have worked with her and she is an excellent nurse ... she is just different. (Amy, r46/47)

The relations of power are also illustrated in the hidden curriculum. This covert curriculum cannot be identified when objective reality only is considered, and it does not allow consideration of the ways that roles are shaped and influenced in the socialisation process. It is not only the overt content, but also this covert hidden curriculum that conveys messages to students about reality. However, that this reality may well be in conflict with the student's own beliefs and experiences is often not acknowledged. This conflict exemplifies the control (power) exercised over students by the school itself and may force the student into acceptance of a reality contrary to their own experiences. It also reinforces the need for adjustment and accommodation on the student's behalf, rather than any attempt to change the situation (refer Kim, r4 chap. 4, p. 88 and Amy, r5 chap. 5, p. 167).

This control over students within the institutional organisations, and the need for their adjustment and accommodation, has an affect on professionalism and the students' socialisation because it prevents the development of the professional ideals of accountability, autonomy and self-responsibility. Instead the students tend to adhere to the dominant institutional ideologies and become self-critical, rather than socially
critical; denying or devaluing their own knowledge and experiences (Hickson, 1988).

In this way, Amy was able to rationalise how she had 'fitted' her behaviour to what she believed tutors expected of her, although it was in conflict with her own ideals and beliefs.

_I have done things like keeping very quiet ... you may think things but you don't stand up and say 'look, I totally disagree with this; it goes back to the old system and I don't want to be part of that'. And I think there is a lot of 'covering up' goes on in the hospitals._

_For example, you see things being done incredibly wrong, like somebody putting up blood and then just walking away. But if anything went wrong there would never be 'but you did that' ... and if you spoke up and said 'but I saw it' that would be seen as such an anti thing to have done ... to 'dob someone in' ... and you pick that up VERY fast._ (Amy, r34/35)

The hidden curriculum, therefore, is inextricably intertwined with learning, with the issues of power, socialisation and with the beliefs students develop regarding nursing education, nursing practice and professionalism. Therefore, while the comprehensive nursing courses appear to encourage autonomy, accountability, confidence and responsibility - characteristics applicable to professional nursing - the students in this study reported experiencing little chance to develop such characteristics. They gained a very clear picture of tutors' expectations of their behaviour, expressing the belief that cooperation, adjustment to and acceptance of existing beliefs, views and practices within the polytech and the clinical agencies, were all mandatory (refer Kim, r28 chap. 3, p. 62). Pam was one student who experienced conflict between her own personal beliefs regarding acceptable professional behaviour and what she perceived were tutors' expectations. Her comment demonstrates she learned that, in order to
meet course requirements, she must exhibit particular traits.

... as students you are encouraged to be assertive on the one hand, but on the other hand if you say too much you get landed ... as I really found out with that particular incident in Obstetrics that I mentioned earlier. I felt that Charge Nurse was incredibly inflexible and extremely rude ... but I got NO support AT ALL from the tutors ... in fact, I was hauled over the coals and my grade was demoted. So at that point I thought 'well, I'm not going to say another bloody word!'  

(Pam, r35)

Thus, the experiences students encounter, whether planned or unplanned, and their perceptions of nursing arising from both the overt and covert curricula, are likely to become fused into their concept of nursing.

An aim of the comprehensive course is for the students to learn to practice individualised nursing care; however, they also appear to learn that they must fit in with the requirements of the agency in which they are working. As a result of this socialisation process, ideological hegemony is maintained and taken-for-granted activities are accepted and remain unchallenged (Perry, 1985). A nursing education course, through its control of knowledge and opportunities for nursing practice, can influence students' conceptions of nursing. Induction of nursing students into a professional culture and their preparation to meet society's health needs are the responsibility of nursing education. Professional socialisation is the process whereby the knowledge, skills, and attitudes characteristic of a profession are acquired. The process involves internalising the values and norms of a profession into one's own behaviour and self-conception. Thus, separation of the formal curriculum from the socialisation of students' is not really possible. Therefore, the process of professional
socialisation must be seen WITHIN the context of nursing education. The philosophy on which students' future actions will be based will result from their interpretation of the environment in which they learn (refer chap. 3, p. 43).

The view of socialisation as a process where the individual learns a role and internalises a set of rules which then regulate professional behaviour offers only a limited explanation. The learning situation, the philosophies of the nursing educators, programme organisation, the types of experiences all influence socialisation of nursing students. As stated earlier (refer chap. 4, p. 75), the structure and constraints which underpin professional nursing must be given consideration.

That nursing educators strongly influence professional socialisation is undisputed. But the contention that students are socialised to readily accept institutional limitations on professional practice is not readily acknowledged. Yet, there is evidence (Perry, 1985; Hickson, 1988) to suggest that students do become socialised in this manner and adjust their behaviour accordingly on entry to hospital practice as registered nurses. They accept the institutional structures as inevitable and unchangeable, and compromise their nursing care to cope with the demands of their working environment. There are numerous examples from the interviews conducted in this study that support this claim. The students described their behaviour in various ways - adjustment to the type of nursing being practised, fitting into a system, and the fact that 'quick socialisation' equates with survival (refer chap. 4 Amy, r33 pp. 92-93 and Emma, r5 p. 97).

Emma reflected on how she felt this would affect her personally.

_The inability to practice as I have been taught is probably going to mean that the goals I've set will have to come down and I'm not going to be_
working toward the standard I would like to reach. It may mean that I
don't find nursing as rewarding as I thought it would be ... or what it could
be or should be. (Emma, r30)

Kim expressed a realisation of how the current situation operating
in hospitals might influence his nursing care.

I can see that I could easily 'fall into' the system; there's definitely a danger
there. That's why I've got to try and keep reality in mind ... it's going to be
VERY easy to just do my job, and get all the tasks over and done with. But
in the long term I'm going to be very frustrated with that. (Kim, r33)

The students were able to reflect on practices they had observed
that were inconsistent with their knowledge and beliefs, but they
seemed unable to capitalise on this reflection with any attempt to alter
the situation. They commented on situations in which they had learned
to keep quiet and not challenge existing practices, rather than
speaking out. The students believed that doing so would be both
unpopular and non-productive.

It appears, therefore, that the socialisation process, which begins
very early in the nursing student's educational experience, serves to
stifle the initiative, creativity and potential of the graduate. The
pursuit of technical rather than emancipatory knowledge (Habermas,
1968) ensures 'prediction and control' and the characteristics deemed
appropriate for 'acceptable' professional behaviour remain
unchallenged. The fact that most nurses are women and that women
are socialised to believe that their actions must be approved by others
compounds the situation and this tends to enforce conformity.

Therefore, while their educational programme may well set out to
promote autonomy, independence and creative thinking, students
experience course requirements which demand compliance and conformity. The students interviewed reported that some tutors discouraged the stimulation of intellectual curiosity and that tutors seemed to view student questioning and disagreement as a personal threat (refer Amy, r53 chap. 3, p. 58). Thus, the outspoken, questioning and challenging student tended to be viewed as 'difficult'. The lack of opportunity to develop autonomy is also enhanced by the influence of the technical approach to education. The fact that the students were answerable to both tutors and nurses in clinical practice limited their development of individual autonomy and responsibility.

Students lack the opportunity to practice critical consideration of their nursing education, instead, they practice self-criticism, adjusting their behaviour and expectations accordingly.

When you get a situation like that arising (criticism) you are almost tempted to throw the whole thing in. And if students don't have the ability and maturity to work through it, then I'm sure it will affect how they will react to things once they are registered. I think we all seem to be conditioned to not respond well when we're in a negative situation ... which is a pity ... and that goes particularly for women. (Sarah, r46/47)

Sarah's discussion explicitly illustrates how the unequal relations of power within nursing education are very likely to ensure ideological consensus and perpetuation of existing social structures. These relations of power are also likely to reinforce for the students the 'desirable' qualities required within the nursing profession. As illustrated, students' comments portray that they believe conformity and compliance are among these qualities. However these requirements do not bode well for the development of professionalism within the nursing profession. The existing relations of power are
likely to influence student evaluation of performance and their acquisition of attributes of professionalism.

The theme of professionalism, as a separate issue, did not have a high profile in the students' interview discussions. However, comments reflect their belief that nursing education was not preparing them to fulfil at least some of professionalism's criteria, identified earlier (refer chap. 5, pp. 122-123). For example, students expressed opinions on tutor supervision and how this affected their ability to develop autonomy and responsibility (refer Amy, r2 chap. 4, p. 104). Emma remarked on this, commenting on how tutor supervision influenced her level of confidence and the impact she experienced during her clinical elective with regard to responsibility.

"The tutor always seemed to come between us and the ward staff ... so we never really seemed to be held responsible ... well, that was the impression I got anyway. I don't think that is particularly good ... I think that if we're providing the care then we should be accountable for it. And it's difficult too to know how much the ward staff want you to be responsible ... and whether you should initiate things or wait to be told ... or ask. I found that very difficult to know ... the degree of responsibility we were expected to take on. I remember thinking during the elective units that the responsibility of the Staff Nurse is a lot more than we EVER had to handle ... or had been given."

(Emma, r19)

Emma's comment reflects her opinions on the lack of opportunity available to students during the course to develop accountability and a remark made by Kim regarding students becoming change agents supports this contention.

"I think many of the students just see themselves as fitting into a system. In our first year we had a session on being a 'change agent' ... what it means ... but it was obvious that a lot of the students weren't at all concerned about that."

(Kim, r77)
Sarah expressed concern about some of the attitudes expressed by a number of the students in her class, and the possible influence of these attitudes on their nursing future.

...what amazed me was it was a lot of the younger students saying these things. Imagine what they will be like when they get into the hospitals ... which is like a microcosm of society ... they will be saying 'Yes sir, no sir' and everything else ... and possibly will be unable to become patient advocates or make any changes.

(Sarah, r31)

It has been suggested that nurses are an oppressed group, a view supported by evidence that nurses lack autonomy and control within nursing. Nurses tend to exhibit personal characteristics similar to those of other oppressed groups, such as lack of self-esteem and devaluing of characteristics often associated with nursing (refer chap. 5, p. 135). If these premises are accepted it can be reasoned, from the data collected in this study, that nursing students are therefore doubly oppressed. Firstly, they are being socialised into a profession already considered to be oppressed and, secondly, as students, they are placed in an inferior and dependent position. It has been stated (refer chap. 5, p. 137) that education, with regard to oppressed groups, has been important in the maintenance of the status quo. The data reported in this study clearly support this contention. However, although recognition of many of the characteristics typical of oppressed groups was acknowledged by the students who were interviewed, there was a general feeling of powerlessness to effect any change. It is therefore debatable whether moving nursing education into the tertiary sector has done much to break this cycle of oppression. It appears that nursing educators are tending to exert power over students by placing them in submissive roles and utilising manipulative strategies to
maintain authority. Until is is openly acknowledged that the preparation of nurses is continuing to perpetuate the characteristics applicable to oppressed groups, and women in particular, barriers to professionalisation of nursing will remain in force. Possible alternatives regarding the curriculum within nursing education will be addressed in chapter seven.

Thus the issue of power is critical within nursing education. Although the theme did not receive direct attention within the interviews or questionnaire, it was referred to indirectly on a number of occasions, and as already demonstrated, can be explicated within the other identified themes - curriculum, socialisation and professionalism. One of the principle issues regarding power as it concerned the nursing students relates to Lukes' third dimension of power, explained earlier (refer chap. 5, p. 143). This concept is based on the premise that people's 'real interests' are sublimated by socialisation into a system. Lukes' theory can be related to the students' experiences of their curriculum, for as he states so succinctly, when addressing the idea of actual conflict being necessary to power "... is to ignore the crucial point that the most effective and insidious use of power is to prevent conflict arising in the first place" (1974:23).

There are numerous examples in the interviews that portrayed this use of power. Many discussions illustrated that the students had either channelled or altered their behaviour to that which they believed was required by those 'in control' (refer chap. 5, Emma, r44 p. 167 and Pam, r35 p. 170). Amy related the issue of power to patient advocacy, and how she believed it was likely to influence her reactions.

I. *What if challenging someone involved patient advocacy ... would you do so then?*
S. Well, you see that's even difficult ... and we're meant to be patient advocates. Well ... I suppose it would depend on who it was ... if it was a lowly House Surgeon then I suppose you could say something, but if it was a Consultant then you would possibly be watching your OWN back ... after all, it's your own career that may be at stake!! So it's VERY tricky.  

(Amy, r37)

The analysis of power, as previously indicated, is compounded by the predominant ideology that maintains patriarchy and therefore advances a particular view of women. The issue of conflict between professional and feminine roles and the impact of feminism on nursing has been addressed. The students seemed aware of this ideology operating, although it is debatable whether they realised the extent of its influence. Their discussions do, however, illustrate this concept (refer chap. 5, Emma, r55 pp. 159-160, Kim, r114 p. 160 and Ann, r14 p. 162) quite clearly. Kim's views on nurses' response to power (refer chap. 5, Kim, r102 p. 169) offer a general summary of how these students viewed nursing's position within the health sector hierarchy.

Thus the four themes - curriculum, socialisation, professionalism and power - are seen as critical to the development of a greater understanding of nursing students' perceptions of their education. The combination of these themes enhances understanding of the students' experiences and the realisation that they are socialised to accept institutional constraints placed on professional nursing practice.

The final chapter draws some further conclusions from this study and discusses resulting implications.
CHAPTER SEVEN

Discussion and Recommendations

This study has considered nursing students' perceptions of their nursing education. The theory and analysis has explored these perceptions from the perspective of four themes - curriculum, socialisation, professionalism, power. The interrelationship of these themes has been demonstrated. This chapter presents further conclusions which might be drawn from the foregoing analysis, and examines some of the educational and practice implications drawn from the study. The main limitations of the study are identified and discussed and recommendations are made for future research.

The central themes arising from the data collected in this study have not been addressed in previous studies utilising both qualitative and quantitative research methods. The theoretical analysis of this data leads to a number of conclusions regarding the nursing students' educational experiences.

CONCLUSIONS and IMPLICATIONS

Curriculum

This study has demonstrated that both intended and unintended learning influences the students' perceptions of nursing and their nursing education. It is contended that an exploration of the design of curricula needs to be carried out as the predominant objectives model reflects an emphasis on control and objective reality. The student becomes a passive product; development of autonomy and responsibility
is minimised and the students' ability to be critically reflective of nursing is diminished.

It has been shown that the way in which nursing knowledge is produced will influence the way students interpret their social worlds. But it has also been demonstrated that knowledge within nursing curricula tends to be treated as 'an object' and therefore prevents possible alternative meanings and realisations surfacing. This concept of knowledge as an object is portrayed in several ways. Mechanistic education (refer chap. 3, p. 40), characterised by the "banking concept", aims to control students' thoughts and action and adjust them to the practice world rather than developing their abilities to transform it. In this way, the educator becomes the "depositor" in the transfer of knowledge and students the "depositories" (Freire, 1973a). The hierarchical relationship between tutors and students ensures that power remains firmly in the educators' control. Evaluation is both formal and explicit and promotes self-criticism, but not self-reflection (Perry, 1985; Hickson, 1988).

The need for nursing educators to recognise the presence of a hidden curriculum and to acknowledge it as a "pedagogical concern" is essential to develop an understanding of the process they are involved in. The relationship between the overt and covert aspects of the curriculum and "school culture" (Bourdieu, 1977) must become a focal point if a nursing course designed to encourage graduates to be critically reflective of their professional practice, is to develop.

Nursing curricula emphasise 'prediction and control' which does not allow the conditions for emancipatory knowledge and transformative action to develop (Habermas, 1968). Butterfield
(1985:102) states "it seems paradoxical, then, that nursing curricula still often focus on the information necessary rather than on the process necessary to develop the desired characteristics". Education needs to be recognised as a personal experience; learning should be in an environment that encourages and is supportive of creative thinking and in which the student is actively involved. Knowledge must not be considered to be a static given product, but arising out of human activity and interests. Nursing education needs to direct attention to process within the curriculum, not only the product.

The theoretical perspectives utilised to examine the theme of curriculum offer a useful framework from which the meanings and influences students derive from the curriculum might be made explicit. The work of Bernstein (1975) and Bourdieu (1977) clarifies the relationship between education and cultural transmission and reproduction. Examination of the role of educational methods, the content of the curriculum and the influence of educators in the maintenance of ideological hegemony is crucial. The process of critical reflection on nursing education must be encouraged if emancipatory knowledge and an education that enables participants to act on their reflections is to develop.

The Review of the Preparation and Initial Employment of Nurses (1986:22) states "curriculum should be seen in its broadest sense, i.e. all the learning that occurs in all contexts". The key word in this phrase is ALL. The comments of the students interviewed in this study demonstrate that heed should be taken of this recommendation. This study exemplifies the lack of nursing educators' acknowledgement of the hidden curriculum; a curriculum students were very much aware of. When the meanings students glean from such a curriculum are not
made explicit, legitimation of educational processes and reinforcement of existing hegemonic structures, is assured.

The 'objectives' curriculum design currently existing in nursing courses needs to be replaced by one that will increase students' sense of personal agency and alter the present hierarchical relationship between tutor and student. A transformative (process) curriculum model offers such an opportunity. This type of curriculum provides contradictions existing between intended and unintended learning to be made explicit. Such a curriculum has been instigated at Deakin University School of Nursing. As Perry & Moss (1988:40) explain

The transformative curriculum is designed to incorporate a dialogue on education and nursing traditions and on the qualitative, lived experiences of students and graduates. In this way the actual experiences, values and knowledge of the student are explored and validated and the structures and constraints which shape nursing education and practice can be critically examined. This enables nurses to challenge the ideology and structures of the education and health care systems both theoretically (in the overt curriculum) and experientially (through the 'hidden' curriculum). The processes of the transformative curriculum allow the hidden curriculum to surface and to be made explicit ... Curriculum then, becomes a living process by which alternatives in nursing action can be generated.

Students in this study related experiencing a dichotomy between the nursing practice propounded in the classroom - individualised, comprehensive, direct patient care - and that encountered in practice situations. The messages they received, via the hidden curriculum, are that the nursing care they are encouraged to practice may not, in fact, be possible to achieve in the existing health care structures. Failure to openly acknowledge this hidden curriculum exemplifies the difficulties students encounter when attempting to challenge these structures and minimises the likelihood of students acting on the basis of critical
self-reflection, rather than self-criticism, regarding their nursing education. Action appears to be prevented by the hegemonic nature of the institutions in which nursing education occurs. However, while critical self-reflection may not result, this study supports the contention of previous research that students and graduates do become self-critical (BUT not socially critical or self-reflective), "perceiving forms of domination as personal inadequacies in their own professional competence" (Perry, 1985:86).

While not a direct goal within this study, the interviews did provide the seven students with an opportunity to take part in critical self-reflection, a situation not available to them within their nursing education. However, this reflection was, to the extent that it was in isolation, limited. It is contended, from the results reported in this study, and those from other qualitative studies (Perry, 1985; Hickson, 1988) that this reflection must become a vital and essential component of nursing courses. This emancipatory knowledge might then lead to transformative action. It would therefore tend to lessen the feelings of powerlessness to effect change that are reported by the students throughout this study.

Socialisation

This study has reinforced the contention that formal nursing education, by attempting to control the acquisition of knowledge, can influence the extent and pattern of students' development of a professional self. The nursing school, with its expectations and anticipations, becomes a reference group for the nursing student. The school determines criteria which are seen as measures of successful assimilation into nursing. Therefore, one of the main purposes of
socialisation is to allow the nurse to develop 'appropriate' professional behaviour. A clearer understanding of who holds the power to decide what is appropriate and an understanding and acknowledgement of the stages of professional development of nursing students would help faculty cope with the feelings and needs of the student more constructively.

Thus, the influence of the nursing education course on students' conceptions of nursing, through control of knowledge and opportunities to practice nursing, must be openly acknowledged. It appears that, while the overt message within their education may well reflect demands for equality for nurses in the health arena, a covert message is present as well. An emphasis is placed on the acceptance of institutional norms, both within the educational and health sectors, and the focus is on how the individual must adapt. By stressing the need for this adaptation to occur at the individual level, maintenance of the system itself is promoted and maintained.

It is suggested, therefore, that the current comprehensive nursing courses socialise students to accept the institutional constraints placed on professional practice (Perry, 1986). While the students are aware that it is unlikely that they will be able to practice individualised, comprehensive nursing care as graduates, they appear to accept this as inevitable. The emphasis on adaptation leads students to believe, or at least accept, that the nursing care they experience in hospital practice is adequate and the only possible way of delivering that care within the constraints of the hospital bureaucracy.

This ideological consensus is reinforced by the students' experiences of a 'lack of control' within their nursing education. Due to a combination of these experiences and the effects of hierarchical
structures and constraints governing their education, it seems logical to predict that these students, on entry to hospital practice as graduates, will adjust to the existing structures and constraints operating in that bureaucratic institution. This contention is supported by the results of previous studies (Perry, 1985; Hickson, 1988).

It appears that the socialisation process might well influence recruitment of new graduates into specific areas. As noted in chapter one (refer p. 3), the Review of the Preparation and Initial Employment of Nurses (1986) suggests that encouragement needs to be given to graduates to recognise the satisfaction that can be gained and the expertise that can be developed in areas such as psychiatric and psychopaedic nursing. Students in this study reported a perceived lack of confidence and competence and a reluctance to enter these areas, particularly psychopaedics. There should be some concern that the adoption of an integrated curriculum within nursing education will foster this reluctance. Perhaps integration may well produce overt and covert messages that psychiatric nursing is not 'real nursing' - a message reported in this study.

As discussed throughout this thesis, organisational practices and existing hierarchical structures serve to socialise students. The students interviewed in the course of this study were clear in the realisation that they should, and were expected to, simply 'fit in' to the existing structures of the institutions in which their nursing education was taking place. The students were able to reflect on practices they had observed that were inconsistent with knowledge and beliefs, but they seemed unable to capitalise on this reflection with any attempt to alter the situation. They commented on situations in which they learned to keep very quiet and not challenge existing routines and
practices. This led to the belief on the part of students that they lack the ability to challenge the contradictions they observed; the conditions for emancipatory knowledge do not emerge. This situation ensures maintenance of ideological hegemony and the existing professional nursing culture is maintained.

Therefore, it seems that experiences within their nursing education, rather than individual student characteristics, may well negate the possibility of students either being or becoming change agents. As discussed within the theme of socialisation students learn very quickly the steps necessary for survival within the 'system' - they develop an 'inbuilt survival instinct', simply 'slot in' and try to not make too many waves. The fact that students find themselves unable to initiate changes within the polytechnic appears to be a strong influencing factor against making efforts toward change within the clinical agencies.

Use of Bucher and Stelling's (1977) explanation of the socialisation process, examined in chapter four, would raise important questions regarding the influence of tutors, the learning environment, programme organisation, and clinical experiences, on nursing students' professional socialisation. Such an examination is critical if complete understanding of the socialisation process is to occur. Forms of social control, such as the constructs of ideological consensus, hegemony and power relationships, must be realised and openly acknowledged. Until this occurs, the change in nursing practice envisioned when the moves to situate nursing education in New Zealand in a tertiary institution, introduced in the early 1970s, will not eventuate.
Professionalism

The stated philosophies of the nursing curricula emphasise professional nursing. Each stress the development of a therapeutic relationship with clients and the concepts of holism and individualised care. Thus the professional nurse portrayed in the courses' stated objectives operates from a holistic viewpoint and develops an individualised therapeutic relationship with each client. The curricula appear to be structured to progressively develop students' knowledge and skills and to integrate these with the professional nursing orientation of holistic individualised patient care. Specific technical skills, with an associated knowledge base, are given an emphasis, particularly in clinical experience. While in clinical fields students are directly responsible to polytechnic tutors rather than to hospital staff. This in principle means that the control over both the classroom and clinical experience in the nursing curriculum is in the hands of the polytechnic, with an emphasis on professional nursing. However, the organisation of clinical experience around specialities, and the emphasis given to teaching students a particular role of the nurse, means that the nature of the learning experiences are dominated by a bureaucratic pattern of nursing antithetical to professional nursing.

Thus a disparity exists between the idealised individualised client centred objectives of the courses and the bureaucratic, technical experiences of the students in clinical practice. Course philosophies may well contain the goal of producing graduates who are self motivated and prepared to use their knowledge in an inquiring and creative manner. But it appears that (at least from what the students themselves are saying) students are also receiving the message to be safe, obedient and quiet, according to the demands of the nursing
service. As Swaffield (1987:25) outlines, nursing education seems to have become "the unwilling victim of nursing's own history". Nursing practice still often reflects the need for "order". Perhaps, as Swaffield suggests "it is safer for those in service to encourage compliance in order to preserve the status quo" (1987:25).

While all of the students interviewed in this study either viewed themselves as professional, or wished to be seen as such, their remarks suggest that at least some of the criteria characterising a profession did not develop or were not encouraged to develop, via the nursing education course. For example, autonomy and assertiveness may have been espoused, but within very limited constraints.

The theoretical perspectives discussed within this theme provide a starting point for examination of existing characteristics of professionalism within nursing. Feminist theory provides a frame of reference for examining nursing from a historical, political and personal point of view. Such an analysis is facilitated by Freire's (1973b) theory of oppressed groups. Many of the characteristics nurses portray - lack of autonomy, accountability and control - stem from their domination by physicians and powerful societal forces; this attribution of values contributes to maintenance of the status quo. Until this oppression is grappled with, nursing will be unable to achieve true professionalisation. There is a need to define nursing's unique role and describe the areas of knowledge, skill and expertise that should be nursing's prerogative and responsibility.

Nursing education needs to address the incompatibility which exists between the nursing ideals of professional autonomy and accountability, espoused within the courses' stated objectives, and the
structural functions of the bureaucratic institutions in which nursing is taught and practised.

**Power**

While the students in this study appeared to be aware of the contradictions existing between their educational experiences and nursing practice, their discussions reflected an acceptance of established procedures and the explanations they received from tutors and nursing staff. In other words, their beliefs were influenced by those who hold the power to shape their consciousness. In Perry's words "in each situation, the disparity of power between graduates and other agents, enable the 'persuasion' toward ideological consensus to be effective" (1985:42) and, as a consequence, the 'real interests' of these students have been quelled by the dominant ideology of both the polytechnic and hospital systems. Even when they had an awareness of the dichotomy existing between what had been taught in the classroom and nursing practice, they tended to 'fit their behaviour' to what they perceived was required by those who hold the power.

The students in this study expressed feelings of being powerless to influence their education. Several felt unable to change the system and recalled experiencing little autonomy in both the educational and clinical practice environments. The outspoken, questioning and challenging student tended to be viewed as oppositional, with tutors reacting negatively to such behaviour. Such a student could be seen, more constructively, as being better equipped for the future. Student behaviours that are rewarded by faculty may turn out to be antithetical to the professional role.
The study identifies the disparity in the power of the students and the nursing educators. The unequal relations of power operating in the educational and health institutions in which their nursing education took place, ensures that students become part of an ideological consensus (Perry, 1985). Students learn to acquiesce in order to survive in the system. There appear to be no opportunities for students to take part in curriculum development. This situation exemplifies Lukes' (1974) assertion regarding sublimation of people's 'real interests' by socialisation into a system; it is a means of ensuring that conflict between those exercising power and those they exclude does not arise.

Lukes' three dimensional theory of power was useful in understanding the results of this study. In Lukes' view the potential issues excluded by the action of societal forces and institutional practices must be given consideration. An investigation of the effects of institutions and how they socialise individuals into a view of social reality is necessary. This would offer an explanation of how the prevailing ideologies of the polytechnic and hospital systems suppress the real interests of these nursing students, by defining and constructing their behaviour via the socialisation process which confronts them.

It seems unrealistic to expect students, and graduates, to be change agents. In all organisations, the philosophies, attitudes and practices which are critical are those embedded in the institutional structures. Nurses, to be effective patient advocates and accountable practitioners, need assertiveness skills. This need must be recognised and supported by others in the hierarchical structure. Assertiveness must be valued as a means of enhancing professional practice. However, for nurses to
become more expressive and open, changes must occur, not only in the process of nursing education, but also in the culture in which nursing is practised.

Ashley's (1980) analysis of nursing's perceived powerlessness also provides a useful framework for analysing power in nursing. Nurses need to analyse and deal with the effects of patriarchy on the profession, and the view women often have of power and independence as negative characteristics, before moving on to devise new measures to expand their power base. There must also be an examination of why nurses need power: power and its uses are necessary to bring about change. Students and graduates need to learn about the methods of using power to change 'the system'. They must resort to the effective use of power; nurses, individually and collectively, must recognise and cultivate the power they do have and exercise that power in an intelligent and organised manner.

There are many strategies which will lead to empowering of nurses. Internalisation of the feminist's underlying message of self-determination and commitment would be a start. The issues outlined by Lerner (1985) would assist in socialising nursing students to see themselves as persons with power. The development of a transformative curriculum would empower students to become active participants in their own education, rather than passive recipients of predetermined learning objectives. It would allow recognition of their own knowledge and experiences, vital to the development of nursing knowledge. Primary nursing, political activity, and involvement in the general health scene are important means for increasingly empowering nurses. They are also activities that encourage nurses to exercise power that really exists. It is also essential that the power
presently held by those at 'the top' be delegated and that these personnel facilitate the use of power by others. There needs to be empowering of staff to allow them to make their own decisions and be accountable for their own actions.

LIMITATIONS OF STUDY

This study has identified some of the issues which make up nursing students' perceptions of their education.

In a study of this nature a number of imposed, artificial boundaries, produce limiting factors. These boundaries are created by time, contextual validity, extent of data sources and the evidential base.

The constraints of time within this study produced, of necessity, an artificial end point. The collection of quantitative data was governed by the co-operation of the Heads of Departments and the availability of third year students, within the imposed limitations.

As already outlined, the interviews offered an opportunity for these students to begin the reflexive process. While there is no way to assess changes that might occur due to this process, participants did express the value of this opportunity and experience. It is expected that self-reflection will continue, but this thesis can only attempt to describe a small portion of that process. However, it is hoped that the research reported might become the catalyst for the growth of such reflection within nursing education.

A second limitation that might be identified relates to the interpretive or contextual validity of the study. The descriptions of the interviews is critical to making the dialectic explicit. Within this research this was achieved by the use of excerpts carefully drawn from the interview transcripts, while remaining true to the body of data.
from which it was drawn. The small number of students interviewed in this study could be seen as a limiting factor. The study does, however, provide the opportunity for readers to experience the realities and complexities of the situation and to make naturalistic generalisations. As Stake (1978:6) states

> When explanation, propositional knowledge, and law are the aims of an inquiry, the case study will often be at a disadvantage. When the aims are understanding, extension of experience, and increase in conviction in that which is known, the disadvantage disappears.

This study is also supported by other qualitative studies (Goldsworthy, Pickhaver & Young, 1984; Perry, 1985; Perry, 1987-89; Hickson, 1988; Walton, 1989).

The third possible limitation of this study relates to its evidential base. However, two research methods (interviews and questionnaires) were employed; the questionnaire results being used to determine if the interpretations derived from the qualitative data were in agreement with the views expressed by the wider sample of students. And, as discussed earlier (refer chap. 2, p. 17), the interviews might be considered case studies, as they offer a synopsis of each student's perceptions of aspects of nursing education. Also by producing critically reflexive dialogue the value and meaningfulness of the interview is extended. If this premise is accepted, the interviews can be seen as a dual data source; the study therefore employing methodological triangulation. Thus, a form of cross validation of evidence was utilised in this study.
RESEARCH IMPLICATIONS

This study has focused on one aspect of nursing and has attempted to demonstrate that nursing education is not contained within one institution or context. Instead, it is a broad process that encompasses a number of situations and experiences.

The study suggests that consideration of nurse educators' perceptions of nursing education might well elicit similar or further processes that ensure maintenance of ideological hegemony and govern the development of personal and professional autonomy. Research that examines such perceptions would offer the framework for further exploration of nursing education with a broader focus of both educator and student. Research could also be extended to an examination of the nature of the institutions in which nursing education occurs, and the relationships which operate within them.

Longitudinal research would help to elicit what changes occur in the students' perceptions of their nursing education as they progress through the course. Students in this study reported changes in their views after the first year and research of this type might well determine these changes and why. Such studies would provide a basis for transformative action. Studies such as this one could also be extended to follow students into graduate practice, with an examination of how their perceptions of nursing education affect their 'assimilation' into nursing.

This study has also suggested the need for research into particular recruitment areas, namely psychiatric and psychopaedic nursing and what influence age might have on nursing students' perceptions of their education.
CONCLUDING STATEMENT

Through an examination of nursing students' perceptions of their education, this study has demonstrated that knowledge is embedded in social practice, and must be seen as being produced within particular historical/socio-political contexts and structures. Such structures may operate to constrain the development of personal and professional autonomy, accountability and responsibility. It is critical that nurses find ways to overcome such constraints.

This study has added to the accumulating evidence that students, in general, do perceive these constraints within their nursing education. Legitimation of these perceptions and experiences needs to occur and acknowledgement of students' powerlessness. A radical critique of the social institutions in which nursing education and practice take place would allow recognition of these constraints; this is essential if critical self-reflection and emancipatory knowledge are to emerge. Allen, Benner & Diekelmann state:

What is essential about experience in nursing education is that students learn to analyse the sources of their own interpretations, to question and resist the predefined meanings we educators encourage them to adopt, and to develop the tools to negotiate a world of nursing in which the twin goals of autonomy and responsibility are achievable. (1986:36)

The process of self-reflection must be developed early in nursing education and its continuance be assured, both in education and practice environments. This quote offers a challenge to everyone involved in these settings; it must happen if nursing is to progress.
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APPENDIX 1

Education Department
University of Canterbury
Private Bag
CHRISTCHURCH

1 March 1988

Ms
Head of Department
Nursing Studies
Polytechnic

Dear Ms

I am embarking on a thesis this year to complete requirements for an M.A. in Education at Canterbury University. I am a registered comprehensive nurse, I have a B.A. in Nursing Studies and Education from Massey University, and I have considerable experience as a nursing tutor in a polytechnic.

My research proposal is two fold

1) A student questionnaire - to determine students' reasons for entering nursing, their perceptions of nursing education, intentions for graduate practice and continuing nursing education.

2) To research the students' concepts of the psychiatric and psychopaedic nursing areas within their curriculum.

However, in order to carry out any such research, I would naturally require a good deal of assistance and co-operation from staff of the Nursing Studies Departments within several of the polytechnics. I would therefore be most grateful if you would let me know, at your earliest convenience, your willingness to assist me with my research. Should you be in agreement I would then forward a request for specific assistance and information.

I can be contacted at the above address, phone 667-001, ext 8213.

Thanking you in anticipation.

Yours faithfully

Heather Forbes, M.A. Student
Department of Education
University of Canterbury
This questionnaire is designed to obtain information on nursing students' experiences of their nursing education. A great deal has been said and written about comprehensive nursing students, but little from the perspective of the students themselves. To assess the situation, and to analyse some baseline data, I would be grateful if you would assist me by completing the following questions.

Please be assured that your answers will be kept confidential - the questionnaire is coded so no personal details could be identified. The processing of data will be carried out entirely by myself. I need your I.D. numbers so that I am able to check that all third year students have had a chance to fill in the questionnaire.

Thank you for your assistance.

Heather Forbes
For each question please enter the appropriate number into the box in the right hand column. For example, if you are now aged between 30 and 39 years you would enter 4 in the box at the right for question one.

1. What is your age now?
   1. Under 20
   2. 20 - 24
   3. 25 - 29
   4. 30 - 39
   5. 40 - 49
   6. 50 and over

2. Are you
   1. Female
   2. Male

3. What is your ethnic origin?
   1. European
   2. Maori
   3. Asian
   4. Samoan
   5. Tongan
   6. Other (specify)

4. To what extent do you think Maori, or non Pakeha cultural values have influenced your nursing education?
   1. A great deal
   2. Occasionally
   3. Not at all
For each question please enter the appropriate number into the box in the right hand column, or follow particular instructions.

5. What was your highest academic attainment before entry to the comprehensive nursing course?
   1. No formal qualifications
   2. School Certificate (3 or more passes)
   3. University Entrance/6th Form Certificate
   4. 7th Form/Higher School Certificate
   5. Bursary (A or B)
   6. University qualification
   7. Other (please specify) ____________________________

6. At what time did you make the decision to enter nursing?
   1. Have always been interested in nursing
   2. Primary or Intermediate School
   3. Secondary School
   4. After completion of schooling
   5. Spur of moment decision

7. Some of the following may have exerted some influence on your choice of a career. Please indicate up to three which have had the most influence, by placing a tick in the appropriate boxes in the left hand column.

   [ ] Parent(s)
   [ ] Partner/spouse
   [ ] Relatives
   [ ] Friend(s)
   [ ] Teacher(s)
   [ ] Career Adviser
   [ ] Vocational Guidance
   [ ] Radio or TV
   [ ] Printed material
   [ ] None of the above
   [ ] Other (please specify) ____________________________

   (For coding use ONLY)
For each question please enter the appropriate number into the box in the right hand column.

8. To what extent is the most significant other in your life (e.g. parents/partner/family) supportive of your career choice?
   1. Very supportive
   2. Fairly supportive
   3. Neutral
   4. Not particularly supportive
   5. Non supportive

9a. Have any of the following family members been a nurse, or involved in health related fields?
   1. Mother/Step mother
   2. Father/Step father
   3. Brother/sister/Step brother/sister
   4. Grandparent
   5. Uncle/Aunt
   6. Cousin
   7. None of the above

9b. Did any of the above nurses have any influence on your choice of nursing as a career?
   1. Yes
   2. No
   3. Don't know
   4. Not applicable
For each question please enter the appropriate number into the box in the right hand column, answer in the space available, or place a tick in the box in the left hand column.

10a. Was nursing your first choice of career?
   1. Yes
   2. No

10b. If it was not your first choice, what occupation would you rather have entered?
   01. Teaching
   02. Medicine
   03. Physiotherapy
   04. Occupational Therapy
   05. Pharmacy
   06. Social Work
   07. Law
   08. Other (please specify)

10c. If applicable, please indicate why you did not enter this occupation.

11. Have you previous qualifications/experience that you see as relevant to nursing. If so, please tick in the appropriate boxes in the left hand column. (For coding use ONLY)
   - University
   - Teaching
   - Occupational Therapy
   - Social Work
   - Physiotherapy
   - Pharmacy
   - Enrolled Nurse
   - Nurse Aid
   - Parenting
   - Child Care
   - Other (please specify)
12. Please indicate, by placing a tick in the appropriate boxes in the left hand column, which of the following characteristics you feel best describe your personality.

- [ ] Confident
- [ ] Introverted
- [ ] Emotional
- [ ] Warm
- [ ] Sense of humour
- [ ] Objective
- [ ] Autonomous
- [ ] Cheerful
- [ ] Outgoing
- [ ] Dependable
- [ ] Cautious
- [ ] Quiet
- [ ] Sociable
- [ ] Sensitive
- [ ] Independent
- [ ] Optimistic
- [ ] Achievement oriented
- [ ] Capable
- [ ] Dominant
- [ ] Intellectually curious
- [ ] Extraverted
- [ ] Shy

(For codin use ONLY)
For each question please enter the appropriate number into the box in the right hand column.

13. Many researchers have suggested lists of desirable qualities in the "ideal nurse".

For each of the following, please indicate with the appropriate number the extent to which each quality reflects your concept of the "ideal nurse".

A great deal 1 2 3 4 5 Not at all

a) Sincerity
b) Friendliness
c) Tolerance
d) Patience
e) Sense of humour
f) Efficiency
g) A liking for people
h) Ability to carry out technical procedures
i) Ability to make decisions
j) Mastery of subject material
k) Clean and neat appearance
l) Dedication
m) Intelligence
n) Integrity
o) Desire to help others
p) Ability to impart knowledge
q) Empathy
r) Change agent
s) Communicative skills
t) Cultural sensitivity

If there are any other qualities not on the list which you consider to be more important than those above please specify

__________________________________________________________________________
For each question please enter the appropriate number into the box in the right hand column.

14. For each of the following, please indicate with the appropriate number the extent to which you believe each quality reflects nursing educators' concept of the "ideal nurse".

<table>
<thead>
<tr>
<th>A great deal</th>
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<th>3</th>
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<th>5</th>
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<tr>
<td>a) Sincerity</td>
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<td>b) Friendliness</td>
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<td>e) Sense of humour</td>
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<td>g) A liking for people</td>
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<td>j) Mastery of subject material</td>
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<td>k) Clean and neat appearance</td>
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<td>l) Dedication</td>
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<td>o) Desire to help others</td>
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<td>p) Ability to impart knowledge</td>
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<td>r) Change agent</td>
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<td>s) Communicative skills</td>
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<td>t) Cultural sensitivity</td>
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</table>

If there are any other qualities not on the list which you consider might be more important from the point of view of nurse educators than those above please specify
For each question please enter the appropriate number into the box in the right hand column.

15a. Many factors may have influenced your decision to enter nursing education. For each of the following, please indicate with the appropriate number to what extent each was an influence.

<table>
<thead>
<tr>
<th>A great deal</th>
<th>1</th>
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<th>4</th>
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<th>Not at all</th>
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<tbody>
<tr>
<td>a) Prospects for career advancement</td>
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<td>b) Family pressure</td>
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<td>c) Mother/father/family member a nurse</td>
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<td>d) Wish to help others</td>
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<td>e) Personal satisfaction</td>
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<td>f) Career adviser's suggestion</td>
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<td>g) Nothing else I wanted to do</td>
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<td>h) Security</td>
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<td>i) Improving own education</td>
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<td>j) Opportunities for overseas travel</td>
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<td>k) Prestige and standing in the community</td>
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<td>l) Opportunity to make friends and meet people</td>
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<td>m) Opportunity to work with others</td>
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<td>n) Could not get into Teacher's College or other training programme</td>
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<td>o) To be dealing with people rather than things</td>
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<td>p) Feeling of special capacity for the work of nursing</td>
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<td>q) Other (please specify)</td>
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</table>
For each question please enter the appropriate number into the box in the right hand column.

15b. Some people consider the following to be disadvantages of nursing as a career. Indicate, with the appropriate number, whether you consider each factor to be so.

A great deal 1 2 3 4 5 Not at all

a) Inadequate tertiary grants for students [42]

b) Low salary levels

c) Amount of study time required

d) Length of nursing course

e) Lack of prospects for promotion

f) Frustration arising from nurses' tasks

g) Shift work

h) Low prestige of nursing
In the following section, you are asked to express your opinions of various parts of the nursing course you are about to complete. Please try to give an overall rating within each area, even though you may feel differently about various parts of your education.

Please enter into the box at the right the number on each of the scales that most accurately applies to your feelings about the education you have experienced.

**16a. Theory - Social Sciences**

This section refers to all nursing theory and social science subjects, such as psychology, sociology.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Boring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well taught</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Badly taught</td>
</tr>
<tr>
<td>Easy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Difficult</td>
</tr>
<tr>
<td>Well planned</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Poorly planned</td>
</tr>
<tr>
<td>Useful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Of no use</td>
</tr>
<tr>
<td>Heavy workload</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Very light workload</td>
</tr>
<tr>
<td>Well related to practical experience</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Poorly related to practical experience</td>
</tr>
</tbody>
</table>

**16b. Theory - Sciences**

This section refers to all science subjects, such as chemistry, biology, physics.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Boring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well taught</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Badly taught</td>
</tr>
<tr>
<td>Easy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Difficult</td>
</tr>
<tr>
<td>Well planned</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Poorly planned</td>
</tr>
<tr>
<td>Useful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Of no use</td>
</tr>
<tr>
<td>Heavy workload</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Very light workload</td>
</tr>
<tr>
<td>Well related to practical experience</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Poorly related to practical experience</td>
</tr>
</tbody>
</table>
Please enter into the box at the right the number on the scale that most accurately applies to your feelings about your clinical experience throughout the comprehensive nursing course.

<table>
<thead>
<tr>
<th>16c. Clinical Experience</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Boring</th>
<th>Poorly planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interesting</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well planned</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td>Poorly supervised</td>
</tr>
<tr>
<td>Well supervised</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rewarding</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td>Frustrating</td>
</tr>
<tr>
<td>Easy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td>Very difficult</td>
</tr>
<tr>
<td>Varied</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td>Repetitive</td>
</tr>
<tr>
<td>Well related to theory</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td>Unrelated to theory</td>
</tr>
<tr>
<td>Not stressful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td>Stressful</td>
</tr>
<tr>
<td>Unhurried</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td>Hurried</td>
</tr>
<tr>
<td>Confidence building</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td>No opportunity to build confidence</td>
</tr>
<tr>
<td>Positive interactions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td>Negative interactions with health professionals</td>
</tr>
</tbody>
</table>
For each question please enter the appropriate number into the box in the right hand column.

16d. Course organisation

Please indicate how well each of these statements reflect your nursing education.


   a) The objectives (goals, purpose) of the programme were made clear. ☐

   b) There was considerable agreement between announced objectives of the programme and what was actually taught. ☐

   c) Course materials were well prepared and carefully explained. ☐

   d) Class sessions were interesting and stimulating. ☐

   e) Tutors made it clear how each topic fitted into the total course programme. ☐

   f) There was a clear relationship between nursing and related subjects (e.g. psychology, biology). ☐

   g) Assignment requirements were clear. ☐

   h) Assignments were challenging. ☐

   i) Examinations reflected the important aspects of the course. ☐

   j) Evaluation of student work was fair. ☐

   k) Ways of evaluating student work were appropriate. ☐

   l) Teaching methods were flexible enough to accommodate individual student differences. ☐

   m) Tutors were responsive to student questions and interests. ☐

   n) Tutors were open to points of view other than their own. ☐

   o) Students were encouraged to suggest possible course changes. ☐

   p) Students' suggestions for changes were taken seriously. ☐

   q) Tutors were adequately accessible to students during office hours or after class. ☐

   r) Tutors made students feel welcome in seeking advice/help. ☐

   s) Nursing tutors set a good example as nurses. ☐

   t) Textbooks required for the course were worthwhile. ☐
This section refers to your recent clinical elective option/pre-graduation experience.

17a. For each of the areas below that you went to for this clinical elective please indicate, using the following code, the main purpose in going there.

1. Own choice
2. Educational (i.e. skill deficit, make up time, no previous experience)
3. Tutor's choice
4. Only available placement

Hospital

☐ Accident and Emergency
☐ Coronary Care
☐ Geriatric
☐ Gynaecology
☐ Intensive Care
☐ Medical
☐ Obstetric
☐ Operating Theatre
☐ Paediatric
☐ Psychiatric
☐ Psychopaedic
☐ Specialist Department
☐ Surgical
☐ Other (please specify) ____________________________

(For coding use ONLY)

☐ 50
☐ 51

Community

☐ District Nursing
☐ Practice Nurse
☐ Public Health Nurse
☐ Other (please specify) ____________________________
For each question please enter the appropriate number into the box in the right hand column.

17b. During your recent clinical elective/pre-graduation experience did you:


a) Plan your own workload.

b) Assess, plan, implement and evaluate nursing care for your clients.

c) Write a care plan for each client you nursed.

d) Contribute to the written nursing care notes for each of the clients you nursed.

e) Provide individualised nursing care.

f) Meet the goals established for the elective.
For each question please enter the appropriate number into the box in the right hand column.

17c. Please indicate which of the four categories best describes your experience in relation to each statement, with regard to your clinical elective.


a) The institute had clearly planned goals and objectives for my clinical elective experience. [ ]
b) I understood the purpose of my clinical elective(s). [ ]
c) The nursing personnel were clear on the purpose of my elective. [ ]
d) There were adequate guidelines to direct my experience. [ ]
e) I knew what my responsibilities were. [ ]
f) I knew what was expected of me by the nurses in the clinical area(s). [ ]
g) I knew what was expected of me by the tutors. [ ]
h) I had effective contact with a tutor while working in the clinical area(s). [ ]
i) I felt that I was adequately prepared for the work. [ ]
j) I had just the right amount of work to do. [ ]
k) I had enough time to complete my work. [ ]
l) I used a problem solving process to assess, plan, implement and evaluate my nursing care. [ ]
m) I felt too much was expected of me by nurses in the clinical area(s). [ ]
n) I had to do things differently than I had been taught. [ ]
o) I had to do things that contradicted what I had been taught. [ ]
p) I was able to follow the procedures I had been taught when giving patients medications. [ ]
q) I had to work under vague directions. [ ]
r) I received incompatible requests from two or more people. [ ]
s) The registered nurses in the clinical area(s) understood my learning needs. [ ]
t) I received positive comments about my comprehensive education. [ ]
u) I was given on-going evaluation about my progress in the clinical area. [ ]
For each question please enter the appropriate number into the box in the right hand column.

18. For each of the following objectives please indicate the extent to which you feel your nursing education has made you competent, i.e. your ability to function as a registered nurse.


a) Assist people in the maintenance of health.

b) Determine priorities for nursing care.

c) Provide comprehensive nursing care.

d) Provide individualised nursing care.

e) Utilise the nursing process to guide nursing care.

f) Determine and organise your workload effectively.

g) Work efficiently.

h) Establish effective interpersonal relationships.

i) Accept responsibility for own nursing actions.

j) Function as a member of the health team.

k) Be accepted as a member of the health team.

l) Initiate and promote health teaching.

m) Supervise and guide the work of others (e.g. Enrolled Nurses).

n) Act as a patient advocate.

o) Promote and participate in nursing research.

p) Maintain ethical and legal standards.

q) Become involved in professional nursing concerns (e.g. NZNA).
For each question please enter the appropriate number into the box in the right hand column.

19. Please indicate how important the following factors will be to you in achieving personal satisfaction in nursing.

1. Very important  2. Important  3. Of some importance  4. Of little importance

a) Acquisition of knowledge.

b) Caring for others.

c) Emotional satisfaction.

d) Involvement with others.

e) Job security.

f) Type of work experience.

g) Salary levels.

h) Professional status.

i) Opportunities for ongoing education.

j) Job opportunities.

k) Control over your nursing care.

l) Variety of work.

m) Membership of a health team.

n) Control over shift work rosters.

o) Hospital "perks" (e.g. living conditions).
For each question please enter the appropriate number into the box in the right hand column.

The following section relates to your plans for graduate practice.

20a. If you do not intend to practise as a registered comprehensive nurse, please indicate the primary reason.
   1. Family reasons
   2. Do not enjoy nursing
   3. Unable to get job of choice
   4. Travel
   5. Have another job
   6. Other (please specify) ________________

20b. If you do intend to practise as a registered comprehensive nurse, please indicate your first practice area preference.

Hospital
   01. Accident and Emergency
   02. Coronary Care
   03. Geriatric
   04. Gynaecology
   05. Intensive Care
   06. Medical
   07. Obstetric
   08. Operating Theatre
   09. Paediatric
   10. Psychiatric
   11. Psychopaedic
   12. Specialist Department (e.g. Radiology, Out Patients)
   13. Surgical
   14. Other (please specify) ________________

Community
   15. District Nurse
   16. Practice Nurse
   17. Psychiatric Domiciliary Nurse
   18. Public Health Nurse
   19. Other (please specify) ________________
For each question please enter the appropriate number into the box in the right hand column, or follow particular instructions.

20c. If you will not be practising in this area next year, please state why not.

________________________________________________________________________

20d. Please indicate, by ticking the boxes at the left, the three main reasons for your choice of practice area.

- It offers broad experience.
- Theory component was most interesting.
- Enjoyed clinical experience.
- Offers a challenge.
- Prior knowledge of the area.
- Offers a chance to specialise.
- Received information from the employer.
- Influence of an individual tutor.
- Has always been my area of interest.
- Area of most recent clinical experience.
- Consolidation of experience.
- Other (please specify)______________________________

(For coding use ONLY)

21. Do you intend to continue your nursing education after graduation?
   1. Next year i.e. 1989
   2. The following year i.e. 1990
   3. In three to five years
   4. Sometime in the future
   5. Never

22. If you do decide to continue your nursing education, please indicate the course you would be most interested in taking.
   1. Advanced Diploma in Nursing (one year)
   2. Diploma in Nursing (Massey)
   3. Bachelor Degree (BA) in Nursing/Social Science
   4. Masters Degree (MA, MSc, MPhil)
   5. Short courses (such as Intensive Care)
   6. Other (please specify)______________________________
This question relates to your interest in psychiatric and/or psychopaedic nursing. Please complete 2 of the 4 responses.

23a. Would you choose to work in the psychiatric field in the next five years?
   a) If yes, why would you make this choice?

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

   b) If no, please indicate why you would make this decision.

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

23b. Would you choose to work in the psychopaedic field in the next five years?
   a) If yes, why would you make this choice?

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

   b) If no, please indicate why you would make this decision.

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
If you have any comments about this questionnaire, please feel free to write them here.

Thank you for your co-operation in completing this questionnaire. I hope that the data will be helpful for planning of future comprehensive nursing programmes. I will notify each Polytechnic when the results are available.

Please feel free to contact me if you have any queries.

Good luck for State Examinations.

Heather Forbes
Postgraduate student
Education Department
CANTERBURY UNIVERSITY
APPENDIX 3

Education Department
University of Canterbury
Private Bag
CHRISTCHURCH

7 November 1988

Dear

I understand that you have indicated to your Head of Department ......... that you would be willing to take part in some in-depth interviews with me, reflecting on your nursing education.

This research is part of requirements for an M.A. thesis in Education at Canterbury University. I wish to conduct these interviews to gain a better understanding of nursing students' experiences of their education. I believe that it is vital that such education is analysed from the point of view of you, the student.

As a participant in this research you will remain anonymous and all interview material will be confidential. Any written documentation will be such that individuals, clinical areas, and events will not be identifiable.

You will be fully informed of the nature and consequence of this type of research, and will be free to discontinue participation at any time. Your right to privacy will be respected so that you will be able to divulge as much or as little information as you yourself decide.

I realise that you are now facing State Finals. But, as I need to confirm just how many students are willing to be interviewed, I would be most grateful if you would contact me regarding this request at your earliest convenience. I can be contacted at the above address, phone 667-001, ext 8213 between 9 and 3 p.m. week days, or at my home, 113 Gayhurst Road, Christchurch 6, phone 852-679. We can then arrange to conduct the interviews at your convenience.

Thank you for your assistance, and the best of luck with your examinations.

Yours faithfully

Heather Forbes, M.A. Student
Department of Education
University of Canterbury