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**REFLECTIONS ON MEDICAL
POWER AND ITS INFLUENCE ON
NURSES' LEARNING FROM
CLINICAL PRACTICE**

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ABSTRACT OF THE STUDY

The starting point for this investigation into reflective practice in nurse education is the realisation that while reflective practice is increasingly dominating the nursing arena, there is still a great deal to understand about how nursing students learn/do not learn through reflection. In order for the students to become conscious of the oppressive forces that restrict practice, they need to reflect at the critical level because they become aware of the power relationships that constrain their practice. The literature review implies that the students are reflecting but does not provide clear evidence of students reflecting beyond the levels of descriptive and recalling feelings. Also, the literature does not disclose the factors that facilitate/do not facilitate reflection at the critical level. Thus, as a result of the literature review, an ethnographic approach was used to examine at what level the students were reflecting at; the reasons for reflecting/not reflecting at the critical level and whether the group process facilitated/hindered the reflective process.

The findings from this study reveal some evidence that most of the students' reflections on practice encompass reflection at the technical level of reflection. The reason why the majority of students do not reflect at the critical level is because they are not consciously aware that nurses are an oppressed group. Thus, the students fail to examine the origins of the nurse's subordination and how those in power perpetuate and extend their power base. In addition, the students do not explore the consequences of their oppressed status. The result of the nurse's lack of power is that nursing care is viewed as subordinate to medical cure. This lowly opinion of nursing care may be attributed to the notion that nursing care is seen as a natural extension of the female role in the home. Therefore, as nursing is linked with womanly virtues, this legitimises caring as low status. Furthermore, because nursing is labelled and undervalued in the health care system as a type of domesticated service thus, nursing is associated with the low opinion society has acquired in relation to caring that is socially constructed. Although nursing has attempted to raise the status of nurses through professionalisation and restratification, this has not resulted in nurses gaining more power. Restratification has tended to result in the perpetuation of a nursing hierarchy, in which an elite core of registered nurses undertake technical tasks that used to be the remit of junior doctors, but remain under the doctor's control whilst, assigning basic nursing tasks to the lower paid health care assistants.

The effect of this medical power is that many students reflect at the technical level because this embodies the doctors' knowledge base that is the dominant paradigm. The result is that some students fail to recognise that because they have internalised the medical model, they base their assessment of patients on labels, as well as being unaware that at times, they display a paternalistic attitude towards patients. In addition, the students fail to realise that carrying out care at the technical level does not always address, or solve the uncertain and unique clinical situations that the nurse is faced with on a daily basis, as well as failing to meet the individualised health care needs of the patient. Furthermore, the students do not recognise that when nurses use their power to implement patient-centred care, in which the nurse gains autonomy, the development of new practice knowledge based on humanistic and existentialistic aspects is attained. Therefore, the students in this study tend not to reflect at the critical level, because they are unaware how medical power constrains their practice.

INTRODUCTION

2.1 The factors involved in my decision to undertake my PhD

I first became aware of the idea of reflection in the early nineties when the pre registration courses at the nurse education centre where I worked became diploma courses. Thus, for the first time the course programmes used the term reflective practice. Similarly to myself, none of my colleagues on questioning appeared to understand what was meant by these words because none of us had heard of this term before. I assumed that the expectation of my senior nurse education managers was that my colleagues and I would introduce this concept to the diploma students, despite the fact that we had little or no knowledge of what was meant by the term. The reason for this thought was that this term seemed to have been introduced into the diploma course with no prior discussion or explanation of the term, to the tutors who were facilitating the students on this course.

However, as my working life was extremely busy at that time I gave very little consideration to the fact that I really should find out about what was meant by these words until one day I was asked to facilitate a reflective practice group for an hour as the students' usual tutor was off sick. I had no idea what was expected of me and asked my senior tutor for advice. The answer given was – *'Oh just get them to talk about their experiences from the clinical area and ensure that the discussion is not reduced to a general chat/moan about the ward'*. In retrospect I now realise that luckily for the students and for me that particular reflective practice group session was cancelled. I was relieved that the session was cancelled because I did not know how to reflect in a meaningful way. Therefore, I would have been unable to adequately facilitate reflection in the students.

In August 1994, I took up the option of early retirement/redundancy. On leaving my lecturer's post I decided to look for posts in nursing research. I did not have long to wait as the Nursing Times advertised a suitable post in October 1994. This post was based at a University and entailed the successful applicant joining a team of lecturers who were evaluating the use of groups to facilitate the development of reflective practitioners on a 2-

year part time post registration diploma course for nurses and midwives. I was successful in obtaining this post, which was to be of ten months duration with the chance that this period of time may be extended. The reason I wished to participate in this specific study was that the topic reflective practice interested me because this phrase appeared to be used loosely both within the content of nurse education courses and within the nursing press. Therefore, as reflection appeared to be a new concept I wished to understand more fully the meaning of this term.

When I commenced my post in April 1995, my first task was to write a literature review with a view to having this published. I duly spent time in a variety of local university libraries searching for the relevant literature using CINAHL and ERIC. I eventually narrowed the field down to an examination of the various methods used to promote learning through reflection on practice in the nursing and teaching professions. The reason pertained to the fact that the project's aim was to evaluate from the student's perspective how useful he/she found the reflective practice group in facilitating learning through reflection on practice. Also, in the early stages of the research I found that most of the literature concerning reflection was to be found in the educational journals.

In the meantime, in June/July/August 1995 I commenced interviewing the first cohort of 11 nursing students using a questionnaire, which had been devised by the project director and myself. In July, the project director applied for further funds so that my research post could be extended for another year. However, I was also asked if I wished to enlist for a PhD. I agreed readily, because by now my interest in reflective practice had gained momentum. I recognised that undertaking a PhD would be extremely useful, as I would have the opportunity to explore aspects of reflective practice, which interested me in more detail, but differed from the study that was currently being conducted by the research team. Thus, I duly enrolled for my PhD in June 1996 with the initial broad aim of exploring the factors that facilitate/hinder reflective practice.

2.2 National Factors

Whilst undertaking the literature search into reflective practice I realised that currently the process of reflection as a learning tool (Atkins & Murphy, 1993) was becoming increasingly prominent in nurse education (James & Clark, 1994). Some of the reasons for this rise in interest may be attributed to the changes that took place during the last two decades of the 20th century, both within the nursing profession itself and nurse education (Gobbi, 1995).

Gobbi proposes that the publication of Schon's work (1983; 1987) was timely because nurses as a group were actively seeking professional standing within the market place and required a viewpoint from which to act. Therefore, Schon's publications (1983; 1987; 1991) that had gained approval by the educational sector provided a tool, which could promote the reflective process and possibly the knowledge base of nursing. Larcombe and Maggs (1991) cite the work of Schon (1983) and Benner (1984) to support their recommendation that one of the key characteristics of a profession is the development of a knowledge base and this may be achieved through reflective practitioners. However, Gobbi (1995) argues that the implementation of Project 2000 in the late 1980's and the increasing development of Continuous Professional Education (CPE) also provided the impetus for reflective activities. Furthermore, the UKCC (1995; now the Nursing and Midwifery Council, NMC) contributed another incentive for reflective activity when they advocated mandatory updating for registered nurses. This could be achieved through reflection on practice. In addition, the movement of nurse education into higher educational establishments during the 1990's as well as the demographic changes in the population (eg growing percentage of elderly) provided the momentum for nurses to become reflective practitioners (O'Brien & Watson 1993) because reflection is perceived as a key concept in professional development (Burnard 1992; Ford & Walsh 1994).

On the other hand, this developing interest in reflection may be attributed to the increasing interest in women as an oppressed group (Annandale, 1998). Stacey (1988) identified a gender division within the health care system where nurses are a subordinate group in relation to doctors and according to Carpenter, 1993, Ford & Walsh, 1994 and Maslin-

Prothero & Masterton 1999), the new wave – mainly male – managers. Therefore, Taylor (2000; p148) suggests that '*emancipatory reflection*' is the cornerstone to providing nurses with a systematic way of critiquing the power relationships in their clinical areas. However, Taylor (2000), Lumby (1998) and Ford & Walsh (1994) argue that through reflection nurses become conscious of their oppressed status and are able to examine how those in power perpetuate the status quo. Furthermore, Taylor (2000) contends that reflection on practice enables nurses to question aspects of the repressive social contexts in which they work besides facilitating nurses to become knowledgeable doers who can change practice.

Therefore, in the light of this growing interest in reflective practice, some of the questions that need to be answered are:

- 1) What are the differing meanings of the term reflective practice?
- 2) What type of knowledge is revealed through reflective activity?
- 3) Do the nurses in this study provide evidence of their oppressed status through their reflection on practice?
- 4) Through reflection on practice are the nurses in this study able to provide evidence that they are conscious of the unequal power relations within their clinical areas?
- 5) What techniques are available to facilitate reflection?
- 6) How useful are these methods in facilitating reflection?
- 7) What skills are required by the practitioner in order to reflect?
- 8) What are the barriers to reflection?

CHAPTER 3

THE LITERATURE REVIEW

The literature review consists of two objectives. First, models and frameworks are to be reviewed alongside suggested techniques for promoting learning through reflection. Secondly, research pertaining to the use of the group process is to be considered and critically reviewed in order to evaluate if this technique actually does promote learning through reflection on practice. In order to unearth the research pertaining to these latter aspects, the educational and nursing and allied health databases (ERIC and CINAWL) from 1979 to 2002 were used.

3.1 Models and Frameworks

Most of the models (Schon, 1983; 1987; Zeichner, 1981; Zeichner & Liston, 1987; Fish et al, 1991; Pollard & Tann, 1993; Jaworski, 1994) depicted within the literature relate to the process of reflection and are based on key educational theorists' ideas such as Dewey (1933) and Kolb (1984). There are numerous models to be found within the literature but only 4 models will be discussed in this section in order to show the range of models that have been used to explain the processes of reflection, as well as depicting the variety of techniques that may be used to promote reflection within professional practice. The frameworks to be discussed are those of Schon (1983; 1987), the critical theorists, Zeichner (1981), Zeichner & Liston (1987), Boud et al (1985) and Johns (1994; 1998).

There are many reasons for choosing these models. Firstly Schon's and the critical theorists' models reveal the two main epistemological bases in which professional practice is assumed to be embedded. In addition their frameworks and especially that of Schon's have been influential because most other models used to promote reflective practitioners appear to be adapted from Schon's ideas. Although Schon and the critical theorists have gone some way in identifying the professional's knowledge base and have revealed some of the techniques used to develop knowledge, their models do not clearly identify the skills and specific processes involved in learning from reflection. It is the model of Boud et al (1985), which

clearly identifies the different phases of the reflective process and also reveals suggestions as to how specific skills may be developed during each stage. Lastly Johns's (1994; 1998) model is discussed because it incorporates Carper's (1978) ideas who suggest that many nursing actions are based on the practitioner's personal knowledge. In addition, Johns's guidelines can be used on a much smaller scale, for example in a one-to-one situation in a clinical area. Therefore, three of these models, those of Schon, the critical theorists and Johns highlight the differing knowledge bases that professionals use in their practice. Furthermore, all the models use a variety of methods to develop reflection such as diary entries and discussion within a group, or with another person.

3.1.1 Schon's Model of Reflection

Schon's (1983; 1987) model, proposes that reflection consists of 5 stages, which are knowing-in-action, surprise, reflection-in-action, experimentation and reflection-on-action. Schon suggests that during the first phase, the professional brings to the practice arena, knowing-in-action, which refers to the cumulative, tacit, knowledge of practice which is developed by the experienced, skilled professional, from different practice situations and which drives the individual's action. This knowledge-in-action is dynamic and situational and not easily reduced to rules and procedures and often - because this knowledge is intuitive - the practitioner is unable to make it verbally explicit (Adler, 1991).

It is the second stage, termed surprise, which acts as the trigger to set the reflective process in motion. Schon (1983) purports that reflection-in-action unfolds once the professional reacts with surprise to a routine practice, which does not provide the expected outcome. However, the third and fourth phases, termed reflection-in-action and experimentation, are interdependent because the professional thinks about the problem whilst in the midst of action and, at the same time the practitioner experiments in an attempt to deal with situations of *uncertainty, instability, uniqueness and value conflict* (Schon, 1983; p50). These two phases are important because whilst the professional is thinking on his/her feet, framing happens. In other words, the professional attempts to put meaning to the problem and, according to Schon, attains this by confronting the problem, deciding which features to

notice, the order to impose and the direction in which to try and effect change. Also, whilst doing this, Schon (1983) suggests that the professional may reframe the situation taking into account past experiences or previous knowledge and that this reframing, or a change in the meaning of the circumstances, is an attempt to make sense of a new and unusual situation. During these two latter steps interplay between framing, reframing, experimentation and dialectical backchat occurs. It is during reframing, that practitioners construct new knowledge about their practice settings. However, Schon (1983) does not clearly explain the steps in the process from framing to reframing or what actual skills are involved.

The last step, which Schon (1983) defines as reflection-on-action, is where the professional retrospectively, contemplates aspects of practice in order to uncover the knowledge used in a particular situation and to identify alternatives which may help solve problems.

Figure 1 Shon's Reflective Model

1] Knowing-in-action

Tacit knowledge, which drives our practice and which often, the practitioner is unable to verbalise

2] Surprise

Curious about some aspect of the clinical setting

3] Reflection-in-action

The practitioner frames the clinical problem in terms of the particulars of the setting and then may reframe that problem in the light of past knowledge or previous experience

Reframing is a critical point because the practitioner constructs new knowledge about practice

4] Experimentation

This reframing leads to an on-the-spot experiment such as altering the type of dressing on a wound which may form the basis for a plan for future action

5] Reflection-on-action

Involves looking back upon action with a view to exploring how they contributed to the outcome and if alternatives which may be implemented in the future, will effect change

Schon (1987) proposes that coaching in a clinical practicum is one method that may be utilised to facilitate reflection because it focuses on learning by doing. The aim of coaching is to promote dialogue among students and between coach and students in order to promote proficiency in reflection-in-action. Thus, the students learn by doing under the tutelage of experienced practitioners. In the practicum students are involved in experiences that simulate practice but which are relatively *free of the pressures, distractions and risks of the real world* (Schon, 1987; p37). So the students learn to recognise good practice, to build up images of competence and to think in the midst of acting.

However, there are some criticisms relating to coaching and the clinical practicum as advocated by Schon. For example, Greenwood (1993) suggests that pre-registration nursing students may find that the names and frames they learn in the practicum setting, may be less than adequate in the real world clinical setting and so the students may acquire a different set of names and frames within the clinical setting in order to deal with real situations. On the other hand, Munby and Russell (1989) contend that Schon does not identify *precisely what it is a coach does* (p74) despite the fact that he describes 3 models of coaching, e.g. '*hall of mirrors*', '*follow me*' and '*joint experimentation*'.

3.1.2 The Critical Theorists Model

In comparison to Schon's framework, which incorporates all levels and types of reflection, the critical theorists' model identifies three components of reflection, which imply a hierarchy of reflective activities. They use the work of Van Manen (1977) who proposes three levels of reflection, which, in turn, are derived from Habermas (1972). Gore & Zeichner (1991) refer to this model as consisting of a social Reconstructionist orientation because students learn the importance of reflecting across all three domains. However, Taylor (2000) contends that there are 5 key ideas encompassed in critical knowledge from which the critical theorists' model evolved. The first concerns *false consciousness* (p139), which relates to the individual and collective ignorance that members of a society may have about themselves and their organisation. Taylor (2000) suggests that many nurses working in bureaucratic organisations may relate to this concept because they fail to question oppressive

daily rituals, as they are unnoticed. The second key idea concerns *hegemony* (Taylor, 2000; p140) in which nurses perceive that there is little that they can do to change the power relationships in their work areas. The third relates to *reification* (p140) in which Taylor asserts that the rituals and practices of nursing are accepted and unquestioned. Thus, during critical reflection the power relationships, routine practice and why nurses believe they are unable to change their lowly position in the health service hierarchy need to be challenged so that change may occur. Taylor (2000) identifies the last two important ideas as emancipation and empowerment in which, through critical reflection, nurses gain the freedom to practice as the patient's advocate and to establish their worth within the health care team.

The framework utilised by the critical theorists consists of 3 levels namely, technical, practical and critical theory.

Technical level

This level is concerned with the methods needed to attain given objectives. Goodman (1984) argues that the value of these aims are not open to criticism and the methods in the main are limited to *what works* (Goodman, 1984; p17) in order to be efficient and effective. An example of this level is that the nurse figures out the best way to proceed with the drug round so that there are no interruptions whilst handing out prescribed drugs.

Practical or Reflectivity level

This level implies the need to assess the techniques by which the professional achieves the objectives as well as examining the consequences and implications of both action and beliefs (Goodman, 1984). At this level, reflection goes beyond questioning what technique is efficient at attaining goals. Instead, the professional examines how certain choices of practice are constrained and influenced by institutional, social and historical factors (Adler, 1991). In addition, he/she may look for the hidden meanings within the practice context, as well as focusing on the relationship between nursing/teaching ideology and practice (Goodman,

1984). Goodman argues that at this level of reflection, it is not enough to give a reason for an action, such as the implementation of primary nursing will enhance patient care. Instead, the professional needs to assess how traditional and environmental factors within the practice area, as well as other people's beliefs may constrain/facilitate the implementation of primary nursing. Zeichner and Liston (1987) argue that, at this level, the professional goes beyond a consideration of what works efficiently and effectively - he/she considers how every action is linked to specific, value commitments and so the practitioner thinks about the worth of competing, educational objectives.

Critical Reflection

The third step, critical reflection (Hatton and Smith, 1995) as well as including thinking from the previous two levels, also incorporates reflecting on the moral, ethical, cultural and political contexts. At this level, the professional becomes critically aware of how and why his/her assumptions about the world in which he/she operates, limit and distort his/her understanding of him/herself and his/her relationships. This is termed transformation (Silcock, 1994; Burnard, 1985) through which the practitioner reflects on decisions and whether or not his/her professional action is equal, just, honest and respectful of persons or not (Hatton and Smith, 1995). Principles such as justice, equality and emancipation are used as criteria in reflecting on the value of goals and practice (Goodman, 1984). Zeichner (1981) and Zeichner and Liston (1987) argue that, at this level, critical reflection involves questioning the taken for granted, learning to make decisions based on ethical and political consequences and an awareness of the alternatives. In other words, reflecting on whether to continue with/switch off a life support system, for a patient who is in a consistent, vegetative state is an example of critical reflection, which takes into account the legal, ethical/moral and political implications of the consequences of that action.

Zeichner (1981) incorporated this model into a teacher-training curriculum with the aim of preparing teachers to view knowledge and situations as problematic and *socially constructed rather than as certain* (Zeichner & Liston, 1987; p26). The techniques which the latter used to develop reflective teachers were firstly, students were expected to take an active role in

curriculum development, not simply to implement ideas and aims developed by others; secondly, they were required to do a project (such as action-research, ethnography or curriculum analysis) which would involve them in critical analysis; thirdly, they were expected to keep journals which students used for self reflection and to initiate discussions with their university supervisors; lastly, supervision and seminar involvement were used as techniques so that the students were able to consider the long range effects of teaching practices as well as examining their own assumptions and socialisation (Zeichner, 1981).

3.1.3 The Reflective Learning Model

The reflective learning model (Boud et al, 1985) also involves three levels. These are interrelated and cyclical in nature and their framework depicts some of the affective and cognitive processes involved in reflection. Besides an explanation of their model, Boud et al (1985) provide suggestions during each stage on how to promote the skills required for reflection. During the first phase termed '*returning to the experience*', they propose that the student is given a set period of time in which to record the sequence of events that happened during the experience, either in a diary or by talking to another person. This enables the student to return to the experience and give a descriptive account of the thoughts and feelings provoked during the initial event. Similarly, in the second stage, termed '*attending to feelings*,' Boud et al (1985) propose that the student describes his/her positive and negative reactions and emotions of the event either in a diary or to another person. However, in order for the student to adequately assess the experience any negative feelings need to be resolved. Therefore, Boud et al (1985) suggest that cathartic interventions or meditative techniques can be used to help work through these negative emotions, which can create a barrier to learning.

The third level, termed '*re-evaluating the experience*' is more complex than the previous two steps as it consists of four stages. These are association, integration, validation and appropriation. These four phases represent the process of reflection. Therefore, the skills required to re-construct the events that occurred during the experiential phase in order to make sense of them are more complicated and abstract than during the first two levels. Boud et al (1985) mention several different techniques that may be utilised to facilitate progress

through the association phase; free association, group brainstorming, writing, drawing and tape recording are proposed as methods that will help to link ideas and feelings with existing knowledge and attitudes. In the integration phase the techniques suggested are brain patterns (Buzan, 1982; quoted in Boud et al, 1985; p32) concept maps (Novak, 1977; quoted in Boud et al, 1985; p32) or venn diagrams (White, 1982; quoted in Boud et al, 1985; p32) so that thoughts and feelings can be related in order to gain new insights. In the third phase - the validation stage - rehearsal of how to put the plan into action or guided imagery and role-playing activities are proposed so that experimentation and modification of new ideas and feelings become authentic.

However, during the last or appropriation phase, which involves creating a personal understanding of the experience, no methods are proposed. Boud et al (1985) propose that the synthesis, validation and appropriation of knowledge are outcomes as well as being part of the reflective process. Furthermore, they suggest that the clarification of an issue, the development of a skill or new perspectives on experience or a change in behaviour and the resolution of a problem are all possible outcomes of the reflective process.

Figure 2 Boud et al's Reflective Learning Model

PHASE 1 – Experience: Behaviour, Ideas and Feeling

PHASE 2 – Reflective Processes: Returning to the experience, Utilising positive feelings, Removing obstructive feelings, Re-evaluating experience.

PHASE 3 – Outcomes: New perspectives on experience, Change in behaviour, Readiness for application, Commitment to action.

3.1.4 The Model of Structured Reflection

Johns's (1994; 1998) model of structured reflection (MSR) has developed over several years and differs from the previous frameworks in some respects. Originally, the structure evolved as a natural sequence through which practitioners examine their experiences in supervision (Johns, 1994) and is used in combination with other techniques such as diary structure. Johns (1998) proposes that the original model (see figure 4) is a heuristic device that did not prescribe how to reflect. Instead, the model's intention was to enable the practitioner to work out the meaning of reflection by actually living through the experience in such a way that the student could learn from the experience. In addition, the questions within the MSR (see figure 4) are based on grounded theory (Johns, 1994) in which the professional is encouraged to divide the description of the experience into events, causal and contextual. Johns (1998) discovered, however, that the latter interfered with the practitioners as they were revealing their stories. Therefore, he has developed a series of reflective cues (Johns, 1998; see figure 5) that reflect the cognitive, affective and temporal aspects of the experience, as well as enabling the practitioner to focus on the fundamental ways of knowing as identified by Johns (1994) and Carper (1978). The idea is that the practitioner begins to comprehend the way in which the personal, ethical and empirical ways of knowing have informed the aesthetic response. In addition to these 4 patterns of knowing, a fifth way of knowing was added termed *reflexivity* (Johns, 1998; p7) in which he asserts that

Reflexivity acknowledges that an experience is not an isolated moment but part of a continuous flow of experience over spatial and temporal time. As such an experience is always a reflection of past experience that anticipates future experience... this is a fundamental learning process, of making sense of the present in terms of the past, with a view towards the future.

The reason why Johns encompassed Carper's (1978) ways of knowing is because the latter are of equal importance and together influence the way in which the nurse practices. For example, '*empirical*' includes facts and principles, which form the basis of hands on care (Shepard and Jenson, 1990). This may be equated with Schon's (1983) concept of technical rationality (Johns, 1995) in which the known interventions of elevation, compression and ice may be used to help decrease pain and swelling of a soft tissue (Shepard and Jenson, 1990).

Personal knowledge on the other hand, relates to the understanding of self in relation to practice. Vaughan (1992) provides an example of how self-awareness may help the practitioner to understand the barriers that may exist in practice. She argues that for example, the practitioner may need to come to terms with his/her own mortality in order to prevent difficulties when caring for a patient who is terminally ill and dying. Ethics involves making a judgment as to what is right or wrong in a given situation such as euthanasia or abortion. In contrast to the previous three types of knowing, aesthetic concerns the varying types of appropriate and skilled interventions that may be used in response to events occurring in the clinical area. Schon (1987) reinforces the aesthetic concept when he talks of the expert who is surprised by an event and calls on a range of past experiences in order to be able to plan a new course of action that does not always appear to make sense initially.

Figure 4 Model of Structured Reflection (Johns 1994)

Core question - What information do I need to access in order to learn through this experience?

Cue questions-

1.0 Description of experience

1. Phenomenon Describe the 'here and now experience'
2. Causal What essential factors contributed to this experience?
3. Context What are the significant background factors to this experience?
4. Clarifying What are the key processes (for reflection) in this experience?

2.0 Reflection

1. What was I trying to achieve?
2. Why did I intervene as I did?
3. What were the consequences of my action for?
 - Myself?
 - The patient/family?
 - For the people I work with?
4. How did I feel about this experience when it was happening?
5. How did the patient feel about it?
6. How do I know how the patient felt about it?

3.0 Influencing factors

1. What internal factors influenced my decision-making?
2. What external factors influenced my decision-making?
3. What sources of knowledge did/should have influenced my decision-making?

4.0 Could I have dealt better with the situation?

1. What other choices did I have?
2. What would be the consequences of these choices?

5.0 Learning

1. How do I *now* feel about this experience?
 2. How have I made sense of this experience in light of past experiences and future practice?
 3. How has this experience changed my ways of knowing?
 - empirics?
 - aesthetics?
 - ethics?
 - personal?
-

Figure 5 Revised Model of Structured Reflection (Johns 1998)

Write a description of the experience.
What are the significant issues I need to pay attention to?
Reflective cues:

Aesthetics

What was I trying to achieve?
Why did I respond as I did?
What were the consequences of that for-
The patient?
Others?
Myself?
How was this person/s feeling?
How did I know this?

Personal

How did I feel in this situation?
What internal factors were influencing me?

Ethics

How did my actions match my beliefs?

Grid for considering 'How did my actions match my beliefs?'

Patient/family perspective	Authority to act	The doctor's perspective
Conflict of values?	The situation/dilemma	Ethical principles?
The nurses' perspective	Power relationships?	The organisation's
perspective		

What factors made me act in incongruent ways?

Empirics

What knowledge did or should have informed me?

Reflexivity

How does this connect with previous experiences?
What would the consequences be of alternate actions for;
The patient?
Others?
Myself?
How do I now feel about this experience?
Can I support myself and others better as a consequence?
Has this changed my ways of knowing?

The similarities between all 4 models are that all have been used in research studies and all suggest that their frameworks help practitioners to reflect into the experience in a structured and meaningful way. Likewise three of the models (Johns's, Schon's and the critical theorists') depict methods to facilitate an epistemology of practice. However, the type of knowledge to be elicited differs in that Schon stresses practitioner knowledge gained through experience in the practice setting, whilst the critical theorists highlight the significance of analytically applying technical knowledge as well as focusing on the connections between the practice area and the social and political contexts in which it is embedded (Gore & Zeichner, 1991). On the other hand Johns's model concentrates on unearthing personal knowledge in order to develop therapeutic skills and knowledge.

3.2 Critique of the Models

There are several aspects, which are open to question, and these centre on the levels of reflection; knowledge and skills and the students desire to reflect.

3.2.1 Levels of Reflection

The first criticism relates to the levels depicted in Schon's, the critical theorists' and Boud et al's frameworks. Schon's model appears to include all levels of reflection (Hatton & Smith, 1995) whilst the critical theorists and Boud et al mention elements/domains which they maintain are not distinct and unrelated but are interrelated and that the student does not proceed linearly through each element/domain. This assumption that the student may reflect at any stage at any one time is questionable because the skills required suggest a hierarchical basis. For example, at the technical and returning to experience level the professional uses practice know how and descriptive skills, whilst at the re-evaluating, critical, and reflection-in-action stage, cognitive skills such as critical thinking and analysis are used. These lower order skills of achieving competence on how to do something and describing the features of a situation need to be mastered before the higher order skills of analysis and synthesis are acquired (Stephenson, 1985).

Another confusing aspect relating to the differing levels concerns the fact that Boud et al (1985) appear to utilise Mezirow's (1981) ideas into their model. Mezirow believes that when the professional consciously recognises that his/her assumptions limit and distort his/her understanding of him/herself and his/her relationships then the professional has become transformed. However, Mezirow suggests that there are two paths to transformation. The first is sudden insight and the second in which the professional proceeds slowly through a series of transitions, of which Mezirow depicts seven. However, Boud et al's three elements do not clarify the issue of Mezirow's levels of reflection and whether the student reflects at just one level or at different levels during the reflective process. In addition, the model does not show how these levels can be facilitated or address the connection between the cognitive processes and levels of reflection as illustrated by Mezirow. A further factor which adds to the lack of clarity relating to these three elements, is that Boud et al mention that the *capacity to reflect is developed to different stages in different people* (p19) and they state that *it may be this ability which characterises those who learn effectively from experience* (p19) - yet they fail to explain what they mean by this statement.

3.2.2 Forms of Knowledge

There are some criticisms concerning Schon's (1983) knowledge-in-action and reflection-in-action. Munby and Russell (1989) contend that it is difficult to follow how reflection-in-action happens because Schon's written analysis fails to make clear the relationship between the components of experience and the elements of cognition. In addition, Greenwood (1993) argues that Schon never precisely defines what he means by *naming and framing* (p1186). She suggests that 'name' is a conceptual label and that frame is *a more complex and inclusive conceptual structure into which the labelled concept fits* (p1186). Greenwood contends that her explanation of the terms name and frame contributes meaning and adds coherence. However, Greenwood does not explain what she means by a more complex and inclusive conceptual structure.

On the other hand, Greenwood argues that, through socialisation, the nurse's knowledge-in-action may differ from that of espoused theory, in that nurses may learn that nursing care

consists of getting through the workload at any costs and according to ward routine, instead of helping clients to maintain their individual optimum state of well-being, through the use of appropriate research findings, nursing models and an individualised problem solving approach to care. In addition, Greenwood suggests that nurses may not recognise the detrimental effect this ethos of getting the work done at all costs may have on client care.

There are several researchers e.g. Munby & Russell (1991; quoted in Schon 1991) and Clarke (1994) who have explored Schon's framing and reframing concepts, in an attempt to reveal the development of professional knowledge of teachers - yet - these studies, similarly to Schon's, fail to adequately explain the aspects which relate to practice experience and those which concern the cognitive and theoretical features, during the framing and reframing process. The question here relates to how can this process of reflection-in-action be adequately explored and explained - because - it appears that most of the research involved in unearthing this practice knowledge, relies heavily on verbal reports and these according to Greenwood (1993) are bound to fail because practitioners may only report espoused theories and not what they actually do in practice.

However, Munby and Russell's research (1989) does show that puzzling about a problem leads non-logically to a different question. They propose that this shift is prompted by the events of the action and by the professional coming to see them differently - but they stress the fact that the professional does not realise this change. For example, Munby and Russell reveal that Nancy's (research participant) reflection-in-action problem is where to go for reliable information on classroom management. Initially this is framed as looking for information in authoritative sources such as books, workshops or lectures. A month later, Nancy reframes the problem in terms of her own experience in the classroom - Nancy is more willing to rely on her own experiences rather than authoritarian sources, but Nancy is unaware of this change. So how can the professional become conscious of their learning through experience? Boud et al (1985) contend that it is this consciousness that allows the practitioner to make active and aware decisions in practice.

A second questionable feature to be considered relates to the knowledge gained through reflection-in-action and that acquired through reflection-on-action. All of the models, with the exception of Schon's, focus on knowledge that is gained retrospectively. Munby & Russell (1989) believe that when reflection consists of looking back at an action some time after it has taken place, a portion of professional knowledge is overlooked - that part which resides in practice - reflection-in-action. So is there a difference between the type of knowledge obtained retrospectively and that attained whilst simultaneously reflecting and doing? Taylor (2000) proposes that in nursing whether reflection-in-action is really possible is considered a debateable point because of the need to act quickly within a complex situation (Clinton, 1998).

The third puzzling aspect concerns the fact that Schon (1983) proposes that often a professional is unable to give reasons for his/her action. For example, Schon (1983) stresses that the knowledge base for reflective practice is grounded in the professional's appreciation system (i.e. values, theories and practices). He also suggests that this knowledge is tacit. In other words the professional uses perceptive knowledge based on experience and very often is unable to give a reason for his/her action. Yet, Schon (1983) assumes that through reflection in practice the professional will learn new knowledge about how to effectively and competently solve problems which are not able to be solved through a technical rational approach. The point to be made here is how does the professional learn new knowledge when he/she is unable to articulate this tacit knowledge? Schon (1991) mentions the notion of the reflective turn in that it is the researcher who attempts to unravel the things that practitioners say and do - with the result - that in order to discover the sense in someone else's practice, the researcher questions their own. However, Schon's idea relating to the reflective turn still does not appear to adequately explain the processes involved, when the professional gains new knowledge through experience.

It is possible that Benner's (1984) work into intuitive skills may provide a partial explanation as to how nurses learn new skills/knowledge? Her research reveals that intuition appears to be an essential aspect of clinical judgement and it is this intuitive skill that distinguishes expert human judgement from decisions made by beginning nurses. In other words, this

tacit/intuitive knowledge belongs to the expert nurse. Using Dreyfus's model of skill acquisition that comprises six key aspects in intuitive judgement, Benner's (1984) research shows that to gain this expertise, which enables the nurse to make lifesaving /effective decisions, the nurse may pass through 5 levels of proficiency –novice, advanced beginner, competent, proficient and expert. Her study reveals that the novice is rule bound when faced with unfamiliar situations but it is at the expert level in nursing that the real change occurs. Benner (1984) contends that the expert nurse views the situation holistically and is no longer reliant on principles such as procedural books, nursing models etc to make clinical decisions. The expert draws on past concrete experience and hunches to make sophisticated, clinically sound judgements. Thus, Benner (1984) suggests that it is the expert nurse who notices the subtle signs of improvement or deterioration in the patient and this expertise is based on tacit knowledge that is embedded in their practice. The expert nurse knows how to make decisions without necessarily being able to express the theoretical knowledge of 'knowing that'. Despite the fact that Benner reveals the different stages through which the nurse may progress to become expert she does not appear to show how the nurse gains knowledge. However, Benner's work highlights one important point and that is to question why it is that some nurses become expert whilst others do not move beyond the novice stage. Johns (1998) contends that the practitioner who fails to consider the unique context of a situation and responds in a routine and habitual way can never be described as an expert despite the fact that he/she may have 20 years of experience (Benner, 1984).

Rolfe (1998) on the other hand, argues that there are limitations to Benner's ideas. He proposes that one of the main problems is that Benner believes that the expert nurse is unable to justify his/her decisions and this is due to an *unknowable intuitive grasp* (Rolfe, 1998; p25). The result is a form of elitism in that the expert is never wrong as well as being safe from attack because his/her expertise is inexplicable. However, Rolfe contends that Benner is wrong to suggest that the intuitive process cannot be explained and he suggests that the latter may only be appropriate for advanced motor skills. Rolfe asserts that professions such as nursing, which rely on advanced cognitive abilities in order to make on the spot decisions, require practice that is based on conscious reflection in action which means that the nurse moves beyond expertise to become what he terms the reflexive practitioner. He also suggests

that the latter formulates and tests his/her own personal theories in a continual spiral. Thus, Rolfe's reflexive practitioner is able to acquire and generate knowledge so that he/she can justify his/her clinical decisions, but in comparison to Benner's expert nurse, the reflexive practitioner can provide a reasoned argument as to why he/she acted in the way he/she did.

Another aspect to be considered, relates specifically to the knowledge base of the critical theorists' model. Hatton and Smith (1995) contend that the latter framework fails to identify a suitable knowledge base for helping beginning students to understand the concepts of reflection, and then to apply the more complicated forms to their practice. Hill (1989) also argues that it is difficult to identify what type of theory is necessary for reflection within the three levels as posited by the critical theorists. He suggests that at the practice and critical stages, the learner requires knowledge of school effects and cultural differences as well as an understanding of the major, analytical theories of power in society. Hill believes that this theory is required in order to reflect and explore the inequalities that exist within the educational sector such as racism, sexism and discriminatory, prejudiced, stereotyped curriculum materials.

On the other hand, Hill suggests that the introduction of a more school based preparation for new teachers may have a detrimental effect on the development of the learner's knowledge base because reflective activities are limited to the technical level where, through the apprenticeship scheme, students learn how to teach by copying the expert teacher. At this level the student does not question the inequalities that exist within education and neither does the student develop self-awareness or an understanding of the why of teaching. Thus, it can be determined that government policies such as the introduction of a school based approach to learning how to teach, is an attempt to reduce theory input and critical reflective activities because these policies specifically focus on exploring methods which facilitate teaching and learning at the technical level only.

In comparison, Day (1993) points to the fact that because very little is known about how the professional gains knowledge through the reflective process thus, it is not possible to know if the practitioner has gained empowerment in which the professional views his/her practice

within the wider social, cultural, political and ethical context. Similarly, James and Clark (1994) argue that, because reflection is an intangible topic it is difficult to judge whether a person is reflecting and whether a change has been effected. One of the students in Jaworski's (1994; p38) study supports these ideas as he (Nolder) maintains that he found it difficult to observe change within himself because he couldn't see it. However, the student was able to explain that over a period of time he became conscious of the change within himself but Jaworski fails to explain how this change occurs possibly, because, the student was unable to provide an adequate explanation.

The last feature to be reviewed is the epistemological base of Johns' framework. His model incorporates the views of Carper (1978) who proposes that nurses utilise four types of knowing; that of empirical, aesthetic, personal and ethical that need to be balanced and integrated. However, Chinn and Kramer (1991) argue that if one aspect of knowing is emphasised more, in relation to another, this can create the potential for bias. For example, an emphasis on empirics can result in control and manipulation whilst, too much personal knowing may result in isolation and self-distortion whereas, too much aesthetics may produce prejudice and injustice and too much ethics may result in rigid doctrine and insensitivity to the rights of others.

Johns (1994), however, does identify some of the difficulties appertaining to the use of his model when eliciting the differing types of knowledge especially that of personal knowing. He argues that practitioners may not recognise the significance of their own personal knowledge and may only value research based knowledge. Moch (1990) supports this latter perspective as she contends that eliciting personal knowing is fraught with complications because of the abstract and personal nature of the concept. In addition, she suggests that because the nature of personal knowing is phenomenologically based, so practitioners may not perceive it as important as the scientific aspect of nursing.

Johns (1994) cites other complications pertaining to the use of his model. He suggests that practitioners may just answer the series of cue questions encompassed within his framework and fail to give a holistic view of interpersonal encounters within the clinical field. In

addition, Johns believes that some practitioners may have limited perceptions of how they view themselves and their work and would prefer to stick to routine and ritual practice rather than confront the fact that in order to change obsolete practice requires reflective activity which is dependent on a questioning attitude and commitment.

3.2.3 Type of Skills

None of the models explicitly explain the type of skills required in order to reflect in and on practice. Yet, implicit in the models is the fact that descriptive; critical thinking, analytical, synthetical, evaluative and self awareness skills are required in order for the practitioner to learn from the reflective process. For example, descriptive skills mean that the professional is able to describe the prominent events and key features of an experience (Boud et al, 1985) as well as giving the thoughts, feelings and reasons for the situation (Jaworski, 1994).

However, Newell (1992) suggests that the individual's cognitive structures affect the reconstruction process. He maintains that how the professional reacts to stress and difficult interpersonal interactions, as well as the length of time since the event and the mood of the individual practitioner, may all contribute to a decrease in memory performance. Thus, the professional may not provide an accurate account of the practice problem. Another factor, which may influence the practitioner's recollections of events, is hindsight bias (Jones, 1995). Jones' findings are contentious because although the nurses in his study did show evidence of hindsight bias - in that they made sense of what they thought had happened, rather than analysing the data independently - it was not possible to differentiate between whether the bias was due to the doctor's influence because they provided the provisional diagnosis, or due to the fact that the nurses knew the outcome, that is solely hindsight bias.

However, Johns (1998) opposes the latter criticisms because he believes that what is important is the meaning the practitioner gives to the situation not the description. Also, Johns (1998) contends that if the interpretation of the experience is distorted, that is not significant because it is the reasons as to why the situation has been misrepresented that need to be examined.

In comparison to descriptive skills, critical thinking involves recognising the assumptions underlying the professional's beliefs and behaviours, challenging those assumptions and exploring different perspectives. In other words, critical thinking is crucial to understanding personal relationships, and envisioning alternative and more productive ways of organising the work place and becoming politically aware (Brookfield, 1987). In addition, critical thinking consists of analysis (Pollard & Tann, 1993), which encompasses inductive and deductive thinking (Stephenson, 1985). Inductive thinking is where the professional makes a generalised assumption from a specific example e.g. as primary nursing provides effective quality care in the intensive care unit, so this type of nursing may provide quality care in any nursing speciality. Deductive thinking moves in the opposite direction from generalisations about a phenomenon to a specific example. Through analysis, synthesis occurs which is the integration of new knowledge with previous knowledge. However, in order for critical thinking, analysis and synthesis to happen requires self-awareness so that the professional recognises how this sense of self influences professional beliefs, and practices (Pollard & Tann, 1993). Also, an understanding of these personal beliefs is necessary if the professional is to change action in the direction of a more desired objective (Pearson & Smith quoted in Boud et al, 1985; p74).

One factor that may affect the use of these latter skills is that reflection is perceived as an academic pursuit, therefore, the professional may not value reflective activities (Hatton & Smith, 1995). The practitioner may prefer to make excuses that because he/she perceives teaching and nursing as the immediate present and instant pragmatic action thus, he/she does not have the time, energy or commitment to reflect on the decisions made within the practice area, with colleagues (Johns, 1994; Fitzgerald, 1994). Similarly, Zeichner (1990) suggests that the student's lack of experience and their differing values relating to technical skills and reflective activities may affect the reflective process. For example, Zeichner (1990) contends that the students may view reflection as an esoteric and useless diversion, in which they can utilise the time allocated to reflective activity more effectively in mastering the necessary technical skills required to survive in the practice areas. In other words, students concentrate at the technical level of reflection.

The points raised from the latter discussion concern whether some students are capable of reflecting only at the technical level during their initial professional training or do some students critically reflect and examine how teaching and nursing ought to be practised? Do they require all the skills mentioned in order to learn from reflective activities and how are these developed?

3.2.4 The Student's Intent

Boud et al (1985) propose that the intention of the student is the most important factor in the learning process because this desire to learn overcomes many implicit, obstacles and inhibitions. One of the assumptions within Boud et al's model and implied within all the frameworks mentioned is that it is the student who directs reflective activity. Thus, it may be assumed that the student directs the type of situation to be reflected on, as well as influencing the way in which the experience is reflectively processed. Boud et al also mention Habermas' (1972) idea of critical intent which assumes that the student who has the disposition to reflect also has the ability to utilise differing forms of reflectivity when reconstructing an aspect of social and moral concern in order to achieve enlightenment and emancipation. However, Boud et al fail to describe in adequate detail the characteristics of this disposition i.e. the student with critical intent. The question is - what constitutes this disposition to reflect? Do all professionals possess it or does it have to be developed?

Zeichner and Liston's (1987) revelations may throw some light on what kind of disposition is required in order to reflect. They base their ideas on Dewey's (1933) and suggest that certain attitudes such as whole heartedness, open mindedness, a sense of responsibility, commitment, energy and a willingness to learn are required for reflective activities. Wholeheartedness involves energy and enthusiasm and the maturity and the ability to balance idealism and realism so that the professional does not feel threatened by the scrutiny of reflection (Dewey, 1933). However, despite being wholehearted about reflection Hatton and Smith (1995) argue that the practitioner may feel vulnerable about exposing his/her weaknesses to others and, to protect him/herself from anxiety, the professional may attempt to think him/herself into a situation less frightening than the one he/she is actually

experiencing. Thus, the consequence of this tactic is that the professional limits his/her awareness of the experience (Sundeen, 1989) and the experience presented for reflection may be lacklustre and non problematic, or may be omitted completely from the practitioner's reflective repertoire (Newell, 1992).

In addition to wholeheartedness, open mindedness and a willingness to learn, listening to others, trying to see a situation from another practitioner's perspective (Fitzgerald, 1994), attempting not to feel threatened even when other people exhibit threatening behaviour (Pollard & Tann, 1993) and a willingness to challenge one's own personal assumptions, prejudices and ideologies as well as that of others are also required for reflective practice (Johns, 1998). On the other hand, a sense of responsibility enables the practitioner to explore the results and implications of clinical action (Goodman, 1984) as well as a search for meaning within a situation (Dewey, 1933) However, Boud et al (1985) contend that often even if the student is willing to learn this may not happen because the student does not always progress smoothly through each stage to the re-evaluation stage. They suggest that the reasons may be due to the fact that the student may have evaluated the experience at the time of the experience and thus not see the need to re-evaluate the situation. Secondly, they argue that emotional barriers may occur which may prevent the student's progress through the reflective cycle. Fitzgerald (1994) supports this latter idea of Boud et al's as she contends that the plethora of emotions such as fear, suffering, distress, relief and disgust which students deal with in the clinical situation may prevent them from learning through the reflective process. The question here is are there emotional barriers to reflection and if so what are they and are there any other problems that may affect reflective activity?

3.3 Techniques/Methods used to promote Reflection

Within each model, various techniques are described such as the use of different writing methods e.g. diaries, journals and logs as well as individual and group discussions (Johns, 1998; 1994; Boud et al, 1985). However, some research studies into the methods that are used to promote reflection on practice appear to use these writing techniques as a pivot to instigate discussions with either another person (Lyte and Thompson, 1990) or within a group

(Durgabee, 1996; Brommeyer, 1994). Despite the fact that the latter studies use diary entries as well as discussions to facilitate reflection the authors only report on the diary entries and fail to examine the discursive elements of reflection on practice.

Although there is a dearth of research which investigates the use of these writing and discussion techniques, that which is available in the main tends to concentrate on the student's evaluation of these methods. In addition, some of the research fails to examine if the students really are reflecting beyond the stages of description and attending to feelings. Most of the models seem to provide less detail about how to promote reflective learning through the critical thinking, analytical, synthetic and evaluative stages. However, Boud et al (1985) suggest using journals and diaries during the description of the experience stage and returning to the experience phase; whilst during the re-evaluation stage they suggest techniques such as brainstorming, venn diagrams, concept maps, guided imagery and rehearsing; and Gore and Zeichner (1991) propose the use of a written action research report to provide evidence of reflective learning. On the other hand, it does seem that group discussion and questioning (Johns, 1998) feature more as the student progresses through the stages of learning.

However, Johns & McCormack (1998) argue that reflection should always be guided and it is the nature of this coaching which is of interest, yet there is very little research that has been located which looks specifically at this process. It is possible that where research has been conducted into techniques for promoting reflection it tends to concentrate on the use of writing techniques rather than on methods such as discussion and group work where the guidance advocated by Johns & McCormack (1998) may be taking place. The reason may be because the discussions need to be observed/tape recorded and this may provide a barrier to reflection.

3.3.1 Group Discussion

Discussion groups have often been described as places where students can interact in an informal environment, which is instrumental in relating theory to practice and developing

insight into themselves and their practical experience. Thus, groups are perceived as providing a suitable environment to enable students to develop professionally and personally. In addition, the dialectical nature of discussion enables the group members to view a situation from multiple perspectives and see alternatives to their thinking which are vital elements of reflection (Wade, 1994).

Franks et al (1994; p1164) using the ideas within the personal construct theory suggest that groups may be effective in promoting learning because *the individual nurse would be more likely to experience conceptual change when faced with the construct systems of others*. Miller et al (1994) and McGill and Beatty (1995) contend that groups are a powerful way of providing support and challenge that students need, to push them to learn from experience and to move on to the later stages of the reflective learning cycle. Additionally, Snowball et al (1993) suggest that group work allows for the public testing of ideas and assumptions leading to greater learning.

Yet, some of the research reviewed actually only reported on the use of diaries/journals despite the fact that the latter initiated discussions within a group. There are calls for the development of reflective practitioners through the establishment of groups but there are very few studies devoted to how effective group discussions are in facilitating reflection. In the main, the literature involves descriptions of group dynamics (Lindsey et al, 1976; Nelson Jones, 1986), ideas on how to run effective groups (Ogborn, 1994; Gandy & Jenson, 1992; Brockhaus et al, 1981), how to maintain group direction (Daum, 1993), how to create nursing work groups (Davis and Cox, 1994) the factors which promote or provide barriers to effective group functioning (Anderson, 1993), how to use an action learning group to reflect on clinical practice (Graham, 1995) and the use of an individual reflective written assignment that was discussed in a group session (Mountford & Rogers, 1996).

Lyte and Thompson's (1990) pilot study of 16 post basic RMN students concentrates on reporting the findings from diary recordings despite the fact that the aim of these diary entries was to form a pivot from which the student and teacher/mentor could evaluate problem-solving activities, re-negotiate clinical learning objectives and provide feedback at regular

intervals. Lyte and Thompson's findings support Burnard's (1988a) results that if the students tried to catch up by recording the observed interpersonal encounters in the diary at the end of the week, those students found it difficult to recall the events and, these students found the process of diary writing as being of less value than those who made regular entries. Moreover, some students required help initially to complete the diaries. However, their results fail to comment on the student/teacher discussions and the impact that this may have had on the student in attaining his/her objectives.

Durgabee's (1996) survey of 110 post registered nurses examined the impact of a diary and group discussions in relation to whether the student valued reflective practice. The diaries were used to guide group discussions that were facilitated by Durgabee and were held for 2 hours every week for 6 weeks. His findings reveal that the diary acted as a conscious-raising process in that some of the students learnt to perceive their practice in a different way and gained insight into nursing theory so that they were able to challenge their own philosophies and prejudices. In addition, the students questioned their practice, which, led to an increase in dialogue in an attempt to penetrate the complexity of clinical situations, and, the students increased their listening and observation skills. Although, Durgabee encouraged the students to use the diary entries as a focal point for discussion during group meetings, his findings appear to consider the impact of the diary only and he fails to reveal the effect of these group discussions on reflective activity. Also, it would have been useful to know how much and the type of experience these post-graduate students had gained and if any of the students had not found the experience of diary keeping useful.

Brommeyer's (1994) study explored reflection on action (praxis) through the medium of journaling and group discussion in graduate nurses at a children's hospital. The aim was to see if reflection actually did assist the students to develop in four previously, identified areas relating to role development. These areas were professional, paediatric, personal and clinical. The results indicate growth in all these areas but some students complained that journal writing was very time consuming. However, the students met for an hour per month to participate in-group reflection where problem solving was facilitated. Brommeyer attributes this development to the activity of journaling and similarly to Durgabee does not consider the

impact of this group work.

Goodman (1984) used a case study approach, to examine the seminar experience of students in an elementary teacher education programme that emphasized the importance of reflection, over a six-month period. There were 5 seminar groups and students were randomly assigned to these groups. Goodman selected eighteen students from one seminar group after taking their life histories. Her sampling technique appears confusing because Goodman states that these 18 students formed the primary sample group. She also indicates that other students were included within the sample, but Goodman fails to adequately describe the other participants within her study and does not reveal clearly which group of students were observed and interviewed. Furthermore, although Goodman states that she interviewed the students on a weekly or bi-weekly basis she does not say for how many weeks.

The data from Goodman's study was analysed using Glaser and Strauss's (1967) constant comparative method. The results reveal three different types of educational role of the seminar - the liberal, the utilitarian and the analytical. These roles were dependent upon the ways in which the group members and the facilitator defined the seminar's goals and how the latter acted upon their interpretation. However, these various approaches within the seminar did affect the kind of reflective activities that occurred. For example, if the seminar was perceived from a liberal point of view in which the students were encouraged to be unique, creative, positive, warm and flexible in their teaching and not to use threats and corporal punishment, this did occasionally encourage reflection. Goodman suggested that if the seminar encompassed this liberal role the students' reflective abilities represented the first level of Van Manen's (in Goodman, 1984; p17) notions of reflection; in that the students concentrated on what worked and did not explicitly analyse the reasons why it worked i.e. they did not examine why creative teaching was effective. They took it for granted that creative teaching worked. Similarly, if the seminar was seen from the utilitarian stance in which the students' reflective activities centred on the students' needs on how to efficiently organise the day's teaching activities and control discipline - this also promoted Van Manen's first level.

In comparison, Goodman suggested that when students questioned the value of what was occurring within their teaching placements, or raised educational problems and analysed the underlying principles implications and issues, this meant that the seminar took on the analytical role. Goodman proposes that this latter stance represented Van Manen's second and third levels of reflection because the students demonstrated reflective abilities, which focused on the relationship between educational principles and practice as well as analysing ethical and political issues relating to education. However, Goodman's research indicates that in the main the seminars tended to emphasise the utilitarian approach and her study also implies that the existence of a seminar component within a particular programme does not necessarily mean that reflection will result. On the other hand, although Goodman implies that there is a group and facilitator effect, these could have been explored in more detail.

In comparison to Goodall, Franks et al (1994) set up discussion groups for 9 student nurses undertaking a pre registration certificate course during the first two wards of their clinical placement, with the intention of exploring if these reflective, discussion groups actually improved interpersonal communication. These discussions were to be informal and were held on a weekly basis for a period of six months. The aim of the group was for the students to focus on the nurse's interpersonal relationship with their patients. However, Franks et al's study had three objectives. For example, the team explored the relationship between intrapersonal roles; the constructs in relation to patients; the changes that may occur through sharing constructs with other members of the group and the processes that occurred during the lifetime of the group. The repertory grid was used before and after the two placements in order to explore the changes that may have occurred in interpersonal skills whilst, Glaser and Strauss's (1967) hypothesis-generating process was used specifically to answer the third objective which, was to examine the group processes over time.

The results described the group's development over time. For example, during the first half of the group's lifetime the group members were uncomfortable and uncertain about their roles. In addition, they kept asking about the purpose of the group. Furthermore, the students revealed avoiding and defensive behaviour, in that they did not attend meetings and avoided discussing sensitive issues by either laughing or talking anecdotally about their clinical

placements. By comparison, during the second half of the group's lifetime the group members renegotiated the format of the group meetings from unstructured to a more structured approach, in which specific topics like body image etc. were discussed. During these structured meetings the atmosphere was more relaxed, attendance improved and there was much more personal disclosure. Also, members still discussed many interpersonal issues and became more certain about their roles as student, group member and nurse. Thus, in the light of these findings Franks et al suggest that the effectiveness of this type of group discussion appears to be reliant on the provision of a balance between structure and space. This possibly means that the group required more structure to their group sessions in order to disclose personal feelings concerning the emotional burden of nursing (Smith, 1992).

On the other hand, it is unclear from the study whether or not the students' interpersonal skills as measured by the repertory grid changed or not. However, the authors argue that the results may be a feature of either the early stages of group development or the early part of pre registration training as a reaction to stress and anxiety. If students do need a more formal structure in order to exploit these kinds of learning opportunities this, would seem parallel to the findings from the review of the use of the diaries where, it was also found that many learners needed instruction in how to use such techniques (Lyte & Thompson, 1990).

Wade (1994) investigated the factors that motivate undergraduate teacher students to participate in class discussions concerning reflection. Data was collected by questionnaire and open-ended interviews. 227 students completed the questionnaire, whilst only 30 students were interviewed. Data analysis included frequency distributions on each item within the questionnaire and correlations between the two groups of items e.g. one group concerned interest and enjoyment of speaking whilst the other set reflected the difficulties and problems with speaking. In addition, ANOVA and *t*-tests were computed to assess any difference among student 'talk' scores due to age, school, programme area or gender. The findings suggest that men and older students of both genders had higher talk scores and a greater belief that their contributions were important. Whilst the younger female students had lower talk scores and did not believe that their contributions were important. However, Wade does not provide the results of these statistical tests within her report and it is not possible to

deduce if there is a definite gender or age difference in talk scores.

The interview data was analysed following the exploration of the questionnaire data in an effort to corroborate and elaborate on the questionnaire results as well as identify negative evidence and opposing explanations. The findings reveal that there are problems as well as benefits. The main complications encompass personal issues, classmates' action and the teacher's behaviour. Personal problems relate to a lack of confidence in the worth of their own ideas, fear of potential judgement, or criticism and difficulty in expressing ideas whilst, other members' action that would prevent students from speaking pertained to rude and annoying behaviour, rambling off the topic, dominating the conversation and arguing with, as well as not listening to, another person's viewpoint. On the other hand, the teacher's behaviour that would deter the student from talking concerned interrupting or cutting off a discussion, dominating the session, making a fool of someone, ignoring student comments, and not being open to students' ideas.

However, one of the interventions that would encourage students to participate in discussions was choosing a suitable discussion topic, which supports the findings of Franks et al (1994), because if students were interested in and knowledgeable about the topic, they were more likely to contribute to the subject area. In addition, students were more likely to speak if a caring climate was fostered, in which students felt the teacher cared about them as people and the other members of the group valued their ideas and gave encouragement to each other's viewpoints. The last step, which would induce participation in the conversation, was giving the students the opportunity to prepare the topic in advance. Although Wade's research does not reveal if the students actually reflected during discussions her research does give some indications as to what facilitates/does not facilitate discussions.

Similarly to Wade, Richert (1990) investigated reflective conversations; though her research examined how a reflective conversation with a partner, (who was another student teacher) and not within the group situation, facilitated reflection in novice teachers. This technique was compared with three other methods. However, Richert only examined and reported on two techniques. Thus, she was unable to conclude which method provided the most effective

way of facilitating reflection. Richert's sample consisted of nine student teachers and the data was collected by questionnaire and interviews after a partner had observed the participating student's teaching once, during the week, and after tape-recorded conversations between the student teacher and partner had been carried out. Richert states that these audio taped dialogues provided the data for exploring these partner conversations. Yet, the evidence provided within the results section appears to comprise data from the interviews only. As well as reflective dialogues between the novice teacher and partner, the latter also observed the teacher, teaching on at least one occasion during the week and, it appears that this observation period was used as the pivot to facilitate reflection on practice during the student's conversation with his/her partner. The results revealed that the participants saw this observation component as an important and valued component of the partnership. The reasons given were that observation establishes rapport, provides a common framework through which reflection can take place; provides feedback and validation of the research participant's own reflective activities; and provides a different viewpoint.

In addition, to these results pertaining to the value of peer observation, Richert's findings possibly provide some evidence, pertaining to which specific structural, aspects of a reflective conversation with teaching peers were found to be particularly important in facilitating the reflective process. For example, the results showed that having the time to reflect; having safety in which roles and expectations were clearly defined so that the teacher could reflect without fear of criticism and judgement; having a partner to observe the teacher teach, which provided a broader and different perspective of teaching; having a partner who was knowledgeable about subject matter, teaching and in facilitating the reflective interview; and having a legitimate opportunity to talk about their teaching, all helped in the reflective process.

There are several aspects relating to Richert's research that need to be considered in more detail. Firstly, the number of participants within Richert's study was small being only nine in number, but she does state that because of the small sample size these findings may not represent the views of the larger population of novice teachers. Another questionable aspect concerning Richert's study is that despite the fact that she tape-recorded these conversations

and suggests that reflective conversation enhanced reflection; she fails to provide evidence to show that these student teachers actually did learn through their practice. This is possibly due to the fact that the observation period and reflective conversations were only carried out over a very short period of time i.e. a week. The third feature of Richert's study is that she stated that one of the aims of her research was to compare the four techniques. Yet, she only reports the results from two of the methods - that of the discussion between the student teacher and partner and the portfolios. Furthermore, she fails to compare these two techniques and only provides evidence concerning the student's valued aspects of each. On the other hand, parts of her analysis does provide compelling evidence that possibly guided conversations if skilfully exercised, may be a more powerful technique than either diaries or journals in developing analysis and understanding of classroom events. Fifthly, it is also interesting to note that some students suggested that it would be even more useful to obtain a wider range of perspectives than that obtained in one-to-one conversation thus, providing an argument in support for group work, which could further enhance learner opportunity, through enabling the student to consider differing viewpoints about his/her own experience. Lastly, the findings show that having an observer also helped with reconstructing the practice situation which, may address some of the concerns of Newell (1992) and Jones (1995) about recall problems due to anxiety and hindsight bias.

Similarly to Richert's study, which examined the reflective dialogue between two people, Fish et al's (1991) analysis explored the effect of a reflective dialogue between the student and one/two others. However, in comparison to Richert's exploration of the dialogue between two students of equal status, the dialogue in Fish et al's study was between two/three people of unequal status i.e. between the student and a supervisor and/or class teacher. The dialogue similarly to Richert's study followed a period of observation in the practice area, of the student by the supervisor. The method used to collect the data was by observation and interview. Also, Fish et al created their own framework using the ideas of Schon (1983) through which they analysed the data for reflective levels. Their research participants consisted of four student health visitors and four student teachers; and the dialogue was between students and supervisors i.e. between both a health visitor student and a community practice teacher (CPT); or between a student teacher and a college based supervisor and class

teacher. Therefore, the discussion following the observation period was either between two people of differing status i.e. CPT and student health visitor or three people of differing status i.e. student teacher, college supervisor and class teacher.

The results of the health visitor student's dialogues in which the student health visitor reflected on the observed community nurse's practice, indicated opposite outcomes to Richert's findings. The conversations revealed what Fish et al termed *lost learning opportunities* (p36) in which the chance for the student to integrate theory with practice, to establish levels of knowledge, to respond to student's questions and to follow up topics that related to practice was missed. Furthermore, Fish et al contend that the discussions represented the factual strand of reflection because they were mainly descriptive, recalling events and processes in the clinical situation and concentrating on the here and now. Also, client behaviour was examined rather than the issues surrounding practice. One of the reasons for these findings according to Fish et al may be related to the fact that in health visiting the debriefing sessions are held in informal settings away from the practice area which, may have induced the health visitor student to engage in informal talk and not concentrate on reflective activities.

Similarly, the results from the student teachers' discussions with the college supervisor and the class teacher immediately after observation did not differ very much from those of the student health visitors. Here, the exploration of the conversations showed that there was no previously agreed agenda so roles and relationships were not clarified. There was no clear idea of how to commence the debriefing session and the student often became the receiver of direct teaching, advice and simple criticisms. In addition, there was lack of knowledge on how to reflect and how to enable students to reflect. The reason for these results, according to Fish et al, may be attributed to the fact that the supervisors were under pressure of time as they carried out these conversations either at the end of a morning or afternoon, or during break/lunch time. Furthermore, because the student teacher was in discussion with two others of differing status, they may have competed with each other in terms of credibility, knowledge and importance instead of promoting the student's reflection on practice. The results of this study, in terms of lost opportunities, suggest that the problem may be attributed

to the idea that some supervisors do not understand or value the knowledge to be gained through the reflective process, as well as lacking the facilitation skills required to develop the students' reflective abilities, rather than be attributed to any inherent problem with the approach used.

In contrast to Fish et al's study, part of a small study by Snowball et al (1994) identified some of the factors required in order to help small group peer discussions be effective in promoting reflection. One aspect of their research examined the potential of using reflection as a tool for learning and for enhancing professional education. One of the techniques used to enhance this process was a group discussion in which three dissertation supervisors met on a fortnightly basis to discuss the more experiential components of supervision. However, besides this method, they also recorded their meetings with their dissertation student in a diary and these diary accounts formed the basis for the subsequent reflective group discussions. The data for analysis was the tape recorded discussions and individual written accounts of dissertation supervision meetings with students. Data analysis centred on codes and categories and major themes were identified.

The findings indicate that because the group members were able to communicate critically, openly and supportively in a safe environment, they were able to self disclose their weaknesses and their strengths. Also, each member within the group was given time during the meetings to discuss their reflections and when appropriate the speaker was encouraged to reflect further. On the other hand, within the group there was a tendency to dwell on what the authors had not done well - weaknesses rather than strengths. However, Snowball et al propose that the group process did benefit them because it helped them to reflect and to link theory to practice. Though they do point out that the outcome may have differed if the group dynamics had been different. The outcome in this case was the development of a framework for dissertation supervision and the study focuses on this outcome rather than provide evidence pertaining to how reflection facilitated the authors to arrive at this outcome. Additionally, Snowball et al propose that the discussions provided evidence of episodes of Schon's (1983) reflection-in-action and reflection-on-action – yet, nowhere within the study is there evidence of Schon's framing and reframing aspects. Also, when quoting data within

their report, Snowball et al do not identify the sources of their data that is - whether it relates to the tape-recorded discussions between the three lecturers or to the diary entries.

Shields (1995) examined if there was any evidence that student nurses were developing reflective skills and if they were learning through reflection after following a Common Foundation Programme (CFP) for one year. Eleven students participated in the study. However, the researcher was the student's personal tutor and she assumes that because of this, the rapport with the students was good. Shields assumes that this rapport led to a more effective and complete data collection. She fails to consider problems such as the fact that the students may provide her with the answers that they think she wants because of her status in relation to the students.

The methods used to facilitate reflective activity were journal submissions and debriefing sessions. The journal entries related to each of the five clinical placements during the CFP and also formed part of the assessment strategy for the nursing part of the course. However, these journals were also used as the focus for the debriefing sessions between the student and supervisor, which occurred at the end of each of the five clinical placements. Data was collected by tape recording a semi-structured interview but Shields does not inform the reader when this interview was undertaken. Analysis was carried out through exploration of themes.

The findings reveal the initial list of themes which were then grouped together where possible to produce major themes such as journal writing; debriefing; mental previewing; students values, perspectives, decisions and moral dilemmas' concerning reflection. Besides these themes, Shields also depicts the reflective skills the students developed during their first year of training. These she identifies as self-analysis, critical knowing, behaviour changes and problem solving skills. Although Shields does provide some evidence of problem solving skills and the behaviour changes the students intend to change at some time in the future - she does not give examples of self analysis and critical knowing skills and neither does she reveal how the students developed these skills. In order to explore if students are developing reflective ability the research possibly needed to be undertaken over a period

of time e.g. interview the students at the beginning of the year, six months later and at the end of the year in order to eliminate the fact that these students may already have possessed these skills when they entered nurse training. A further questionable aspect of this research is that the evidence reveals student opinion about the value and usefulness of the journals and debriefing sessions. The results do not depict the effectiveness of journals and debriefing sessions in facilitating reflection and neither do the findings show/not show if the students are learning through reflection, which was one of the main aims of the research.

The last research article to be considered is Sebren's (1995) which is one of the few pieces of research, which examines how practice knowledge is developed in teachers through the medium of reflective practice sessions. Sebren explores seven pre-service teachers' reflections and knowledge development during a field based physical education methods course and considers the potential influence of reflective experiences on the pre-service teachers' development. The teachers' reflective activities were facilitated through reflective sessions, which were designed as a component of the course and were scheduled weekly, outside classroom hours and throughout the length of the semester. Sebren's primary role within the course was to facilitate the reflective sessions. The data was obtained by audio taping the weekly, reflective practice sessions. Also, three individual audiotape interviews were undertaken during the early part of the semester; the middle of the semester and, at the end of the semester. Data analysis used the grounded theory approach as described by Glaser and Strauss (1967).

Results reveal that firstly, three of the group of seven teachers changed their view of classroom management from control for survival to an understanding of management related to learning in which they linked specific aspects of their lessons such as organisational patterns, spatial concerns, equipment distribution and the amount of time the teacher spent talking with their ability to provide quality practice time, to observe and give feedback. Also, she identified the fact that these same three teachers who changed their view of classroom management had not yet developed their knowledge of the subject matter as a whole. They viewed the latter as pieces of information that are more or less conceptually isolated.

Whereas Sebren suggests that the remaining four teachers already possessed this knowledge

of classroom management and entered the semester being able to plan lessons taking into account the students' past and future learning experiences. However, by the end of the semester the former three teachers' knowledge matched that of the latter four in that they were able to conceptually link at different times and to different degrees their content decisions to past and future learning. The third aspect revealed that initially all seven teachers did not possess an understanding of how the children respond to their choice of words for directions and tasks. However, at the end of the semester all teachers began to recognise the effect of their words on the children's ability to understand as well as the effect of that connection on the lesson. Lastly, Sebren suggests that what the students did not develop was pedagogical content knowledge, which involves an understanding of how children respond and what they would have to do to help the children learn what they were trying to teach.

Thus, Sebren's findings imply that three of the pre-service teachers' knowledge progresses from disconnected ideas about classroom management and subject matter to more integrated understandings. Whilst her study reveals that four of the pre-service teachers already possessed integrated comprehension of classroom management and subject matter at the beginning of the semester - yet, Sebren does not provide evidence of whether their knowledge increased even further within these areas by the end of the semester. It possibly would have been useful to know if these four teachers acquired further knowledge than the other three because it appears from the report that Sebren actually compares the development of reflective ability between these two groups of teachers especially in relation to knowledge pertaining to classroom management and subject matter. On the other hand, Sebren does not really address the issue of whether these reflective sessions helped these teachers to develop knowledge from their practice, because she has not included any data from the reflective sessions within this report, which may possibly have revealed some of the impact of these reflective sessions on practice knowledge development.

3.3.2 Discussion

The studies reviewed often assume that students are reflecting (e.g. Shields, 1995; Richert, 1990) yet, do not clearly state at which stage of the reflective cycle the students are reflecting. Also, they do not always provide adequate examples of the learning that is taking place (e.g. Shields, 1995). There appears to be little evidence of students reflecting beyond the descriptive, recalling situations and feelings, level. Sebren's (1995) study is one of the few pieces of research which explores the development of practice knowledge, but Sebren does not reveal the level at which the pre-service teachers are reflecting. The findings from her data imply that the pre-service teachers are reflecting at the technical level because they gain knowledge of methods required to meet given objectives. Sebren's research is useful because it shows some of the topics that pre-service teachers reflect on. However, the reader is unable to conclude from the results, whether the group reflective sessions facilitate learning because Sebren does not include data from the tape-recorded reflective groups. She includes data from the interviews only, which means that other aspects from the course might have influenced the students' learning.

In comparison, Fish et al's (1991) study appears to be the only piece of research, within this review on conversations/group discussions, that examines the level at which the students are reflecting. Their research is valuable in that their results show lack of learning opportunities, possibly due to the fact that the supervisors do not possess knowledge of the reflective process or of how to effectively facilitate reflective discussions.

What the research into group discussions appears to demonstrate mainly, are some of the factors that may possibly have an effect on reflective activities. For example, Fish et al (1991) identify lack of skills in the facilitator as a problem, whilst the style of the facilitator may possibly influence the level of reflection that students engage in (Goodman, 1984). Additionally, the stage to which the group develops or the stage of training (Franks et al, 1994) may have an effect on reflective activity because the more mature or experienced practitioners appear to be more confident in talking (Wade, 1994) and more willing to disclose strengths and weaknesses (Snowball et al, 1994). Other aspects, which may

influence learning through reflection, are teacher/facilitator and classmate's behaviour and the place where the discussion is to take place (Wade, 1994; Fish et al, 1991).

A third aspect to consider relates to journal/diary entries and the observation periods, which preceded the discussions as well as forming the focus for the discussions/conversations (e.g. Shields, 1995; Richert, 1990; Snowball, 1994), yet, there is no evidence to show how these have an effect on the discussions that ensued. In addition, most of the research does not reveal how group discussions or conversations with one/two others of either equal/differing status facilitated reflection. What seems to be reported was the student's perceptions and opinions about the usefulness of these various techniques.

Another feature concerns the fact that some of the researcher's assume that because the students participate in these group sessions, reflection is taking place, yet, the evidence within the reports does not provide adequate support for this assumption. For example, Snowball et al (1994) state that within their discussions there was evidence of reflection-in and on action, yet, nowhere in their study do they provide evidence for this, despite the fact that the aim of the study was to explore the effectiveness of reflection as a learning tool. The reason may be possibly due to the notion that Snowball et al may not have provided data from their discussions, because within their report they do not identify where the quotes come from i.e. the tape recorded discussions or the individual reflective written accounts of dissertation group meetings with students.

This problem concerning the differing types of data collection appears to be a trait of some of the research articles because although some studies tape recorded group discussions they did not appear to use this data in the analysis section and only appeared to examine data from interviews e.g. Sebren (1995); or as in the case of Snowball et al (1994) and Shields (1995) did not identify the source of their quotes e.g. interviews and/or discussions.

The sixth aspect pertains to the setting up of the group/supervisory sessions and group dynamics, as some of the research (i.e. Richert, 1990; Shields, 1995; Snowball et al, 1994) do not describe in detail how these were facilitated, what the facilitator's role was in relation to

the students; what were the ground rules and how these were set. In addition, none of the reports considered the group dynamics and the effect these may have on reflective activity.

The last feature relates to the lack of critical analysis within the studies as most with the exception of Fish et al (1991), appear to report their findings uncritically and neither do they report the limitations of their studies. For example, the authors could have examined if they could have improved the sampling, methodology, data collection and analysis aspects in order to obtain the aims of their research. Additionally, some research papers do not report on all aspects of research milieu. For instance, Richert (1990) did not report on the different conditions within the design and neither did Franks et al (1994) provide the repertory grid findings after a group intervention. Thus, it is difficult for the reader to establish whether there was a change in interpersonal skills as a consequence of group intervention.

3.3.4 The Research Question

The literature review reveals several models that explain the differing levels of reflection. However, the studies show little evidence of the students' reflecting beyond the descriptive, recalling situations and feelings or technical level. Therefore, this study will explore the factors that facilitate/do not facilitate the students' reflection beyond the technical and practical levels because at the critical level of reflection, nurses become conscious of how the power relationships within the health care service may constrain their practice. Critical reflection may also result in praxis whereby the means for change are sought through collaborative processes that challenge the dominating effects within the health care system (Taylor, 2000) This praxis enables the nurse to have autonomy as well as become the patient's advocate (Taylor, 2000). Therefore, this study will also examine whether the students have autonomy in practice as well as investigating whether they question the daily oppressive routines and rituals that are present in nursing practice (Taylor, 2000).

Many of the studies reviewed used discussion groups to facilitate reflection as well as the utilisation of diaries. However, some of their findings failed to comment on the impact these discussions may have in facilitating/not facilitating reflection (eg Durgabee, 1996; Brommeyer, 1994). In addition, the setting up of the groups was not described and neither

was the facilitator's role discussed in relation to the students (eg Shields, 1995). Also it appears that the group members (eg Snowball et al, 1994) or the group facilitator (eg Brommeyer, 1994) decided which topics were to be reflected on prior to the group discussions. Therefore, it was decided that self directed groups would be set up in order to analyse the effect the empowering group process may have in facilitating/not facilitating reflection on practice.

The last aspect to consider is the knowledge the students reveal during the reflective practice group discussions. Sebren's (1995) study is one of the few reports that identifies the type of knowledge developed by teachers during reflection on practice, whilst many of the nursing studies fail to highlight the kind of issues discussed during group discussions. Therefore, this study will examine the type of clinical problems the students reflect on and what knowledge and skills they gained through the process of reflection and the diploma course.

CHAPTER 4

METHODOLOGY

Introduction

Reflection in and on practice is a human experience shaped by our past, the present and what we wish to achieve in the future. It is conceptualised in our thoughts and expressed in our language and action, besides being an experience that is moulded by the social context within which it occurs. In other words, knowing in practice is a constructed knowledge that comprises subjective, holistic and contextual knowing (Johns, 1998a). Therefore, subjectivity rather than being a hindrance is extremely important if I was to gain an understanding of the learning that occurs through reflection within the practice context. The knowledge to be constructed from this study was from the practitioner's own personal experiences and expressions. Hence, the epistemological approach was an important consideration in order for me to gain a true picture of the student's construction of their clinical practice through reflection on practice.

4.1 Epistemology and the Feminist Influence

Epistemology is a philosophical consideration of knowledge that explores the origin, development and limitations of knowledge, as well as the differing criteria by which knowledge is accepted (Meleis, 1985). Sociological epistemology evolved from the Enlightenment an 18th century movement based on the ideas of reason and rationality (Annandale, 1998). These early social scientists' knowledge that was rooted in rationality and reason meant that they uncovered the reasons for inequalities besides viewing the world in terms of a fixed and natural binary opposition to each other like male/female, reason/emotion and working class/middle class (Annandale, 1998). However, Riska (1993) contends that none of the early, mainstream sociological accounts of professions and professionalisation addressed Stacey's (1988) argument that there is a gender division within the health care system. For example, Walby et al (1994) propose that most sociological

studies relating to management in the health care system presume that they are dealing with two groups (doctors and managers) and fail to consider nurses who comprise a large proportion of the work force and expenditure in the health system. Riska (1993) argues that the dominance of the medical profession in research on the health labour force derives from the positivist perspective that, according to Parker (1991), Comte developed from the work of Descartes in the 19th century. This positivist framework does not take into account the historical legacy, under which the doctors became a profession and neither does this paradigm explore the power struggle that resulted in the medical division of labour and its hierarchy (Riska, 1993). In addition, positivism failed to examine the concomitant subservience of other health-care occupations (Parry & Parry, 1976). It was not until the challenge to male domination in the 1970's by the feminists who emphasised women's invisibility that gender in social research gained in prominence (Annandale, 1998). As the feminist movement gained momentum, it was increasingly obvious that women's experience could not easily be explored (Annandale, 1998) through the current *public* (Edwards & Ribbens, 1998; p1) and *androcentric* (Mies, 1993; p65) dominant, research paradigm of positivism (Rolfe, 2001).

Positivism as a research methodology is derived from the natural sciences that underpin the hypothetical-deductive methodology (Vaughan, 1992; Parr, 1998; Rolfe, 2001). The researcher looks for evidence to test hypotheses and this leads to the assumption that there is a single, tangible reality that everyone defines in the same way (Parr, 1998). One of the problems with the positivist approach to research is that meanings, motives, feelings and emotions are unable to be observed or measured in an objective way (Parr, 1998). In addition, positivism stresses researcher objectivity that requires the researcher to exclude his/her own values from the research arena (Renzetti & Lee, 1993). Thus, the positivist research method ignores the humanistic aspect of the human respondents in the research process besides being intolerant of ambiguity (Reinharz, 1988).

Currently, researchers have drawn from the work of Habermas and others from the Frankfurt school of thinking (Vaughan, 1992; Mies, 1993) to present a new post-positivist paradigm based on hermeneutics that is termed constructionism (Rolfe, 2001). This epistemology, in

comparison to the positivist perspective does not seek an objective reality (Bergen, 1993) but searches for the meaningful construction that people use to make sense of their situations and create realities because truth resides in the minds of people (Rolfe, 2001). Instead of the rational, detached, value free characteristics of the positivist paradigm (Bergen, 1993), constructionist research considers the physical, psychological, social and cultural context that forms the respondent's constructs. Also, this approach comprises respect for people's dignity, integrity and privacy besides treating them as equal partners in the research process, rather than subjects of an experiment or objects of the study (Bergen, 1993).

4.1.1 Locating Self/Subjectivity

This study is concerned with understanding the social and cultural context of the nurses' reflections on practice. Hence, feminist research principles were applied because they were important in raising consciousness (Reinharz, 1988) of the effect of structured, gender inequalities within the health care system (Stacey, 1988). Thus, I needed to recognise that as the researcher I was a *variable* in the research process, because I would be bringing my own life experience to this research, besides structuring what the research is about (Edwards, 1993). The whole research process is subject to *double subjectivity* (Lewis & Meredith, 1988; quoted in Edwards, 1993; p177) because it comprises the characteristics and biases of the researcher as well as the research participants' perceptions of the research and researcher (Edwards, 1993).

Bias is an essential element of the positivist paradigm and because I chose not to conduct my study within this epistemological framework it became less significant. However, bias was unavoidable in this research and the difficulty was how to recognise and accept it besides incorporating it into the research process. By using an ethnographic methodology I hoped to establish *intersubjectivity* (Taylor, 2000; 176) with the students with whom I conducted the research, in order to create research that considers the students' experiences as female nurses (Bergen, 1993). Thus, I did not ignore or minimise this subjectivity because its presence may be used and understood as part of the research process (Edwards, 1993).

Negotiating my subjectivity and bias besides being attentive of all facets, effects and subtleties of the research required reflexivity. Many authors, especially the feminists emphasise the importance of reflexivity within the research process (Hammersley & Atkinson, 1983; Edwards & Ribbens, 1998). Reflexivity is the critical self-awareness of the situated self in the research process that is attained by a process of self consciously turning back one's experience of oneself (Mauthner & Doucet, 1998) that is termed the *reflexive turn* (Edwards & Ribbens, 1998; p4). Thus, in order to unravel the sense in someone else's reflections on practice required uncovering and questioning my own tacit practice, including my self-imposed limitations (Schon, 1991). Furthermore, reflexivity comprises the exposure of one's own role within the research process, through the continual self-questioning of the nature and assumptions of the knowledge being produced (Edwards & Ribbens, 1998). In addition, reflexivity involves constantly comparing and contrasting my interpretation of the data, against other data and findings to find similarities and differences (Edwards & Ribbens, 1998). Hence, the way in which this research was conducted and produced tells a story as much about myself as well as the students I was researching (Birch, 1998). Birch (1998; p172) succinctly describes this reflexivity that informs a sense of self as

A journey into the research process from the theoretical exploration at the outset 'going there', and the participation in the field, 'being there', to the final stages of analysis and writing up, 'being here' ... this final stage 'being here' becomes a personal private space even though seeking to create a more publicly acceptable story for the sociological audience ... the dilemma of producing sociological knowledge from the stories of others remains both a personal and public dilemma.

One way of solving the dilemma of producing knowledge from the stories of the students within this study was to be reflexive, honest and explicit about the reasoning procedures used in carrying out the research process (Edwards & Ribbens, 1998; Edwards, 1993).

Furthermore, I questioned whether the theories being used were representative of the students' narratives as well as exploring whether they were being organised in a logical sequence.

4.1.2 Own Voice Representation

The issue of voice is contentious mainly because it is used without adequately defining the meaning (Mauthner & Doucet, 1998). Mauthner and Doucet argue that rather than grappling with the issue of voice, the researcher needs to recognise the dynamic and fluid quality of the stories that are being told and understand that the respondent makes choices about what to emphasise and what to hold back. In addition, Mauthner and Doucet propose that the analysis stage is important because it has the potential to decrease or amplify the respondents' voices. They contend that there is a contradiction between the feminist principle of representing the research respondents' voices on and in their own terms and the recognition that it is the researcher who ultimately shapes the entire research process and product. Therefore, by using an ethnographic approach I hoped to ensure a balanced representation of my voice, the variety of voices of each of the students that I interviewed and who participated in the reflective practice groups and the voices and perspectives represented within existing theories in my research area and those that I brought to the study (Mauthner & Doucet, 1998). Thus, instead of using the students' stories to substantiate my theories, the theory was derived from the data.

On the other hand, as the research progressed I became aware of Stacey's (1988) contention that I needed to move beyond the descriptive and anecdotal to expose and challenge the nurses' oppressive status within the health care system. Edwards and Ribbens (1998) contend that researching the largely hidden and subordinated ways of being (like nurses reflecting on their practice within the health care system) requires considerable sensitivity. Also, Edwards and Ribbens (1998) argue that another challenge arises when the researcher attempts to represent and translate these private subservient ways of being into the terms of academic discourses located within the public domain. Thus, I required an approach that moved beyond the feminists' emphasis of the centrality of *women's subjective experience* (Annandale, 1998; p62) within the research process to the use of analytical categories that generalise beyond the individual case.

4.2 Ethnographic Methodology

The reason I used an ethnographic approach was because it would enable me to construct a theory that highlighted the ways in which the students' knowledge about their practice and its constraints is located within social activities and systems of socially, constituted meanings. Therefore, I required a design that focused on the students' views of their activities and the meanings that the students ascribed to their clinical practice.

Ethnography has a multitude of definitions like

The inductive research approach for in-depth investigation of a culture, in which data related to the members of the culture are collected, analysed and described. (Dempsey & Dempsey, 1992; p314)

However, Grills (1998; p199) defines the ethnographer as

One who writes about people.

Grills (1998), proposes that the ethnographer is the storyteller who attempts to represent the respondents' views while writing for an audience who usually comprises those outside the community being studied. The position of the ethnographer according to Grills is a privileged one because the voice he/she adopts influences the questions asked of the data and what aspects are to be presented and what issues are silenced or neglected. When the researcher uses the ethnographic approach, the writing of the story is social as well as being reflexive (Grills, 1998).

Besides my research incorporating Grills's (1998) ideas of a reflexive, social story, my study also integrated the assumptions that Hammersley (1998) identifies as being distinctive of ethnographic research. For example, this study was carried out in a naturally occurring situation, in that the reflective practice groups were not set up specifically for the research, but were an integral part of the students' diploma course (see appendix 1). In addition, I was not an observer during the reflective practice group sessions and neither did I record these group discussions. The two group facilitators recorded the sessions. This minimised researcher effect on the behaviour of the respondents during the group discussion and

hopefully, as argued by Hammersley (1998), increased naturalism in order to develop the chances that the findings may be generalised to other settings that have not been researched.

Understanding is an important feature of ethnographic research hence the researcher requires knowledge of the cultural perspective, in order to explain human actions that are culturally based (Hammersley, 1998). The fact that I was a qualified nurse may be both valuable and problematic, because, being familiar with the culture of nursing may lead me to assume that I already know the respondents' perspectives. The way to overcome this misunderstanding was to ensure that I used qualitative methods to collect the data, so that I familiarised myself to the different ways in which nurses view their working situation.

The last characteristic of ethnography, according to Hammersley (1998), is the conception of the research process as inductive thinking rather than being limited to the testing of explicit hypotheses. I began my research with minimal assumptions as well as an interest in reflective practice that Hammersley proposes maximises learning. In addition, because I did not start the research with hypotheses, I was able to change the focus of the research substantially, besides, developing theoretical ideas that described and explained the respondents' views.

4.2.1 Advantages and Disadvantages of the Ethnographic Design

The advantage of using the ethnographic design is that it is not far removed from the sort of approach we use in everyday life to make sense of our surroundings (Hammersley, 1998). Hence, the respondents' group discussions were recorded in the normal, everyday contexts of student life and not under conditions created by the researcher. In addition, this type of approach is useful when conducting a study comprising a small number of respondents besides having the advantage of gathering data from semi/unstructured interviews and informal conversations. Lincoln and Guba (1985) propose that the collection of non-numeric data is advantageous because the researcher is able to explore the multiple interpretations and meanings from the respondents' data. Furthermore, theory induction is desirable in areas where very little research has been conducted (like reflective practice) and to provide new insights into paradigms that have run their course (Henwood and Pidgeon, 1992). Thus,

statistical analysis plays a subordinate role in ethnographic research (Hammersley, 1998).

On the other hand, Hammersley (1998) contends that ethnography is often criticised for its lack of scientific basis, as studying small samples produces findings that are of little value because their findings are not generalisable. He argues that survey research in comparison to ethnography, sacrifices depth for breadth. Hence, relevant information may be lost with the consequence that the significant features of the situations under examination may risk being misunderstood. In comparison, ethnographic researchers may claim that the findings are representative, without relying on statistical sampling, by comparing the characteristics of each situation studied with aggregate data about the target population (Hammersley, 1998). Furthermore, ethnographers are more interested in making theoretical inferences rather than empirical generalisations by studying small samples that represent key dimensions of the culture to be explored (Hammersley, 1998).

The second problem, concerns small samples in natural settings because the researcher is unable to control the variables and as a result fails to identify causal relationships (Hammersley, 1998). However, Hammersley argues that even if social causal relationships existed, they are not the same as those in the physical world. Thus, they are not accessible to scientific investigation. Furthermore, the ethnographer is able to trace patterns of relationships among society in a way that neither experiments nor social surveys are able to do, by means of comparative analysis of cases (Hammersley, 1998).

The third criticism, that Hammersley (1998) identifies relates to the notion that ethnographers unlike scientists are unable to check the findings of an experiment by repeating it, because they do not follow a well-designed and explicit procedure. However, Hammersley (1998) contends that replication is not the only technique used to assess a researcher's work because even when replication is possible, this may not happen. Therefore, he argues that replication is not an essential feature of science and neither does it guarantee validity. Thus, Hammersley argues that because it may not be possible to replicate an ethnographic study this *does not therefore detract from the validity of ethnographic findings* (Hammersley, 1998; p12).

The last aspect of ethnography that has been criticised is the subjectivity of the unstructured, data collection methods (Hammersley, 1998). This has been discussed in section 4.1.1 but will be discussed further. In this research I used a semi-structured interview schedule, but I followed up leads during the interviews as well as utilising the recordings of unstructured, reflective practice, group discussions hence increasing subjectivity and bias (Hammersley, 1998). Hammersley contends that despite quantitative researchers using structured data collection techniques in order to overcome subjectivity, yet, the respondents may react to the structure itself, thus, increasing the chance that the behaviour studied is an artifact of the research process. Also, structured schedules do not solve the problem of subjectivity, because, if the researcher asks the same question at the same point in an interview, the respondents' response may vary because they may have differing views (Hammersley, 1998). In this study I used a variety of techniques to collect data and according to Hammersley this ensures that the findings are not an artifact of the research design because I was able to compare data from different sources.

On the other hand, Mauthner and Doucet (1998) argue that data analysis is a relatively neglected area of qualitative research literature, yet, the process that the researcher uses to transfer the respondents' individual and personal experiences into public theories are critical to assessing the validity of these theories. This problem of keeping the respondents' voices alive, whilst simultaneously recognising that the researcher's role can shape the research process and product (Mauthner & Boucet, 1998) may be further compounded by the researcher becoming the advocate for particular perspectives, or members (Grills, 1998). However, Grills (1998) maintains that the focus of ethnography should be upon improving the lot of those with the least power. This study concerned female nurses and their reflections on practice. Thus, it was important to consider the nurses' view of their gendered power relations within their clinical areas because of their subordinate role within the health care service.

4.3 The Setting and the Ethical Issues in relation to the Respondents

The setting was the Health Studies Department in a University situated in the South of England. The main respondents who were asked to participate in this study were 2 cohorts of post registered and post, enrolled, nursing students who were undertaking a 2 year part-time Diploma in Professional Studies where I worked as a research assistant. The reason for the inclusion of these students was that the course set a high priority on reflective practice and included a module specifically set aside for this aspect that was not formally assessed (see appendix 1). Thus, these students were important respondents because they represented the essential dimensions of the culture to be explored (Hammersley, 1998)

4.3.1 Ethical Considerations

As a researcher I needed to be mindful that my respondents are real people with their own needs and wants, not just numbers on a piece of paper. Thus, ethical concerns were applied to ensure the protection of the respondents' dignity and safety besides ensuring that the research would be valuable in developing further knowledge about learning through reflection on practice. Most ethical codes are based on the Articles of the Nuremberg Tribunal that were devised after the trials of the Nazi doctors accused of war crimes following World War 2 (Dempsey & Dempsey, 1992). Despite ethics being defined as a highly debatable issue (Hunt, 1994) yet, ethical controversy was not a feature of this research because all the respondents were capable of understanding informed consent. However, I was aware that this research could have subtle, adverse effects on the respondents, hence it was important to consider the ethical aspects surrounding the research process.

The first issue that required my attention was that my research should adhere to the idea that the potential for harm should be minimised (Dempsey & Dempsey, 1992) besides ensuring that the relationship between the respondent and myself did not comprise exploitive aspects (Polit and Hungler, 1991). The second feature, concerned respect for human dignity in that the respondents in this study should be treated as autonomous humans capable of self-determination, by the assurance of informed consent (Dempsey & Dempsey, 1992). This

means that the respondents have the right to make informed, voluntary decisions on whether to participate/not participate in the study and this should be based on a full description of the nature of the research. The last aspect relates to the respondents having the right to fair and equitable treatment before, during and after their participation in the study, besides ensuring confidentiality in that the respondents' privacy is maintained throughout the study (Polit & Hungler, 1991).

4.3.2 Ethical Issues in relation to the Reflective Practice Groups

The difficulty here was that I was only involved in observing and tape recording two group sessions with the first cohort of 11 students, at the end of their second year of the Diploma course, to see if it was a viable and valuable method of obtaining data. These 2 groups from the first cohort of students had been set up nearly 2 years prior to my taking up the post of research assistant. However, prior to tape recording the 2 sessions, I did obtain informed consent because I met the group when I first began my research post (see appendix 2). However, when this first cohort of students evaluated the group sessions at the end of their Diploma course, they indicated that they found the presence of an outside observer (myself) a threat. Therefore, it was decided that the facilitator/s would tape record the group sessions with the second cohort of 20 students. I was not involved with data collection from this second cohort of students' reflective practice groups. On the other hand, I felt it was important that written permission was gained from the students in order to tape record these sessions (see appendix 2), because collecting this data went beyond the students' professional role. Furthermore, I would be using the data for my study, as well as utilising the data for the research that was being conducted by the Health Studies department into an evaluation of the reflective practice groups.

The second ethical dilemma related to the notion that as I was not involved either in setting up the groups, or in facilitating, or in tape recording the reflective practice groups from the second cohort of students. I had to rely on the facilitator who was the director of the research project to provide information, in order for the students to give informed consent. For example, prior to tape recording the group sessions, the facilitator/s provided the students

with full information about the purpose of the study and the groups, besides giving them the freedom to choose to attend or participate in the tape-recorded group sessions. However, Dempsey and Dempsey (1992) argue that in the case of qualitative research it is not always possible to explain the full nature of the study, because the explanation may become so broad as to become meaningless. Therefore, a brief clarification of the objective of the research was provided in the consent letter (see appendix 2). The facilitators informed the students that no extra time would be incurred because the reflective practice groups comprised an integral part of the Diploma course. To prevent exploitation, the students were told that any issues divulged in the group sessions would not be used against them in any way and neither would their non-participation and non-attendance incur any disadvantages (Polit & Hungler, 1991). These measures ensured that the students were protected from any adverse effects that may be incurred as a result of participating/not participating in the study.

The students also, were acquainted about the steps that would be taken to safe guard their privacy. For example, they were informed that when writing up the study fictitious names would be used and that the tapes would be stored in a locked filing cabinet, besides labelling each tape as either group A or Group B with date the of recording. Furthermore, the students were told that when the tapes were transcribed on the computer, no identifying information would be given and that at the end of the study, the tapes as well as all the corresponding information contained on the computer would be destroyed. In addition, every student undertaking the Diploma course was invited to participate in the tape-recorded reflective practice group session. This ensured the fair and non-discriminatory selection of respondents in order that the risks/benefits are shared (Polit & Hungler, 1991).

4.3.3 Ethical Issues in relation to the Interviews

The interviews were conducted when the students finished their course and in contrast to the tape recordings of the reflective practice groups would require the students to give extra time. Therefore, in order to decrease the time accorded to the interviews, I gave the students a choice of venue, like their own home or work place. Prior to interviewing the students, the course director provided the students' names, their contact addresses and telephone numbers.

However, the course director (research director) gained the students' prior permission to reveal these details to me.

Initially, I contacted each student by telephone rather than by letter, because it meant that I was able to allay any anxieties through elaborating and answering any questions the students may have with regard to the study/interview. During the telephone conversation each student was given information about the type of questions that may be asked during the interview, as well as the approximate length of the interview. Also, each student was told that they had the right to consent/not consent to the interview without incurring any prejudicial treatment. The reason for providing these details was to minimise the potentially, adverse psychological effects of the impending interview and to ensure that each student understood their ethical rights, with regard to human respect, in that the students chose whether to participate/not participate in the interview process secure in the knowledge that they understood what their involvement entailed.

Immediately before the interview the information given over the telephone was reiterated. In addition, the student was told that she could withdraw from the interview at any time and refuse to answer any questions, that there were no right or wrong answers because the student's answers to the questions were a valued aspect of the study. Furthermore, I told the student at the end of the interview that she could request that I did not use the material. Also, the privacy aspect was reiterated in that each tape recording would be given a pseudonym and that when the interviews were transcribed, no identifying information would be stored on the computer. When the transcribed data was sent to other members of the research team, the students' identities would not be divulged. The student was assured that when the findings were sent for publication, the student's identity would be disguised by the use of fictitious names, none of which would correspond to any of the students' names and that the tapes would be cleared of any information at the end of the research. Once, I had satisfied myself that the student understood the information given and that no coercion had been applied, the student was then asked if she was happy to participate in the interview and when given an affirmative answer, the student was requested to sign a consent form (see appendix 2)

I was aware also, that each student had the right to an unbiased and respectful response to his or her viewpoints. Therefore, from the start of the interview I aimed to create a relaxed and informal atmosphere, welcoming the student, thanking her for giving me her time and asking whether she had any questions (Parr, 1998). When the interview was completed, the student was given the opportunity to ask any further questions, besides being invited to give their opinions about the way in which the interview was conducted. In addition, each student was given my contact number and address so that they could ask questions/discuss issues relating to the study. These measures were taken in order to minimise any harmful effects of the study.

4.4 Qualitative methods of Data Collection

The methods adopted were qualitative because in order for theory development to occur qualitative techniques are required. The two methods used were audio taped reflective, practice, group discussions and audio taped interviews using a semi- structured schedule. These are valuable, if like this topic – reflection on practice – very little is known, if the issue is sensitive, complicated, not subject to measurement and concerned with relationships and interactions, or relates to the change process, or if the researcher wishes to describe the experience from the ‘emic’ perspective (Field and Morse, 1985). This study involved these features hence qualitative methods were the most suitable way of collecting data.

4.4.1 The Audio-Taped Reflective Practice Group Discussions

The reflective practice group comprised 72 hours and commenced at the beginning of the course and continued throughout the course (see further details in appendix 1). Two cohorts of students participated in the tape-recorded, reflective practice groups during the second year of their course. The first cohort comprised 10 female students and 1 male student. Out of these 11 students the male student worked in the psychiatric unit, 3 were midwives, 2 worked in an oncology area, 4 were ward managers working in orthopaedics, intensive care, cardiology and theatre, whilst the last student was an enrolled nurse who was a bank nurse.

These students were divided into 2 separate reflective practice groups.

- 1) Group A consisted of 5 members.
- 2) Group B consisted of 6 members.

As stated in section 4.3.2 only 2 hours of tape-recorded reflective practice group discussions were obtained from this first cohort of students. Furthermore, during the time that this cohort of students was undertaking the Diploma course, there was a change of facilitator at the end of the first term of the second year of the course.

The second cohort of students comprised 20 female students and out of these 20 students 4 were midwives with 2 midwives working in the community, 3 were ward managers working in general medicine and intensive care, 3 were practice nurses, 1 worked in orthopaedics, 1 worked in elderly care, 1 worked in a day unit, 1 worked in X-ray, 1 worked in psychiatry, 1 worked in a surgical unit and 1 worked in a gynaecological unit and 3 worked in medical units. These students were divided into two groups.

- 1) Group C consisted of 10 members.
- 2) Group D comprised 10 members.

The setting up of the small, reflective practice groups for each cohort of students commenced at the end of the first year, when the students were allowed to choose which group they wished to be in and their attendance and participation in the group was voluntary. In addition, the reflective practice module was not assessed. The reason for avoiding formal assessment arose from a desire to allow students to explore aspects of their practice for which there may be no adequate theoretical explanation or formal body of knowledge (Schon, 1983; 1987). The idea that student assessment may impede learning was based on the notion that where reflective abilities are formally assessed through journals and diaries (Gerrish, 1993; discussed in section 3.3.1) then the students may write down whatever they think the teaching staff expect, rather than truly exploring and reflecting on their own experience (Cameron & Mitchell, 1993).

Although either one or both of the facilitators were present during the group discussions, it was the students not the facilitator/s who determined the issues to be discussed. At the first meeting the students were encouraged to negotiate and devise ground rules in order to promote an environment that encouraged trust and safety. The groups met for one hour every two weeks during term time, in the second year of the Diploma course and in order to minimise distraction the tape recorder was placed unobtrusively on the floor. Thus, 20 hours of tape-recorded group discussions was obtained from the second cohort of students.

The advantages of using the self-directed group to facilitate reflection is to provide a humanistic approach to experiential learning that allows group members to disclose thoughts and feelings spontaneously (Burnard, 1985). This allows the students the opportunity to 'own' these feelings and personal experiences rather than filling the student with facts (Burnard, 1985). In addition, the group process is important to the development of self-awareness because of the presence of self-disclosure and feedback from the other members of the group that are two vital components for awareness (Burnard, 1985). However, Mullender and Ward (1991) contend that self-directed group work is an effective technique in facilitating change based on anti-oppressive values in order to confront the established power structures within the health care system.

The facilitator/s attempted to adopt a non-directive and non-authoritarian stance in order for the students to ascribe their own meaning as to what was going on in the clinical environment. This was done to encourage a sharing of power relationships between the students and the two lecturers who acted as facilitators in order to encourage free expression amongst the students (Boud et al, 1985). This power sharing may be difficult to maintain because the facilitators were both lecturers within the health studies department and were in a position of authority concerning the students' formal assessments and grades, as well as being responsible for the organisation and teaching on the course. Thus, the students' prior experience of education as well as their view of the facilitators as authority figures, may lead to the expectation that the facilitator/s adopt the traditional leadership role by directing the group sessions (Mullender & Ward, 1991). To overcome this problem, the facilitator/s

actions substantiate Mullender and Ward's assertion that the students were made clearly aware from the outset that they, not the facilitator/s direct and determine where the students want the group to go.

4.4.2 The Interview Schedule

The research team developed the interview schedule (see appendix 4) from experience and literary sources. It consisted of both structured and unstructured questions that meant that I was able to follow up leads in more detail. For example, when the students were asked to describe their experience of participating in the reflective practice group, I was able to follow up their accounts because the students' responses directed further questioning. 29 students agreed to participate in the interviews as one student had moved house and did not give a forwarding address. However, 4 students from the first cohort of students requested that one of the facilitators interview them and this request was duly complied with.

One important aspect of the ethnographic approach is the emphasis on achieving intersubjectivity (discussed in section 4.1.1) with the respondents whose life worlds we are studying (Prus, 1998). In other words, whilst conducting the interviews I needed to gain the differing perspectives of what factors facilitated/constrained each student's experience of learning through reflection on practice. Prus (1998; p29) argues that there is no such thing as the *perfect interview*, because the most important aspect is the ongoing receptivity to the viewpoints and practices of the respondents and not the specific questions the ethnographer asks. Therefore, any mistakes and salvaging efforts that I made (like having to go back and re-interview 2 of the students, because unknown to me, a crackling noise was also recorded whilst tape recording the students' interviews. This meant that I was unable to discern what the students were saying whilst transcribing their interviews) are unimportant because every interview was productive, as it produced further material about the reflective practice topic (Prus, 1998).

Prus contends also, that many researchers are unable to recognise the value of the data they are collecting, until they have developed a better understanding of the topic under

investigation. I would agree with Prus' argument because it was not until I stepped outside the positivist paradigm - that Rolfe (2001) contends nurses find difficult – and began to realise how this paradigm blinded me to other viewpoints, that I realised the significance of the material collected.

On the other hand, Shaffir (1998) proposes that the relationship the researcher develops with the respondents is limited in part by how the ethnographic study matches the respondent's frame of reference. For example, some respondents may be favourably disposed to the research whilst others who despite being informed are disinterested (Shaffir, 1998). Although the researcher may view the study as important the respondents may not possess the same enthusiasm. Yet, the respondents will, according to Shaffir, co-operate more as a result of the way in which the respondents judge the researcher's human traits than their evaluation of the study's scientific merit. It was important for me to present a friendly, open and honest attitude (Shaffir, 1998) in order to gain the students' trust (Field & Morse, 1985) as well as listen and hear what is being said (Ribbens, 1989; quoted in Parr, 1998; p95).

One of the biggest problems was keeping control over my facial expressions so that I did not appear judgemental, whilst simultaneously ensuring my expression was sufficiently open and receptive, in order to encourage the student to continue talking to me (Parr, 1998). The other difficulty was that although the interview schedule enabled me to cover certain topics, I tended to allow the students to move the interview along in their own direction and as a result I had to concentrate hard to remember whether particular issues had been covered, or not. The last problem concerned the notion that only one interview, was scheduled at the end of the course. It may have been interesting and more fruitful to interview the students at the beginning and during the second year of their course besides interviewing them at the end.

The sharing of you – reciprocity - (Edwards, 1993) with the women who are the subjects of the research is a feature of feminist writing on interviewing (discussed in section 4.1). This sharing helps reduce the exploitive power balance between myself and the student (Graham, 1984; quoted in Edwards, 1993; p186) and aids in eliciting more information on the topic being researched (Edwards, 1993). For example, some of the questions asked proved

problematic for students, especially the questions relating to applying theory to practice (question 9 appendix 3) and socialisation (question 27 appendix 3). Therefore, I was able to give examples from my own experience of how my nurse training may have affected me and the assumptions applied to particular aspects of clinical practice. This helped the students to provide examples from their own original nurse training. However, they found it difficult to relate theory to practice. In reference to the interview process, several students assured me when asked how they felt about being interviewed, that it had helped them to express their emotions about certain aspects of the course and several of them stated that they had found the questions much easier to answer than expected.

4.5 Data Analysis

Mauthney and Doucet (1998) suggest two problems that the researcher faces during the analysis stage of the research process. Firstly, they argue that the initial stages of actually getting to know the data and identifying what are the key issues feel more intuitive than anything else. Thus, they propose that the qualitative researcher engages in a somewhat unsystematic process of following certain leads and seeing where they take us. However, the reasons why we choose some ideas over others do not always provide logical reasons for our choices and decisions because these early stages are messy, confusing and uncertain. On the other hand, they contend that these kinds of processes are very difficult to articulate especially in the logical, sequential, linear fashion that tends to be required in the analysis section of a study.

The second difficulty that Mauthner and Doucet (1998) identify is that through the analysis of the data we are confronted with ourselves and with our central role in shaping the outcome of the research process. They argue that as a consequence researchers may be anxious about whether we have analysed the data in the '*right way*' (p123). Yet, they contend that even when researchers utilise specific methods for the analysis stage, they interpret these techniques in their own individual ways, besides not going through all the specified steps. Therefore, I decided to base my analysis on the ideas of Strauss and Corbin's (1990) and Waring's (2001) models of data analysis. However, at the heart of this analysis is my

reflexive learning from and about the data (Mauthney & Doucet, 1998) and although the analysis is articulated as a series of sequential steps, these are not linear. They are cyclical in nature, because, in order to unpick the differing levels of reflexivity requires movement backwards and forwards and a constant interweaving process of data analysis, applied theories and my own individual interpretations (Waring, 2001).

4.5.1 First Step - Collection and Transcription of Empirical Data

Initially I set up 2 files for

- A) Transcriptions of reflective practice group discussions.
- B) Transcriptions of students' interviews.

When I received each tape-recorded reflective practice group discussion from the facilitator, these were transcribed and allocated a number and stored on the computer under the file named group discussions. Similarly, when I conducted the interviews each was allocated a pseudonym, transcribed and stored on the computer under the file named interviews. In addition, each transcription of the group discussions and interviews was printed out so that they could be read through and notes made throughout the reading. The aim was to become immersed in the data so that I could enter *the life world* (Burnard, 1991; p462) of the students.

4.5.2 Second Step – Opening up the Enquiry through Analysis/Interpretation of the Students' Narratives

I did not code the data and neither did I follow a specific strict model of analysis. What I attempted to do in this analysis was to be reflexive, by going beyond what the students said. I achieved this by looking for the historical/political/educational reasons that are due to class, status and oppression of women that may explain, why these students' views of their own role appear to limit their capacity to reflect. One of the ideas during this step in the analysis was to compare and contrast each clinical practice narrative that the students raised within

both the reflective practice groups and their interviews, in order to look for practice issues that revealed learning through reflection on practice. The second notion, was to develop an interpretative commentary from the students' stories that would

Uncover an underlying coherence or sense in a text that is confused, unclear, incomplete and contradictory

Get behind and hear the messages in the text

Be reflexive so that explication of the text could be achieved in order to work out the possibilities.

Reflexively go beyond what the students said in order to look for the historical, political and educational reasons that are to do with class, status and oppression of women.

I carefully re-read the transcripts looking for practice issues that may reveal the stage at which the students were reflecting, as well as showing whom the interaction was with. On the other hand, I needed to find out what were the issues within these narratives, that may/may not constrain the nurse's practice and if the students were consciously aware of these constraints. Therefore, I went through the narratives asking questions derived from Lofland and Lofland (1995; quoted in Bryman, 2001; p399). For example, when examining Becky's story (see section 5.1) about a patient who was suffering from pain, I asked myself questions like

What is happening here?

What are the doctors doing?

What is Becky doing?

What is this story about?

What is the patient doing?

What is going on here that is not being made explicit?

What is the meaning of this situation for Becky?

What matters to Becky?

What is it like to be Becky in this situation?

What learning is going on here?

By interrogating the text I was able to perceive that Becky's perception of the situation pertained to the notion that the patient's pain was not being adequately controlled and that Becky intuitively knew her patient's pain was due to cardiac involvement. Yet, Becky could not explain why. However, the reasons why Becky's patient's pain was not controlled seemed to elicit some issues that could be followed up.

For example

- The doctors are not listening to Becky's evaluation of patient's pain.
- The doctor's refuse to prescribe a more potent analgesia, because there was no concrete evidence to prove patient's pain was due to cardiac problems.
- The doctors appear to want to ascertain the correct diagnosis, by carrying out further technical investigations.
- Becky stated that she was not being assertive enough.
- The patient did not show visible signs of pain and the patient appeared not to complain to the doctors that he was in pain.
- This lack of pain control meant that the patient suffered pain.
- The outcome, was that Becky wrote her concerns about the patient in his medical notes.
- The second outcome, was that Becky's hunch was correct as the patient suffered a Myocardial infarction
- The third outcome was that Becky asked the nurses who took over from her, to perform an Electrocardiograph (ECG), the next time that the patient had pain.

Becky's story was compared and contrasted with other data, to see if there were similarities or differences within other students' stories. Zara's narrative (see section 5.1.3) appeared to be similar to Becky's in that her patient's pain was not adequately controlled. However, her narrative differed, in that it seemed that the nurses as well as the doctors required visible signs that the patient was in pain. In addition, the nurses seemed to base their assessment on the label drug addict, as well as labelling his complaints of pain as difficult to handle. This labelling issue appeared in other students' stories (eg. Gemma and Holly in section 6.2). Therefore this was identified as an emerging theme.

The reasons why patients did not have their pain controlled, enabled me to focus on similar/dissimilar aspects within the rest of the collected data, as well as enabling me to open up the enquiry. For example, Lisa and Pat's data concerned conflict with the doctor, in relation to care of the dying patient. Whilst Carol and Kara's perceptions seemed to support Becky, Lisa and Pat's views that doctors do not listen to nurses. Although some of the students provide reasons for doctors not listening to nurses, these are not reflexive, in that they do not appear to reflect on the historical/political/educational reasons for possible constraints within the doctor/nurse relationship.

Therefore, I continued to apply the same techniques, like questioning and making assumptions, to the rest of the data, in order to explore the emerging themes. These were based on my own knowledge and personal experience as a nurse. However, I had to be mindful of my own biases and prejudices. Thus, I maintained a critical reflective stance and sustained an openness and ability to hear questions raised by the text and its challenges to my questions that I thought were relevant

4.5.3 Third Step - Emerging Themes/Issues

During this stage I was reflexive, in that I looked beyond what the students said. The reason was that although the students described clinical situations quite clearly, they did not reflect on the historical/political/educational reasons that may constrain their practice. Zara and Becky's stories pertained to a difference in views between the nurse and doctor and patient and nurses. These were grouped under *different opinions concerning care/treatment*.

The emerging themes from Becky's data were the unequal relationship between the consultant/registrar and Becky (Becky found it difficult to challenge the consultant and the registrar about the patient's lack of pain control), *the difference in knowledge base (episteme)*, (the doctors appeared to allow the identification of the diagnosis to take precedence over Becky's concern with the alleviation of the patient's pain), *socialisation* (Becky may be socialised into her subservient position) and paternalism (the doctor knows

best). Zara's story supported the difference in *episteme*, *paternalism* and *socialisation*, but the idea of *labelling* patients as opposed to assessing patients as individuals emerged. The nurses in Zara's story appeared to label the patient as a drug addict and difficult to handle.

Pat and Lisa's studies were grouped together under '*care of the dying patients*' and similarly to Becky and Zara's narratives, the unequal relationship between doctor and nurse (doctors do not listen to nurses requests or assessment of a patient's condition) is supported, as well as *paternalism* (the doctors aggressively treated these very ill patients by carrying out resuscitation techniques etc and appeared not to take the patient's wishes into consideration) and *differing episteme* (active treatment seemed to take precedence over dignity during the dying process).

Carol and Kara's narratives were grouped under '*doctors not listening to nurses*' and their views appeared to support the theme of *socialisation* (some doctors may learn not listen to nurses) and raised the issue of *hierarchy*, whilst Carol, Paula, Betty, Abigail and Gemma's stories revealed that the *power* theme that appeared to be emerging as a dominant issue was not all one sided, as some nurses seem able to influence what drugs were prescribed (Abigail), the type of care provided for maternity patients during labour (Paula, Betty), as well as informing a doctor about his attitude towards the nurses (Carol), or about the doctor's slowness in discharging patients (Gemma). However, this influence seemed to relate to midwives-consultants, nurses-junior doctors and ward manager-registrar. Theresa's story raised the issue of *autonomy*.

Thus, the emerging themes that appeared to be raised within the students' data were

- 1] Difference in episteme that is care versus cure
- 2] Socialisation
- 3] Paternalism
- 4] Hierarchy
- 5] Power
- 6] Autonomy
- 7] Labelling

Other themes raised within the data related to *workplace dynamics, conflicts and personal problems*. For example, students discussed such issues, as how to give immunisation injections to babies, the self help groups that were available when a mother had a still birth, the lack of communication between midwifery departments, with regards to maternity patients who had children on the at risk register, attendance at a team building study day and problems with colleagues and students. These seemed to reflect workplace dynamics and conflicts. Personal problems were reflected in a student's discussion about the difficulties incurred, when a daughter's friend confides that a family member is abusing her. These themes were not used, because it was felt that they did not explain from the students' perspective how medical power seems to significantly inhibit their reflective ability.

The reason why these themes (eg. *difference in episteme* etc. that are identified above) were chosen is that they explored the constraints more, they had greater explanatory power, they were backed up by consistency – they came up a lot more in the data – they resonated themes found in the literature and they resonated with the ideas and levels and barriers to reflection that were discussed in section 2. They also linked to the main theme, that one of the reasons why some of these nurses are not reflecting might be due to the notion of medical power.

At this stage in the study, I was able to tentatively link the themes to medical power. For example, in some clinical areas, medical power that is hierarchical and paternalistic may mean that the curative model of care may take precedence, because it is more valued than the nursing model of care that comprises humanistic and existential aspects. The perpetuation of this power may be attained through socialisation, in which doctors are taught during their training that their knowledge is superior to that of nurses. The result of this unequal power relationship is that doctors value their autonomy, whilst nurses appear in some instances unable to influence the decision-making process. Another consequence of this medical power is that some nurses base their assessment of patients on labels, rather than on the individual person's needs, because they may have internalised the dominant paradigm of the doctors.

4.5.4 Fourth Step – Selective sampling of the literature and data

During this stage, I searched the literature in order to find out if the current literature supported and explained how these themes (*difference in episteme – care/cure differential, socialisation, paternalism, hierarchy, power, autonomy and labelling*) identified in section 4.5.3 may facilitate/hinder the students' reflective ability. The reason I searched the literature was that I reflexively wished to compare my data with other findings, to find similarities and differences, besides utilising the literature to reflexively question the nature and assumptions of the knowledge being produced (Edwards & Ribbens, 1998). Also, I explored all the data for narratives that either supported the emerging themes, or gave differing perspectives. As stated in section 4.5.3, the data pertaining to the themes of *general working practices, conflicts* and *personal problems* did not seem to clarify the emerging themes, therefore this data was not used. The reason I selectively sampled the literature and the data together is that they are inextricably linked and it appears impossible to separate them.

At the beginning of the study, it seems that although some of the students (Lisa's narrative in section 5.2 and Becky's story in section 5.1) are aware that their patient's condition was deteriorating, or that the patient suffered pain, however, they are unable to say why. Becky and Lisa's stories support Schon's (1983) argument that knowing-in-action is a question of knowing more than they can say. Furthermore, the students appear not to recognise the reason why doctors and some nurses require visible signs of pain (Becky and Zara's stories in section 5.1).

Therefore, I consulted the literature to provide some evidence of the basis of the doctor's knowledge; because I assumed that possibly this may explain the reason why doctors required visible signs of the patient's pain. A literature search revealed that in the main doctors tend to base their knowledge on the positivist perspective (Hagell, 1989). Davey's (1992) text explains that the positivist basis of knowledge may account for the doctor's misconceptions of pain, because this knowledge does not consider the emotional aspects of pain (discussed in section 5.1 and 5.1.1). Nuland (1993) and Elston (1993) go further than Davey, by explaining that one of the reasons for doctors basing their knowledge on the

scientific medical model, rather than on ethics may be due to their socialisation through peer evaluation (discussed in section 5.3).

The literature also implies that doctors are socialised into the belief, that for every condition, there is a diagnosis that has a defined set of treatment strategies. The reason may pertain to the idea that the doctor's approach to care comprises exploring the causes of disease (eg diagnosing through x-rays etc.) and this care is predominantly associated with cure (prescribing drugs), as success is measured in terms of curing the patient (Mackay, 1993; Lupton, 1994; Kendrick, 1995; Snelgrove & Hughes, 2000). Thus, the literature shows that positivism and socialisation may result in the doctors believing that eliciting the correct diagnosis is more important than alleviating pain, that was possibly seen as a symptom (see Becky's story in section 5.1).

Furthermore, the literature supports and explains in more detail the knowledge base of doctors, as well as divulging the idea that doctors are possibly socialised into the perspective that their knowledge base is superior to nurses (Mackay, 1993; Perry, 1993; Adshead & Dickenson 1993; Witz, 1994). One reason is, because they perceive their university-based course as superior to that of nurses (Mackay, 1993). This may explain why the doctors do not listen to Becky's assessment of her patient's pain, or Lisa's evaluation of her patient's deteriorating condition. In addition, the literary sources explain more adequately why the consultant in Janet's narrative (in section 5.4) overtly believes that the doctor's knowledge is superior to that of the nurses (discussed in section 5.4).

Although the literature explains the reason for doctors requiring visible signs that a patient is in pain, the question I now asked myself was, why nurses require visible signs that a patient is in pain (Zara's story in section 5.1.2). Mackay's (1993) and Smith's (1990) studies support Ford and Walsh's (1994) argument, that because the medical model still prevails over the nursing model, some nurses tend to apply the scientific model as the basis for their assessment of a patient's health care needs. This is substantiated by the students' comments in section 7.1.2 that reveal that their original nurse training socialised them into basing their care on the doctor's medical model, besides showing that they were socialised into their

subordinate role.

This socialisation through the nurse training system is supported from literary sources (Davis, 1993; Clarke et al, 1994; Ford & Walsh, 1994; Sullivan, 1998). Therefore, because nurses have internalised the medical model of care through socialisation, this possibly explains why nurses require visible signs that the patient is suffering pain. However, Henderson (1994) argues that gaining knowledge about medical scientific aspects like Electrocardiographs (see Becky's story in section 5.1) is only powerful in providing communication with doctors, because doctors deem this knowledge meaningful. Scientific knowledge does not help the nurse to gain power in the decision making process.

The other theme that emerged from Zara's, (see section 5.1.2) story was the idea that she assesses her patient according to the label *drug addict*. This labelling of patients was explored through literary sources (see section 5.1.4). When examined, it seems that labelling patients does not consider the patient as an individual (Walsh & Ford, 1989; Carpenter, 1993; Kendrick, 1995). Furthermore, Morse et al (1992) contend that nurses label patients (discussed in section 5.1.4), in order to distance themselves from the patient's suffering. Holly, Gemma and Lucy's narratives in section 6.2 support this labelling theme.

However, in order to provide a more balanced view, the issue of patient-centred care was explored, because through my experience and knowledge, I was aware that current nursing theory and literature emphasises patient-centred care (Benner, 1984; Benner & Wrubel, 1989; Jenny & Logan, 1992; Tanner et al, 1993; Appleton, 1993; Radwin, 1995; Wallace & Appleton, 1995). From this literature search, I discovered that some of the studies concerning primary nursing and patient-centred care (discussed in section 5.1.5) reveal that when nurses use their power to practice autonomously, the development of new practice knowledge based on humanistic and existentialistic aspects is attained (Titchen, 2000; Binnie & Titchen, 1999). Thus, it appears that nursing knowledge differs fundamentally from the scientific base that doctors tend to use.

Another aspect that arose within the students' data and seems to be contentious was care of the dying (see Lisa, Pat and Carol's narratives in section 5.2 and 5.3). The students' stories support the findings from Mackay's (1993, 1995) and Walby et al's (1994) studies. I used literary sources to substantiate my assumptions that, because doctors are responsible for deciding not to resuscitate a patient (Attwood et al, 2001) and for prescribing drugs (Walby et al, 1994; Mackay, 1995), this may create conflict. From this literature the issue of paternalism was raised (Candy, 1991), in that *doctor knows best*. Hence, I was able to assume that the patients' views about their impending death and resuscitation definition may not be considered.

This paternalism seems to be a feature of other student's stories, in that the doctor believes that he/she is the best person to assess a patient's pain (see Becky's story in section 5.1), or whether a patient is constipated (see Kara's narrative in section 5.3). It seems at this stage in the study that the data not only raised and supported the issues of paternalism, labelling, and socialisation and the possible difference between the doctor's and the nurse's knowledge bases (cure/care differential) but, that the literature also substantiated and explained in more detail these themes.

I examined the literature concerning patient-centred care (discussed in section 5.1.5) and this raises the contentious issues of power and autonomy and is supported by the students' comments that imply lack of power and autonomy. For example, at the beginning of section 5.3 some of the students remark that doctors do not listen to their opinions. Lisa, Becky, Carol, Pat and Kara's narratives (see sections 5.1, 5.2 and 5.3) support these comments. Thus, the students appear not to have the power to practice autonomously, because they require the doctor to listen to their assessment of the patient's condition and it is the doctor who decides what drugs to prescribe for pain and which patient is not for resuscitation.

In addition, Estelle, Judy and Gemma's narratives (see section 6.2) reveal that some managers, similarly to doctors, utilise socialisation techniques in order to curtail the students' power and autonomy to practice. These socialisation techniques comprise such actions, as expecting nurses to carry out orders without knowing the reasons why (Estelle's narrative)

and providing information on a need to know basis (Gemma and Judy's stories). Therefore, the students' narratives seem to support Engelhardt's (1986) and Yarling and McElmurry's (1986; quoted in Ferrell, 1998; p33) argument that it is difficult for nurses to make autonomous ethical decisions, because nurses are caught in-between the traditional authority of the doctor, the emerging concept of patient's rights and the growing power of hospital managers.

On the other hand, some of the students' data reveals that they do participate in the decision making process (see Paula, Gemma and Betty's narratives in section 5.3). Recent research was elicited that supported the data, in that some nurses overtly have the power to participate in the decision making process (Benner, 1984; Hughes, 1988; Porter, 1991; Allen, 1997; Snelgrove & Hughes, 2000; Aksel Hn Tjora, 2000) Also, these studies support the theme of hierarchy, because it seems that the nurse's involvement in the decision-making process depended on the position of the nurse and doctor in the nursing and medical hierarchy, as well as their experience. From the literature and the students' stories it appears that in order for nurses to practise autonomously, they require power. However, the literary sources reveal that if nurses threatened the doctor's power base, they – the doctors - provided opposition to the nurse's bid for the power to practise autonomously (Keen, 1995; Aksel Hn Tjora, 2000).

At this stage in the study, it seems that the issues of power and autonomy are important aspects. However, it appears that some students do not recognise the implications of autonomy (see Theresa's story in section 5.3). Also, because the students are unaware that lack of power constrains the way in which they care for their patients (eg Becky did not obtain effective analgesia for her patient), whilst Kara's patient underwent a rectal examination that was not necessary), this supports Taylor's (2000) contention that the students are not reflecting at the critical level.

Thus it appears that the theme of power was becoming a significant issue, but whilst reading the literature, Freire's (1970; 1985) work on oppression was mentioned (in Ford and Walsh, 1994; Allendale, 1998). Whilst reading Freire's texts, I realised that his thoughts could be applied to nurses, besides explaining several issues that had been puzzling me, like why do

some nurses continue to base their care on the doctor's positivist perspective (see Zara's story in section 5.1.1) when '*individualised care*' is being promoted within the nursing literature (Smith, 1990; UKCC, 1996). Also, Freire's ideas provide another reason why students may be unable to reflect at the critical level (discussed in section 5.3). Freire suggests that because nurses are an oppressed group, they adopt the culture and myths of the dominant group. One possible result of this oppression is that nurses fail to recognise they have the power to influence care (Binnie & Titchen, 1999; Johns & McCormack, 1998), because nurses are socialised into carrying out task orientated care, ward routines and procedures. Thus, the literary sources support the assumption that due to socialisation nurses tend to be unaware of the power structures within their workplace and this possibly explains why these students do not reflect at the critical level (Taylor, 2000).

However, I decided to search the literature for other aspects of the power theme. From the literature, I discovered Foucault's (discussed in section 5.3) notions on power, as he reveals a differing perspective, in that the individual is able to exert power, because power does not emanate from top to bottom (Sawacki, 1991). Nurses do have the power to change the status quo (Henneman, 1995). So are nurses partly responsible for their lack of power? It may appear from this study that some of the students tend to continue their subservience by taking on tasks that were undertaken by junior doctors (see Sophie's story in section 6.1), by remaining silent (see Janet's story in section 5.4) and by continuing to attend the doctor on his/her ward rounds, that only serves the interest of the doctor (see Becky's remarks in section 6.1).

On the other hand, some of the students' data also supports Foucault's ideas. For example, Estelle's story (see section 6.2) reveals that when nurses exert power, it is productive and provides a more individualised approach to care. For example, the maternity patients in Estelle's narrative (see section 6.2) care are empowered to choose how many friends/relatives they wish to be present during the birth of the baby, in order to support them during labour, despite management's ruling that only one person was allowed in the labour ward. In contrast, Janet's story (see section 5.4) shows that despite challenging the consultant about his decision to induce a maternity patient at 38 weeks, instead of at full term, she was

unable to influence the consultant's decision. This appears to be based on the notion that the consultant exerted power, because he viewed his knowledge as superior. This power differential in which nurses are in a subordinate position to doctors is substantiated by literary sources eg. Perry, 1993; Mackay, 1993,1995; Witz, 1994.

Peters and Waterman (1982, in Walby et al, 1994; p130) identify 6 key components pertaining to medicine that possibly explains why doctors are more powerful than nurses. Other literary sources also support Peters and Waterman's description of these important aspects relating to the medical profession. Firstly, in comparison to nurses, doctors enjoy clinical freedom that is a cherished medical principle. This means that consultants have professional freedom of action in their decisions as to how a patient is treated and considerable discretion over the organisation of their own work (Klein, 1984; Mackay, 1993; Sweet & Norman, 1995; Annandale, 1998; Snelgrove & Hughes, 2000). Secondly, doctors are engaged in active continuous monitoring and modification of treatment plans and they claim that experimentation is the basis of their scientific knowledge (Mackay, 1993; Lupton, 1994; Kendrick, 1995, Snelgrove & Hughes, 2000). Medical personnel are more highly trained than nurses, with longer periods of training carried out in universities and junior hospital positions (Mackay, 1993). Fourthly, doctors similarly to nurses, especially the junior doctors are engaged in a direct relationship with the patient (Mackay, 1993). However, their relationship is episodic, whilst the nurses are involved in direct patient care on a daily basis, over a 24-hour period. Similarly to nursing, medicine has a commitment to the patient, because the aim is to restore health. However, in contrast to nurses, doctors measure their success in terms of curing the patient (Mackay, 1993; Kendrick, 1995; Snelgrove & Hughes, 2000). They do not appear to measure success in terms of transforming the patient's experience of illness, by taking them from the loss of a limb/breast, to adjustment, in order to cope with a false limb, or breast prosthesis (Binnie & Titchen, 1999). Lastly, medicine has a hierarchy based on a consultant-led team with the consultant having the ultimate responsibility for the admission, discharge and treatment of patients (Porter, 1991; Mackay, 1993; 1995; Walby et al, 1994; Sweet & Norman, 1995). Nurses also have a hierarchy, but in contrast to the doctors, nurses do not have the same responsibility as the doctors.

Thus, the literature implies that the result of the doctor's power is that the nurse - no matter how experienced or how senior the position the nurse holds in the nursing hierarchy- he/she is powerless with regard to treatment and diagnosis, because the nurse has to summon the doctor for treatment to be initiated. Becky, Lisa, Pat and Carol's stories in sections 5.1, 5.2 and 5.3 substantiate this notion. Mackay (1993), Walby et al (1994), Kendrick (1995) believe that the reason may be due to the idea that it is the doctor, not the nurse, who possesses the legal responsibility for the patient. Porter (1991) contends that one of the significant factors in the maintenance of medical power is its control over diagnosis, because health care problems stem from diagnosis.

Literary sources provide further reasons for the nurse's lack of power. They imply that the historical development of the nursing and medical professions shows that, although the development of the medical and nursing professions are inextricably linked, it is the medical profession who has established a prestigious place in the health care setting. Authors like Hardey (1998) Annandale (1998) Walby et al (1994) and Klein (1984) reveal that through a series of political moves, doctors especially consultants, gained power and autonomy that meant that decisions about patient treatment were solely in the hands of the consultants (discussed further in section 5.3).

Also, the literature clearly shows that historically, as a result of gendered oppression (Oakley, 1974, 1985; Meleis, 1985; Walsh & Ford, 1989; Gaze, 1991; Jolley, 1995) and political moves medicine attained a very powerful position, in relation to the nursing profession (discussed further in section 5.3). This power is perpetuated throughout socialisation techniques (Perry, 1993; Mackay, 1993). The students reveal some of these methods used by doctors to socialise nurses into their subordinate position eg shouting at the nurses (see Carol's story in section 5.2), being disagreeable (see Kara's narrative in section 5.2) and ignoring the nurse's assessment of the patient's condition (see Becky, Lisa and Carol's stories in sections 5.1, 5.2 and 5.3). Furthermore, it seems that managers use these techniques as well as doctors (see Estelle and Judy's narratives in section 6.2).

By this stage in the data analysis, I had been able to choose cross-sections of the literature and data that comfortably corresponded and explained the emerging assumptions and themes of *different episteme –care/cure differential, socialisation, paternalism, hierarchy, power, autonomy and labelling*. However, in order for these themes to be considered as key findings, they need to be present throughout the whole of the study. For example, in the chapter titled *the role of the nurse*, the issue of hierarchy was elicited in Sophie’s story in section 6.1, whilst labelling and paternalism are raised in Gemma, Holly and Lucy’s narratives in section 6.2. These stories support the labelling theme described in literary sources, as the students base their assessment on medical and behavioural labels that represent the dominant medical model (Kendrick, 1995; Walsh & Ford, 1994).

A further aspect that was raised within Sophie’s narrative was the issue of lack of power that supports Walby et al (1994), Witz (1994) and Hardey’s (1998) proposal, that one possible reason why Sophie’s story shows that nurses may lack power may relate to the notion that doctors are subcontracting their routine and boring jobs, such as cannulation to nurses, yet, remain in control. Further reasons for the nurses’ lack of power are discussed in sections 6.1 and 6.2

However, the care/cure differential appears to be a key issue in this chapter (see section 6.2). The literature appertaining to the care/cure differential raises the view that care is a contentious issue, because it is difficult to separate cure from care (Leininger, 1985; Engelhardt, 1985; Lupton, 2002). In addition, the students’ narratives appear to support the literature. For example, some students reveal that they are using the doctor’s scientific basis to assess patient’s health care needs (see Gemma and Lucy’s stories in section 6.2). This supports the idea that some nurses have internalised the medical model of care. In contrast other students’ narratives identify the importance of emotional care (see Freda, Paula and Abigail’s stories in section 6.2). Whilst Sophie’s story (in section 6.1) reveals that some nurses prefer undertaking the technical tasks that had previously been the remit of junior doctors. Oakley (1974,1985), Meleis (1985), Walsh & Ford, (1989), Gaze (1991), Jolley (1995) and Kendrick (1995) provide some explanation, because they argue that as nursing work is equated with women’s work in the home, it is not valued as much as the doctor’s

technical tasks that provides a male objective perspective of the world.

Although some of the students show that care involves emotional aspects (see Freda, Paula and Abigail's stories in section 6.2), the students seem unaware of the importance of this emotional labour in helping build a relationship with the patients (Smith, 1990; Appleton, 1993). Literary sources show that this emotional care is not valued, because it is perceived as invisible and gendered work (Smith, 1990; Perry, 1993; Reed & Proctor, 1993) and thus, contributes to the perpetuation of the nurse's subservient status, in relation to the doctor's domination (Perry, 1993).

On the other hand, lack of knowledge about the caring aspects of the nurse's role emerges from some of the students' data, like Sylvia, Theresa and Abigail's stories (see section 6.2). Their comments substantiate the assumption that nurses do not always understand the ideas relating to nursing innovations (like the nursing process, primary nursing and nurse led units), besides divulging a lack of knowledge of the law concerning restraining techniques (see Gemma and Holly's stories in section 6.2). Furthermore, some students' narratives substantiate Freire's ideas, in that the dominated group creates rules and regulations that may facilitate the status quo, besides possibly perpetuating the oppression of nurses (see Sophie, Gemma, Judy and Estelle's stories in sections 6.1 and 6.2).

The literature pertaining to nursing innovations, especially in relation to nurse led units is quite contentious. Hardey (1998) argues that the primary nurse team mirrors that of the traditional doctor/patient relationship. However, Hardey (1998) proposes that it is the power relationship in the nurse led units that poses a threat to medical domination (discussed in section 6.2). Witz's (1994) text also, supports Hardey's, but Witz argues that nurses threaten the power base of medicine, because of the notion of the partnership between nurse and patient and the translation of this patient-centred care into practice through nurse led units.

In chapter 7 these themes of *care/cure differential, socialisation, hierarchy, paternalism, labelling, power* and *autonomy* are supported throughout the students' data and the literature substantiates and explains these themes in further detail. For example, the students'

comments (see section 7.1.1) reveal that their original nurse training possibly socialised them into valuing physical care and technical ability above care that is patient-centred. This resulted in some students labelling patients (Gemma's comments in section 7.1.1). Their views also reveal their training was teacher-centred. The literature explains that teacher-centred educations means that the teacher decides what the students need to learn (paternalism/maternalism) and that the students are socialised into knowing his/her place in the nursing hierarchy and do not question persons in authority (Melia 1987; Smith, 1990; Perry, 1993). Also, Perry's (1993) text reveals that techniques, like laughing at a junior nurse's mistakes and not providing knowledge (Kay's story in section 7.1.1) is part of the hidden agenda used to socialise junior and student nurses into their lowly position in the ward hierarchy.

A further, powerful force that may have helped to maintain the traditional non-participative and non-challenging culture within nursing may have been due to fear of the ward sister (see Betty and Carol's comments in section 7.1.1). Therefore, the students in this study may have learnt through socialisation to become passive and not active participants in their own learning. This may partly explain why they were unable to use the self-directing aspect (autonomy) – in which they had the power (freedom) to choose the content and issues that were to be discussed within the group. As a result the self-directing group process may not have been an effective technique for facilitating these students' learning through reflection on practice.

4.5.5 Fifth Step – Integration and Modification of Deductive and Inductive Ideas

During this step the main theme that encompasses the main ideas that pertained to why these two groups of students may not be conscious of how their lack of power constrains their practice and their reflective ability, is identified. This encompasses inductive and deductive thinking about the relevant threads of the main theme that I achieved through using a card system, in which all the emerging themes had been put in a box system. For example, when the labelling theme emerged within the data, I would enter a card and write down what the labels were, who said them and the result of these labels. Similarly, the differing perspectives

on the labelling aspect that arose from the literature would be written down on a card with details of the article/book etc and what had been said. In this way I built up differing perspectives on labelling, as well as other perspectives on how nurses assessed their patients (eg patient-centred assessment).

I used the same system for socialisation, in that I wrote down on the card the type of techniques used, by whom, and the consequence of these methods. However, I separated these socialisation techniques, into those used by doctors and those used by managers. In addition, literature that clarified the socialisation theme more clearly was written down on a card with the name of the article/book, what was said and discussed etc. In this way, I was able to reflexively attain differing perspectives regarding each emerging theme, as well as being able to integrate the students' narratives with the literature.

The next step was to integrate the data and the literature, so that all the themes - *care/cure differential, socialisation, hierarchy, paternalism, labelling, power* and *autonomy* could be linked. It seemed that medical power is one of the main assumptions that explained why the students were not consciously aware of how this constrained their ability to reflect. In addition, the themes (*care/cure differential, socialisation, hierarchy, paternalism, labelling, power* and *autonomy*) supported this idea, concerning the issue of power. Also, during this stage, I linked the perceptions of the students to the wider context of gender, because the literature reveals that these themes are linked to the way in which the medical and nursing profession have developed over time.

I was able to tentatively conclude that although the nursing and medical professions are inextricably bound they have two similar, but separate hierarchical structures. The nurses and doctors are socialised (Mackay, 1993; 1995; Lupton, 1994; Kendrick, 1995; Binnie & Titchen 1999) into their respective cultures, but it appears that the doctors have more power (Walby et al, 1994; Perry, 1993; Walsh & Ford, 1989; Ford & Walsh, 1994; Witz, 1994) than the nurses, especially the consultants who are at the top of the medical hierarchy. The consultant has power, because he is the person who has the ultimate responsibility for the admission, discharge and treatment of patients (Walby et al, 1994; Sweet & Norman, 1995).

The result of the doctor's power is that the nurse - no matter how experienced, or how senior the position the nurse holds in the nursing hierarchy- he/she is powerless with regard to treatment and diagnosis, because the nurse has to summon the doctor for treatment to be initiated (see Becky, Lisa, Pat and Carol's stories in sections 5.1, 5.2 and 5.3). This is because it is the doctor, not the nurse, who possesses the legal responsibility for the patient (Mackay, 1993; Walby et al, 1994; Kendrick, 1995). Therefore, one of the significant factors in the maintenance of medical power is its control over diagnosis, as health care problems stem from diagnosis (Porter 1991). Thus, nurses remain in a subordinate position, because they have to wait for the doctor to articulate his/her orders before they can implement care (Perry, 1993; Kendrick, 1995). In other words, when a patient's condition deteriorates, the nurse has no legal power to implement changes, because it is the doctor who possesses this power.

A further consequence of this medical dominance is that, because nurses are an oppressed group, they adopt the culture and myths of the dominant group (Freire, 1970, 1985). The result of this oppression shows that the students in this study are socialised during their nurse training, into carrying out care based on the medical model (Davis, 1993; Clarke et 1994; Ford & Walsh, 1994; Sullivan, 1998). Thus, patients are assessed according to their label (see Zara, Gemma and Lucy's narratives in sections 5.1 and 6.2) and not according to their individual health care needs (Walsh & Ford, 1989; Carpenter, 1993; Kendrick, 1995). Furthermore, it seems that the students are socialised into carrying out task orientated care, ward routines and procedures (discussed in sections 6.1 and 6.2), with the consequence that the students fail to recognise that they have the power to influence care (Binnie & Titchen, 1999; Johns & McCormack, 1998). In addition, because nurses are an oppressed group they tend to devise rules and regulations that perpetuate the nurse's oppressive status (Freire, 1985). For example, in Estelle's area of practice (discussed in section 6.2), the management - devise the rule that only one relative/friend was allowed to support the maternity patient during her labour - without consulting the midwives or the maternity patients.

On the other hand, the literature reveals that the oppressed group may internalise their own subservience (Freire, 1985; Ford & Walsh, 1994; Harden, 1996). This notion is supported by the students, because some students continue their subservience by taking on tasks that were undertaken by junior doctors that remain under the control of doctors (Sophie's story in section 6.1), by remaining silent about the disadvantages appertaining to an early induction of labour (see Janet's story in section 5.4) and by continuing to attend the doctor on his/her ward rounds, that only serves the interest of the doctor (see Becky's remarks in section 6.1).

Another consequence of this dominance is, that doctors in comparison to many nurses have autonomy, in that they have the freedom to make a professional judgment regarding the type of tests to be carried out, the interventions that are to be taken (eg the consultant in Janet's story had the autonomy to make the decision to induce a maternity patient at 38 weeks and not full term). The literature reveals that the reasons for this power are very complex and are based on the notion that doctor's domination is the result of a socially and politically constructed division of labour ((Oakley, 1974,1985; Meleis, 1985; Walsh & Ford, 1989; Gaze, 1991; Jolley, 1995; Annandale, 1998; Hardey, 1998).

Doctors are concerned with care of the patient thus, medicine in comparison to nursing, intrinsically holds a male world-view of objectivity and value freedom (Kendrick, 1995). Their approach to care tends to involve an explanation of the causes of disease, where care is predominately associated with cure, because success is measured in terms of cure (Perry, 1993; Lupton, 1994; Walby et al, 1994; Kendrick, 1995). On the other hand, the literature shows that nursing care is viewed as value-laden and is traditionally associated with the nurturing aspects of maternalism. Thus, because of gendered differences, nursing care tends to be viewed as women's work and is perceived as inferior to the scientific medical model of care (Meleis, 1985; Walsh & Ford, 1989; Gaze, 1991; Perry, 1993; Reed & Proctor, 1993; Jolley, 1995).

In contrast, medical cure tends to be revered and this is perpetuated through socialisation, as medical students enter medical school because they are good at science (Mackay, 1993). They perceive themselves as scientists with a clear clinical mandate to use these skills to

diagnose, treat and cure disease (Adshead & Dickenson, 1993). In addition, medical students are socialised into valuing their knowledge above nursing knowledge, because they undertake a 5-year university education, whilst all the nurses in this study have undergone a 3-year practical training (Mackay, 1993). Furthermore, medical students are subjected to negative role models who perpetuate the view that nurses are there to help the doctor, as well as being socialised by their colleagues, into the belief that knowledge based on the medical scientific model is valued more than knowledge based on ethical aspects or interpersonal skills (Nuland, 1993; Elston, 1993)

This socialisation of doctors into perceiving that their knowledge and status is superior to that of nurses, has resulted in doctors perpetuating this superiority, through techniques like ignoring the nurses assessment of a patient's condition (see Becky, Lisa and Kara's narratives in sections 5.1, 5.2 and 5.3), shouting at the nurse (see Carol's story in section 5.3), or being disagreeable to the nurse (Mackay, 1993; Perry, 1993). This socialisation has resulted in the notion that many of the students in this study are unaware that they do have the power to influence the decision making process (Hennemann, 1995). For example, Binnie and Titchen's (1999) and Titchen's (2000) findings reveal that when nurses use their power to implement patient-centred care in which they gain autonomy, the development of new practice knowledge based on humanistic and existentialistic aspects is attained. Therefore, because the students are socialised into accepting the power differential within their clinical areas, they are unable to reflect at the critical level, because their narratives reveal that they are unaware of the power structures within their clinical areas (Taylor, 2000).

Summary

I used an ethnographic approach to examine a complex situation through which I reflexively examined the factors that may hinder/foster learning through reflection on practice This involved a cycle where ideas were developed inductively from the data and literature was used to support or refute the evolving theory. The ideas of feminist methodology were considered, in that reflexivity was an important aspect of both the methodology and the analysis of this study. Therefore, in order to develop theory inductively and view the

students' experience from the emic perspective required qualitative methods of collecting data, such as in depth interviews and audiotape, recorded, reflective practice group discussions. Whilst collecting the data, it was important to ensure that the students were given the autonomy to direct their own reflection on practice during the group situation, in order to share power with the other group participants and the facilitators. In addition, the interview was conducted as far as possible on an equal footing, in order to prevent interrogation.

This study was also conducted within an ethic of respect for persons, knowledge and democratic values (BERA 1992). This meant that the students were provided with sufficient information to consent voluntarily, that they could withdraw from the study at any time, that their privacy was protected and that their knowledge was accepted as being of value to the study. Furthermore, the data analysis involved developing the theory inductively through the use of a cyclical process where there was a constant interweaving process of data analysis, applied theories and my own individual interpretations. At the centre of this analysis was my own reflexive learning from and about the data, through which I inductively developed seven themes – *socialisation, labelling, paternalism, hierarchy, difference in episteme, autonomy and power*. These themes will be examined in the ensuing chapters.

CHAPTER 5

REFLECTIONS ON THE DOCTOR/NURSE RELATIONSHIP

Reflections on the doctor/nurse relationship featured prominently both within the students' reflective practice group sessions and their interview schedules. Nursing, unlike other professions like education, works closely and continuously with the medical profession, making the inter-professional relations between these two groups particularly significant (Walby et al, 1994). This research was carried out during 1995/96, when the changes identified in *Working for Patients* (1989) had been implemented. The central characteristic identified within this document is the devolution of authority and ownership to smaller units – NHS trusts and GP budget holders. One of the crucial features of this decentralisation is that staff 'close to the customer' (in health care this means patients) gain greater control over the decision making process (Walby et al, 1994). Thus, the central issue within the students' reflections relates to the extent nurses shared control with the doctors in the decision-making process because, as Walby et al (1994) contend, doctors and nurses care for the same set of patients, yet, each profession is independently structured. However, in order for the nurses to learn through reflection on practice, a collaborative relationship with the doctors is required, one in which nurses share power in the decision making process.

5.1 Different opinions concerning care/treatment

One feature that the students reflect on, which substantiates Walby et al's (1994) research, relates to the limitations of the nurse's professional authority and responsibility concerning patient care, in relation to that of the doctors. During a reflective practice group discussion, Becky reveals the friction that occurs when it is the nurse's responsibility to alleviate pain, yet, is unable to prescribe effective analgesia, because it is the doctor and not the nurse, who has the authority to prescribe (Walby et al, 1994).

Becky: *We had a man who came in with chest pain and the doctors thought that it was gastric pain and had given him some gaviscon and he looked like he was in severe pain but he kept going off to sleep. So I said to them when they went on the consultant's ward round he was on codeine phosphate for pain they thought it was gastritis. Could we give him something else and they just said 'Oh that'll be enough', and at this point he was more settled and then the registrar came back and I said 'look this man really needs some more pain relief' and he said 'look he's just got acute gastritis and what you've given him is enough' ... and then before I went off we called the house officer and said we were unhappy about (his lack of pain control). House officers aren't particularly brilliant and when I came back on the Monday morning he was having an infarct and I thought about it afterwards and felt that I should have been a bit more assertive with them because I could see that he was in more pain and needed something else... but it's difficult when it's a consultant and a registrar... I don't know how I'd go about talking to the registrar really... I didn't feel comfortable with him...*

Group member: *Had he had ECG's (electrocardiographs) done?*

Becky: *He'd had one done on the day of admission but it was normal. But at the end of the day whether it was gastric or cardiac he should have had adequate pain control regardless of the cause... There was a new registrar who didn't know me and the consultant, some of the consultants you feel are a lot more approachable but I find this chap what he says goes... I don't think he listens to nurses... and... when he was going round... in the morning... and I said to him 'he's still in a lot of pain' and he just said 'I think they want to get an endoscopy... oh that's right we'll wait and see what the endoscopy shows.' He was nil by mouth this chap and they went off the ward without telling us whether the endoscopy had been organised. So I telephoned the endoscopy unit and they didn't know about it... I phoned the doctor back and he said oh yeah we haven't been able to organise it and so there was a lot of lack of communication from them anyway. So they weren't prepared to (prescribe different analgesia) until they had this endoscopy back, which hadn't been organised.*

When Becky became aware that the doctors would not prescribe a more potent drug to alleviate the patient's pain, she wrote her concerns in the patient's notes.

Well I was very worried about it (the patient's pain) and the girl who was on with me. We documented it in the notes but it made me feel bad... the reason I felt so bad was I thought this poor man is suffering

Becky's description of her dilemma provides scope for learning through reflective practice. Her account uncovers what Schon (1983; 1987; 1991) argues is a clinical situation of uncertainty, instability and value conflict which, he contends, the professional is faced with on a daily basis. This situation, according to Schon, is unable to be solved by technical and rational knowledge.

Initially, the dispute is between two different views. The doctors wished to confirm a provisional diagnosis of gastritis, because the doctors arranged an endoscopy to be carried out in order to confirm their provisional diagnosis. Becky, on the other hand, considers that the patient's pain needs to be alleviated, regardless of whether the pain originates from the gastric, or cardiac area. The doctors' need to elicit the right diagnosis matches Walby et al's (1994), Mackay's (1993), Kendrick's (1995) and Snelgrove and Hughes' (2000) contention that the doctors view their approach to care as comprising an exploration of the causes of disease (eg. diagnosing through the performance of X-rays, blood tests, ECG's etc) and that this care is predominately associated with cure (prescribing drugs), because success is measured in terms of curing the patient. Becky's remarks also, support Walby et al's (1994) findings that her conflict with the doctors was related to her disagreeing with the doctors' provisional diagnosis of gastritis – a diagnosis that was later rejected when the patient had a Myocardial infarction.

Becky's assumption that the patient's pain may be due to cardiac involvement, like the doctor's, comprises a diagnostic aspect to her evaluation of the patient's pain.

Facilitator: *Well why do you say it was cardiac?*

Becky: *Well just because I don't think you can ever rule out if someone's complaining of gastric pain you can never rule out from experience really... Well I just thought they (the doctors) were barking up the wrong tree.*

Her hunch about the patient's pain originating from cardiac problems is confirmed, because the patient suffered cardiac arrhythmias and a Myocardial infarction (which are life threatening situations) over the weekend, whilst she was off duty. Becky is unable to articulate the reasons for her judgment, which substantiates Schon's (1983) proposal that her knowing-in-action is a question of Becky knowing more than she can say. Schon suggests that this knowing is in our doing, whilst Benner (1984) proposes that knowing occurs when the professional is able to grasp the meaning of the whole situation in a moment and respond appropriately. Becky 'knows' that her patient's pain is possibly too intense to be due to gastritis and it is when she is discussing her patient's pain with the nursing staff, at the hand over report, that she realises the pain may be due to cardiac involvement. The nurses perform an Electrocardiograph (ECG), when the patient next has severe pain, (possibly) to prove that

the pain is due to cardiac involvement.

Becky: I said at handover... I said if you know that there's a chance you can't be absolutely sure and the next time he had this severe pain and it went on they did an ECG and they called the doctors round.

Her remarks imply that when the nurses interpret the ECG readings, some abnormalities were present and thus, requested the doctors to visit the patient.

5.1.1 Positivist Knowledge

Becky's remarks suggest that when the doctor takes little notice of the nurse's evaluation of the pain a patient is suffering, this results in ineffective pain control, because doctors are the only ones allowed to prescribe potent analgesia, such as diamorphine. Becky states that she lacked the assertive skills to persuade the consultant and the registrar to prescribe a more suitable drug. Thus, her patient continued to suffer pain.

However, what Becky and the other group members within her discussion group, as well as the facilitator fail to reflect on, is why the doctors caring for this patient seem to be more concerned with eliciting the correct diagnosis, than with alleviating the patient's pain. This may be attributed to medical knowledge being grounded in positivism that is derived from the same principles and procedures as the natural sciences, such as chemistry and biology (Vaughan, 1992; Davey, 1992). The beliefs inherent in this perspective are that the behaviour of humans/people, like the behaviour of matter, can be objectively measured by criteria such as weight, temperature and pressure (Davey, 1992). This positivist grounding could lead to doctors reasoning that as the patient's ECG was normal, the pain was not due to an abnormality of the heart. Furthermore, because the logic of positivism suggests that the human body can be separated into smaller units of study (Davey, 1992), some doctors tend to see pain as potentially and sensibly segregated into gastric, cardiac, neurological pain etc. Another important feature of this scientific perspective is that meanings, feelings and purposes are considered relatively unimportant (Davey, 1992). The result of this positivist stance is that the amount of pain a patient is suffering, may be misconstrued.

Another reason why the doctors may not have considered the patient's pain as important, is that their medical training tends to socialise them to consider that for every condition, there is a diagnosis, that has a defined set of treatment strategies (Lupton, 1994). During their subsequent hospital experience, Lupton contends that doctors are socialised into viewing the patient as a disease, easily categorised into one-dimensional stereotypes and this enables doctors to make snap judgements, in order to get the job done quickly and in many senses effectively. This clinical judgement is valued and is accorded respect from both nurses and colleagues (Mackay, 1993). Thus, it is possible that through socialisation, the doctor's wish to elicit the correct diagnosis through the performance of an endoscopy, was viewed as more important than alleviating the pain that was possibly seen as a symptom.

Furthermore, it appears that this socialisation process occurs prior, even to entry to medical school, because Mackay (1993) argues that medical schools tend to select those applicants with high scientific qualifications, as suitable candidates for entry. This is supported by Allen (1988), who reports that most medical students stated the reason why they wanted to study medicine was because they were good at science subjects. Thus, it appears that – at least prior to the time of research - the medical schools encourage the scientifically-minded student, rather than the student who had always wanted to be a doctor, or had wanted to help people (Mackay, 1993). This is not to deny the fact that medical schools have been placing greater emphasis on training doctors to attain inter-personal skills, by attempting to cover behavioural studies and social skills in the undergraduate curriculum. Mackay simply suggests the effects of this are debateable, since many doctors mentioned that during their training there was still relatively little such input, or interest in the inter-personal aspects of care. Thus, the continuing emphasis on high academic qualifications in scientific subjects for entry to medical schools, as well as the socialisation within them, may explain why doctors place greater emphasis on the scientific aspects of disease, than exploring the concept of pain that cannot be detected through ECG recordings, or through an endoscopy.

5.1.2 Misconceptions of pain

The doctors' positivist perspective means that they are likely to assume that Becky's patient has gastritis; on the basis that the patient's electrocardiograph was normal on admission. Thus, the doctors' views tend to support Beyerman's (1982) contention, that if a patient is suffering from gastritis, the pain is not as severe as cardiac pain. In addition, when doctors base their assessment of a patient's pain on the positivist approach, they may not take into account the variable and subjective nature of pain which is a unique experience for each individual (Waddie, 1996; Montes-Sandoval, 1999), or as McCaffery puts it *Pain is what the patient says it is and it exists when the patient says it exists* (1983; p37). In addition, the doctors' positivist view is likely to require overt signs that the patient is suffering pain.

Becky; He may have just nodded off but he'd probably not have slept at all and then he would wake up with dreadful pain... He was a man who was quite uncomplaining as well because I could see that he had pain ... and if you went over he'd say 'Oh yes it's still there' but he wouldn't be shouting out because if he had they'd do something about it

Becky's view is that the doctors attributed less pain to the patient, because he does not show any overt expressions characteristic of pain, such as moaning and grimaces, whilst the doctors were present. Also, the patient is asleep, so the doctors assume that he cannot be in pain. The doctors' attitude towards this patient's pain seem to support Walsh and Ford's (1989) assertion, that some doctors may decide how much pain a patient has based on measures other than what the patient says. Thus it may be concluded that doctors following a particular positivist path may not consider the complex psychological, personality, cultural and environmental factors that make up a patient's pain experience (Walsh & Ford, 1989). I would argue along with Walsh and Ford (1989) that no doctor, or nurse, or in fact any person can truly know the pain another person is feeling.

Carol provides a further reason for some doctors tending not to prescribe effective analgesia. She states that an original decision by one of the consultants meant that

He would not allow house officers to write up diamorphine until the doctors had been to see him and then they might have a stat dose... because he (the consultant) was worried that we (the nurses) were giving diamorphine too much where he would rather treat them (the patient) with GTN (glyceryl trinitrate).

Carol's remarks indicate that the consultant may choose to control what the house officers (HO's) are allowed to prescribe. As Walby et al (1994) point out; the consultant is ultimately responsible for the treatment of the patient and may assert his authority accordingly. By contrast, the house officer does not enjoy full clinical autonomy because he/she is a junior doctor in a short tenure training post (Elston, 1994). This wish for control on the part of the consultant relates to the reference in Carol's account to the consultant's preference for prescribing glyceryl trinitrate (GTN), although it is not nearly as effective as diamorphine in alleviating cardiac pain – the reason given being his concern that nurses were giving the patient too much diamorphine. This reluctance to prescribe narcotics seems to apply to other doctors as one group member says that

From personal experience I've had patients who've had acute cardiac pain, definite cardiac pain, who've been diagnosed as cardiac patients and who still cannot get adequate analgesia written up for them. Doctors are still very loath to write up Diamorphine for people.

These remarks imply that some doctors, including consultants, tend to be afraid that a patient may become addicted, yet Walsh and Ford (1989) argue that addiction involves a complex interplay of social and psychological factors, in addition, to the mode of action of the drug. These aspects are absent when a patient is given narcotic analgesia for cardiac pain for a few days. Ford and Walsh (1994) suggest that it is highly unlikely that cardiac patients would become addicted.

During her interview, Zara reflects on a problem concerning pain control. However, the dispute is between the nurse's and the patient's views on how much pain the patient is suffering.

This young man had been to theatre for an internal fixation for a fracture of the tibia and he had a plaster of Paris applied in theatre and when he came back he was in a lot of pain and he'd had some analgesia in recovery but still demanded more. He was in excruciating pain and we didn't know how to handle him... he was in pain despite the amount of opiates... people couldn't think it was because of the plaster of Paris because of what we

have learnt. What we know is that if it is the plaster of Paris then there should be some signs on the neurovascular site on the toes, to indicate that the plaster is too tight, or pressing into the skin or something like that, or onto the nerve or whatever. But those signs were not there so no-one thought that it was the plaster.

The reason why the nursing staff were reluctant to give more opiates was that the patient *Had been a drug user in his time so everyone was thinking that he's probably just making it up. He just wants more Pethidine or Morphine or whatever because he's used to a very high level of drug content in his blood system. So he's making it up*

Zara's story reveals the value conflict between the nurses and the patient that Schon (1983) stresses is grounded in the professional's appreciation system. However, what Zara does not reflect on, is why she required explicit evidence for the patient's complaints of pain. Ford and Walsh (1994) contend that because nurses have internalised the medical profession's scientific knowledge base through socialisation, then nurses like Zara and her colleagues require observable signs of the cause of pain, such as vascular changes in the toes (implying that the plaster is too tight), in order to believe the patient's complaints of pain. Ford and Walsh (1994; p42) argue, that one reason why nurses may have internalised the biomedical model of care is because in the past

Doctors taught nurses, set exam papers, sat on nursing's ruling bodies, wrote nursing text books that consisted of watered down medical knowledge that doctors thought fit for nurses to know and until recently interviewed nurses for nursing posts, it is small wonder that nurses absorbed many medical values.

The influence of doctors in the education of nurses has dramatically decreased over the last two decades, but at the time of the research the doctors' medical model within the hospital setting tends to still prevail over the nursing model of care (Mackay, 1993). This is because the majority of nurses have been trained in the medical model of care (Smith, 1990). Thus, it is probable that because Zara and her colleagues undertook the traditional nurse training, so they have been socialised to base their assessment of the patient's pain on the positivist perspective and not on the patient's need to have his pain alleviated. The result of Zara's positivist stance, a stance similar to many doctors, is that she misconstrued the amount of pain the patient is suffering, hence the patient continued to suffer pain.

5.1.3 The subservient position of nurses and patients within the health care system

As well as not reflecting on why some doctors and nurses require concrete signs that a patient is in pain, the students also fail to reflect on why the doctors would not listen to Becky's assessment of a patient's pain. Perry (1993) argues, that nurses are unable to influence medical decisions because the '*curative science*' that is practised by the doctors is perceived to be naturally superior to the caring work that is the remit of nurses. In the development of hospital medicine, Perry (1993) and Mackay (1993) contend that nurses' and doctors' destinies are inextricably linked, but in comparison to nurses, it is the doctors who have established a prestigious place in health care. The result of this *constructed dominance* (Perry, 1993; p44) is an unequal relationship between doctors and nurses. Perry (1993) argues that doctors tend to use the power of their position to make decisions with regard to patient care, whilst taking little notice of the nurses' opinion and judgement.

On the other hand, Katz (1986) argues that this medical domination may be attributed to a thwarted need for certainty. When doctors are uncertain about treatment, this uncertainty is carefully camouflaged and substituted with an air of professional certainty. Thus, if treatment is unsuccessful the doctor may feel anxiety and guilt and this becomes expressed in authoritarianism, so that if control over disease is not achieved, at least the doctor secures domination over the decision-making process (Katz, 1986). Mackay (1993) supports Katz's argument, contending that because doctors believe they have to exude confidence for the patient's benefit, they - especially junior doctors - will give the impression that they are in control of the situation.

5.1.4 Labelling patients

Zara also, does not reflect on why everyone (which possibly includes doctors as well as nurses) did not believe the patient's complaints of pain. Zara's view was that the nurses did not know how to handle the patient's complaints of pain. Morse et al's (1992) model of empathy that describes the nurse's response to patients who are suffering may provide an explanation as to why Zara and the nurses may not have responded appropriately to this

patient's suffering. Morse argues, that nurses may dehumanise the situation, by acting as a detached stranger expressing false pity. In this way, nurses reduce their own emotional involvement that decreases their personal investment in a patient's suffering. Morse contends that this anti-engaged response is learned.

In the situation described by Zara, a way for nurses to detach themselves from the patient's suffering may be to *'label'* him an ex drug addict and thus view his complaints of pain as a figment of his imagination. However, this labelling of the patient reflects the mechanistic medical model that Carpenter (1993; p100) contends depersonalises and objectifies the patient. Moss (1988; quoted in Ford & Walsh 1994; p191) argues, that when nurses refer to patients by these medical labels like *'drug addict'*, it adversely affects the way patients are viewed. If the patient's behaviour is seen as *'typical'* of the label, rather than the person, then Ford and Walsh (1994) contend that this undermines the individualised care, as advocated by the nurses' professional body (UKCC, 1996). In earlier work, Walsh and Ford (1989) similarly made the point that when evaluating a patient's pain, nurses as well as doctors need to look at patients as individuals and not as stereotypes: the patient with gastric pain or the ex drug addict.

Nichols (1989) in comparison views the label *'patient'* as problematic. This is because traditionally the patient role has been defined as one in which the patient sits/lies passively while all responsibility, decisions, procedures, basic care functions and planning are implemented by members of the health care institution (Nichols, 1989). However, the fostering of this harmful dependency has currently been replaced by an increasing emphasis on the empowerment of patients/clients (Maslin-Prothero & Masterton, 1999). Patients are encouraged to have control in the decision making process, rather than devolving this responsibility to the professionals (Denny, 1999). Gibson (1991) argues that empowering the patient involves nurses moving away from the paternalistic view adopted by many nurses (in that the nurse knows what is best for the patient) to a more liberal stance. This requires nurses accepting that patients have the right to participate fully in the decision making process in partnership with them (Gibson, 1991). However, Gibson (1991) contends that in order for nurses to empower the patient, nurses also, need to be empowered.

Currently, in formal terms nurses support patient advocacy, as well as endorse the patient's participation as an equal partner in the health care team and his/her right to self-determine health care needs (UKCC, 1996), yet the reality is different. For example, Hewinson's (1995) research reveals that nurses use language as a means of exerting power and control over patients in the clinical area. Perry (1993) argues that nurses socialise patients into the subservient role, because the increase in medical, technological interventions requires a greater degree of patient subordination (Carpenter, 1993). Nurses foster patient compliance in order for the patient to conform to doctor's orders (Perry, 1993). The consequence is that patients may be reluctant to challenge decisions about treatment/care for fear of being labelled difficult and because they are dependent on the nurses for care (Maslin-Prothero & Masterton, 1999).

On the other hand, Haynes et al (1997) argue that when a patient senses that his/her autonomy is being denied, he/she may react angrily against the source of the denial and the people associated with it. Lorber's (1975) research reveals that nurses tend to view patients, who complain, are over-demanding and over-emotional, as problematic. When patients are labelled as '*difficult to handle*', this is likely to result in a tendency for the nurses to ignore the patient's problems and respond less quickly to his/her calls for attention (Haynes et al, 1997; Hardey, 1998). Kelly and May (1982) contend that problematic behaviour in patients is not due to them having a difficult personality, but is the result of the interactions that take place between practitioners and patients/clients. Jessica's remarks from her interview support Kelly and May's (1982) argument as she says

I had a problem with a patient who was very aggressive and I was terrified of him and he really upset me. I think he sort of avoided me after that but really there would come a day when I would have to see him again and I didn't really want to have to deal with him. I think it was all to do with our first meeting. I challenged him on certain things and he didn't like it.

However, what Jessica and the students in her reflective practice group do not reflect on was why she was frightened of the patient and why she reacted to his behaviour in the way that she did, namely by expressing the view that she did not want to have to deal with him. It appears that because Jessica labelled the patient as aggressive, this affected the way in which she reacted to him. Graham (1998) contends that when the nurse is frightened of the patient, he/she may not form a caring relationship because of being unskilled in dealing with

aggression.

5.1.5 Patient-centred care

As well as not reflecting on their unequal relationship with the patients, the students do not reflect on current nursing ideology in relation to the nurse-patient relationship, where power is shared between the nurse and patient (Binnie & Titchen 1999). Greenwell (1995) argues that the traditional patterns of the patient-professional relationship where the paternalistic individual (usually a doctor or nurse) cared for the dependent patient has changed, to that of patients taking responsibility for their own health. Thus, nurses have had to move from being paternalistic providers to health facilitators.

To help patients achieve their optimum health requires caring (to be discussed in section 6.2) that is a complex concept, because historically it has been affected by the development of society as well as the development of sciences, especially medicine (Nordman et al, 1998). Nordman et al remind us that caring reflects encounters between nurses and patients that take place in an ethical and cultural context. Ferrell (1998) proposes that as the goal of patient care is health and well being, then nursing actions are designed to bring about good through ethical decisions. However, it follows that the nurse also has the capability of harming the patient, either directly/indirectly or knowingly/unknowingly (Ferrell, 1998). On the other hand, Engelhardt (1986) argues that it is difficult for nurses to make autonomous ethical decisions because nurses are caught in-between the traditional authority of the doctor, the emerging concept of patient's rights and the growing power of hospital managers. Yarling and McElmurry (1986; in Ferrell, 1998; p33) support Engelhardt, but they contend that because nurses lack autonomy (to be discussed in section 5.3), they are unable to be moral agents because of institutional constraints.

Currently there is an emphasis on patient-centred nursing that is a style of practice demonstrating respect for the patient as a person. Binnie and Titchen (1999) contend that patient-centred nursing differs from individualised care (to be discussed in section 6.2). They argue that individualised nursing is a style of nursing that represents a first attempt to

establish nursing practice as independent of medical practice, based on its own theoretical models and achieved through the nursing process (to be discussed in section 6.2). Patient-centred nursing, according to Binnie and Titchen, means that the nurse acknowledges and values each patient's own way of perceiving and experiencing what is happening to him/her. The purpose is to transform the patient's experience of illness, taking them from pain to comfort, from distress to coping and from loss to adjustment. The role of the nurse is being there and through knowing the patient, she/he is able to offer support and expertise so that the patient is able to follow a path of their own choosing and in their own way. The knowledge base of this style of nursing differs fundamentally to that of medicine, as it reflects and is developed from existentialist philosophy and humanistic psychology (Binnie & Titchen, 1999).

Several studies show that nurses are able to transform the way in which they care for patients. This transformation is from the paternalistic, dependent nurse-patient relationships to a more equal nurse-patient relationship in which the patient is empowered (to be discussed in section 5.4). For example, Benner's (1984) research reveals that expert nurses (discussed in section 3.2.2) used the power in caring to empower their patients

They (the nurses) have used their power to empower their patients – not to dominate, coerce or control them. But this relationship is highly contextual. To empower, nurses must sometimes border on coercion as they coach and prompt the patient to engage in painful tasks that patients would not readily undertake on their own. The difference between empowerment and domination can be only understood if the nurse-patient relationship and the situation are understood. Caring out of context will always be controversial, because caring is local specific and individual. (Benner, 1984; p209).

Thus, in order to empower the patient the nurse requires an understanding of the patient and the situation as well as having the confidence to take risks. The problem with this study is that Benner explored crisis situations and not everyday nursing practice, besides not examining the patient's view of the situation.

Benner and Wrubel's (1989) examination of the relationships between caring, coping, stress and health reveal the significance of caring in expert human practice. For example, the nurses aim at establishing a relationship with their patients based on equality and respect and they

help their patients to gain control so that they can actively participate in their own recovery. The nurses listen to the patient's stories about their lives and their illnesses and to how the patients interpret their symptoms, thus attempting to understand the meaning of the illness for the patient and that patient's life, in the belief that such an understanding may facilitate healing.

Other studies indicate that knowing the patient is an important part of skilled judgement and is also a part of clinical learning (Tanner et al, 1993; Appleton, 1993; Radwin, 1995; Wallace & Appleton, 1995). To know the patient comprises a complex interpersonal process characterised by the nursing actions of perceiving, communicating, self-preservation and a show of concern (Jenny & Logan, 1992). Furthermore, getting to know the patient and fostering closeness with the patient is achieved through humour and touch, whilst giving comfort is attained by talking, listening, the provision of information and emotionally supportive statements (Bottorff et al, 1995; Savage, 1995). However, Binnie and Titchen (1999) argue that in order for the nurse to develop patient-centred care, he/she needs to leave behind task-orientated care, ward routines, standardised procedures and physical care-giving that reflects the traditional ward nursing, becoming instead, adult professionals thinking through issues for themselves, weighing up options and making decisions that may be complex and even risky.

Titchen (2000) suggests that although there has been a proliferation during the nineties in research pertaining to the type of knowledge (identified by her as craft knowledge) nurses use in the therapeutic nurse-patient relationships, very little of this research makes links with patient-centred nursing. In addition, she argues that there appear to be no studies that explore how this knowledge evolves, or how it is learned. However, Titchen proposes that the studies indicate the source of the nurse's knowledge and that this is gained from general everyday life, nursing experiences and interpersonal experience. Moreover, her study challenges previous research findings that conclude that intuitive judgement is the hallmark of expertise and the accepted assumption that nurses apply research findings and theoretical principles to practice. Titchen reveals that the artistry displayed in patient-centred nursing is a subtle balance and interplay between intuition and rational thinking and an interpretative and

associative use of professional practice and theoretical knowledge. Therefore Titchen's research from a Foucauldian perspective (discussed in section 5.3) reveals that when nurses use their power to practice autonomously, knowledge is developed pertaining to the humanistic aspects of patient care.

5.2 Conflict relating to the care of dying patients

The second professional dispute raised by two members in response to Becky's remarks highlight the dissension that may occur when doctors refuse to visit patients who the nurse views as poorly or near to death. Lisa recounts a situation where the doctor refuses her request to come and see a patient. The doctor demands an explanation from Lisa but she is unable to explain why she thinks the patient is dying.

Lisa: I think sometimes you've just got to spell out the plain facts to them make them make a decision there and then as well... I mean I've had the experience where I had a man on the ward whose been there for 2 or 3 weeks and he'd just been gradually getting worse in that 2 or 3 weeks. I came to him one morning he was quite a lot worse but there was nothing specific. I mean his blood pressure was no different, his pulse was no different, but he had cancer or suspected cancer anyway and he was dying and I had to phone up the houseman, because he had no resus, no resus definition made on him and told him this man's dying. He said 'How do you know he's dying?' and I said 'Let's just say he's not going to survive the morning'. 'And how do you know?' I said 'Because I just know that he's not going to survive the morning, I suggest you come up and see now before we have to resuscitate him [and how did he respond to that?] he did come up in the end and... he tried to pull out all the stops to save this man, when it's already too late.

Lisa knows her patient is dying but similarly to Becky she is unable to explain the reasons why, which fits in with Schon's (1983; 1987; 1991) research that the experienced professional knows without being able to give a rationale. Pat's account also reveals that similarly to Becky and Lisa she was unable to gain the doctor's co-operation when she requested him to come and see a patient.

Pat: We had two patients who were very ill, and we resuscitated them both and I said to the doctor 'He's not very well. I think he's very poorly you know. Could you come and see him he's on the ward. Could you go in the side room and see him?' He said 'No I haven't got time' and I said 'well I think he's very ill.' Half the night I went on and on and on... we had to resuscitate him because he arrested in the middle of the night his family weren't with him and he died, and I felt awful about that. I felt if I could have got through to him (the doctor) then maybe it (the arrest) wouldn't have happened [what would have happened?]. Then maybe they wouldn't have had to resuscitate him, which I thought was totally inappropriate

The main dispute within Lisa's story is that the doctor would not listen to Lisa's request for him to visit a dying patient because she was unable to provide reasons. Lisa's view is that she wanted the doctor to examine the patient before his condition deteriorated any further. The reason was because the doctors had not indicated in the patient's notes that he was not for resuscitation (no resuscitation definition) and therefore Lisa was aware that if the patient arrested the nurses would need to resuscitate him. Lisa's account reveals that she views the doctor's action (when he eventually examined the patient and commenced intensive treatment) as being too late to achieve a satisfactory outcome. However, Lisa and the students do not reflect on why the doctors had not made a decision with regard to this patient's resuscitation definition. Walsh and Ford (1989) and Hughes (1988) point out that it is the consultant (or a member of the medical team) who is the person responsible for informing the patient that he may have cancer and for discussing the prognosis of his disease. When the patient's death is not sudden or unexpected and is an inevitable consequence of his illness (Walsh & Ford, 1989) – that is to say the doctor is unable to cure the patient – then the doctor needs to discuss with the patient his/her wishes with regard to resuscitation (Attwood et al, 2001). Dimond (2001) argues that cardio-pulmonary resuscitation (CPR) should not be instigated in situations where it is unlikely to be successful and where sustaining the quality of life would not be in the best interests of the patient. Furthermore, Walsh and Ford (1989) argue that when death is an unpreventable consequence of the disease process, then symptom control and allowing the patient to die with dignity is more important than the doctor's treatment of the illness.

Pat's remarks show that (maybe) if she had been able to persuade the doctor to treat the patient earlier, then maybe the patient may not have arrested and the nurses would not have had to resuscitate the patient. Pat's view is that resuscitating a patient who is already very ill was inappropriate. Pat and the students do not reflect on why the nurses executed resuscitation techniques, despite the patient being very poorly. Dimond (2001) argues that nurses implement CPR because the consultant may criticise the nurse on the grounds that there were no *not for resuscitation instructions* written in the notes.

The other aspect that the students and the facilitator in the reflective practice group fail to reflect on is why the doctors tend not to acknowledge the patient's wishes with regard to dying. Bassett (1993) contends that as patients become more knowledgeable about their health, they may wish to have greater control over dying. However, Hayward (1999) argues that many patients do not consider the ethical and financial aspects when making a choice about the way in which he/she is cared for during the death process. This notion that the patient has control over the manner in which his/her death process is managed, has implications for the doctor's decision relating to who is, or who is not an appropriate candidate for resuscitation.

Mason (1997) contends that doctors tend to adopt a paternalistic approach to decisions pertaining to CPR and as a consequence do not consult the patient or nurse (Candy, 1991). This is in direct opposition to the BMA/RCN's (1993) proposal that patients should be involved in decisions relating to resuscitation. Hill et al (1994) and Mason (1997) argue that many doctors justify paternalism using the premise that they do not want to cause the patients undue stress.

Loewy, (1991, quoted in Attwood et al 2001: p1202) contends that discussion of resuscitation with patients may be more painful for the doctor, or nurse, than for the patient and that it could be argued, according to Attwood et al (2001), that when a paternalistic stance is taken the person who is protected is the doctor. This is because this approach negates the need to discuss directly the concept and consequences of CPR with a distraught patient and/or emotional relatives (Attwood et al, 2001). However, when doctors are likely to use their medical knowledge and experience to justify decisions relating to not for resuscitation (NFR), instead of using the patient's wishes as a basis, they fail to acknowledge the autonomy of the patient (Attwood et al, 2001).

5.3 Conflict due to doctors not listening to nurses

A frequent criticism from the nurses in this research that supports Mackay's (1993) and Walby et al's (1994) findings is their perception that doctors simply will not listen to what

they – the nurses – say about patient. The following remarks in response to Becky's reflection provide some reasons.

This is the thing though if they haven't got anything concrete then it won't matter. The doctors tend to look at symptoms like blood pressure and pulse.

They don't seem to be able to have a conversation with you. They can take on board something like they have a urine output of this or that... but they don't seem to be able to talk to you.

They will never know the intuitive bit of nursing. They will never believe that. They just brush it aside.

Or how a patient's feeling. They won't talk about that.. You feel you're hitting your head against a brick wall sometimes.

And I think the fact we spend so much more time with the patients than they do but there are certain doctors that really won't listen to anything a nurse says. Others are very good.

The implication within most of these accounts substantiates Becky and Lisa's comments (see section 5.1 and 5.2) relating to doctors basing their knowledge on the positivist view, hence requiring concrete evidence of a patient's condition, such as high/low blood pressure readings and diminished urine output. Furthermore, these remarks tend to support the notion that because some doctors make decisions rooted in the positivist perspective, they may not recognise the importance of the patient's emotions and neither do they accept the nurse's assessment based on intuition.

However, one of the students suggest that because nurses are with the patients 24 hours per day, so they are possibly in a more suitable position to assess whether the patient's condition is improving or deteriorating. This matches Benner's (1984) contention that because of the episodic nature of the doctor's ward visits, it is the nurse who is the first to recognise the subtle changes in the patient's condition, or the need for imminent resuscitation (like Lisa and Pat's stories). Allen (1997) contends that this difference in temporal-spatial organisation of medical and nursing work creates conflict. The reason is that the nurse's focus is on the needs of the patients on a particular ward, whilst doctors are concerned with the whole directorate and new admissions. The doctor's priority is based on clinical need.

The students do not reflect on why some doctors do not listen to nurses' assessment of a patient's condition. Mackay (1993) argues that many doctors are socialised into expressing a superior demeanor that is often carefully groomed at medical school and is a way in which the ascendancy of the medical profession may be asserted on a daily basis. The consequence, according to Mackay, is that many doctors distance themselves from the nurses and many are unwilling to listen to nurses' views, or seek information about patients from them.

Another reason why doctors may not listen to a nurse's view may be attributed to doctors pointing out the variation in nurses' abilities. For example, Mackay contends that whilst one nurse may be perceived as highly intelligent, another may be viewed as not very intelligent. According to Mackay, it is this perceived variability in nurses' competence that might support the argument that it is only particular nurses, who the doctor respects whose opinions will be sought. This is supported by Sullivan (1998), who argues that trust and confidence in the nurse's knowledge, skills and expertise is required by the doctors, in order for them to listen to the nurse's views. Perhaps in a similar vein, Mackay (1993) proposes that the junior staff nurse, whatever her opinions or abilities will usually find her views unheard (see Carol and Kara's narratives) in which the conflict in practice being between staff nurses and registrar or consultants.

Kara's description also, supports Becky and Lisa's stories that doctors do not listen to the nurse's assessment of the patient's condition. For example Kara's consultant would not listen to her assessment of the contents of a patient's rectum, so he carried out a rectal examination that was not necessary and then refused to acknowledge his mistake in an agreeable way.

Kara: I worked with a consultant. I knew exactly what I'd done and he wasn't very nice to me at all. It was about a lady that ... had come in ... with constipation and had been seen by the surgeons and had got bowel obstruction and I think they really thought she might have a mass somewhere but the surgeon had seen her and said that she was constipated. We'd given her I think 3 enemas and I'd given the last one and there was nothing in her rectum at all, and the consultant came round and said 'oh this woman needs another enema' and I said 'there's nothing in her rectum' and he said 'that's not what Dr C said' who's the surgeon so I said 'I did the enema this morning', and he said 'right get me a glove and some KY jelly' so I said 'alright then' and there was nothing in her rectum at all and he didn't say 'oh I'm sorry' but I mean maybe if it had been anybody else I don't know if they would have said 'oh write up another enema', I don't know...

However, Kara and the other members of the reflective group, fail to reflect on why the consultant was unwilling to accept that her assessment of the patient's rectal contents was correct, in comparison to his colleague's evaluation. The reason, as argued by Perry (1993), Kendrick (1995) and Mackay (1993)) is the difference between cure and care. The consultant views his colleague's evaluation as correct because medical knowledge is perceived as superior to nursing knowledge (Perry, 1993; Mackay, 1993; Kendrick, 1995). The consequence is that the patient underwent an unnecessary, rectal examination that is quite an undignified procedure.

Kara's remarks also, reveal how the crossing of the inter-professional boundary may create difficulties. Kara resented what she saw as an invasion into her professional area by the consultant, but did not reflect on why the consultant was unpleasant. This may be due to the consultant exercising his right to evaluate the health of a patient, because in comparison to Kara, he is legally responsible for the patient (Walby et al, 1994; Sweet & Norman 1995).

Kara attributes her discontent with the way in which the consultant dismissed her opinions in relation to the patient. However, she does not reflect on the causes for her frustration. Perry (1993) contends that because some doctors view nurses as subordinate to them, possibly the consultant is nasty to Kara because he wished to reinforce his position of power at the top of the health care system. Perry suggests that the consultant's disagreeable manner is an example of the methods that staff use within the health service to perpetuate the status quo. Mackay (1993) supports Perry's argument, contending that the consultant may have been dismissive, because the difficult relationships many students and junior doctors experience with their seniors is based upon a circular process of accepting that dominant and brusque attitudes become more acceptable with increased seniority. This ethos is passed down the medical pecking order and is an important part of a hidden agenda between doctors of different seniority and of course between doctors and nurses: Zara was a staff nurse and the doctor was a consultant.

In contrast, Sullivan (1998) argues, that the consultant may not have listened to Kara's views because doctors do not take the competence of nurses for granted, like they do with other

doctors. Mackay proposes that this attitude may not be found when a consultant is dealing with the ward manager, as over time they may have formed a good working relationship and the doctor has respect for the ward manager's competence. However, according to Mackay and Sullivan, respect is given only to those ward managers who have the confidence in their own knowledge and experience to stand their ground and challenge decisions in the face of medical power. Snelgrove and Hughes' (2000) findings support Mackay's and Sullivan's contention as they comment that the doctors justify the involvement of nurses in medical decisions and treatment, on the basis of the nurse's experience, rather than their training.

It is like the relationship I would have on the Coronary Care Unit... I would think nothing of taking an ECG and discussing it with the nurse exactly as if they are a medical colleague because they are so experienced (Registrar)
(Snelgrove & Hughes, 2000 p666).

Benner's (1984) research also, reveals that nurses, especially if they are expert, are involved in the decision-making process with doctors. The nurses' decisions involved such aspects as deciding what analgesia should be given and where the patient should be admitted. However, the nurses in Benner's research were from North America and this may partially explain why they participated in the decision making process. Mackay (1993) comments that a nurse who has trained in countries (like Australia and New Zealand) which she argues are less bound by class and status may enjoy a more equal relationship with the medical profession.

Carol's account also reveals that the doctor does not listen to the nurse's evaluation of the patient's deteriorating condition.

Carol: We had an episode a few weeks ago with a lady who was 48. She had a long history of cardiac problems ... she had not been well over the weekend. I mean I got the team to see her on the Saturday. We had the team to see her twice on the Sunday and they really didn't come up with very much and then on the Monday morning the girls came on, I wasn't on and they felt she was very unwell so they got the registrar up to see her. They had him up three times that morning and on the third time they called him he really told the nurse off.

The nurses in Carol's story similarly to Becky and Lisa's comments (see sections 5.1 and 5.2) knew the patient's condition was worsening and continued to request the doctor to visit. The third time the nurse contacted the doctor he *told her off* in fact he shouted at her. What the students do not reflect on is why the registrar shouted at the staff nurse. Perry (1993)

contends that shouting at a member of staff is the consequence of the nurse's low status in relation to medical power because some doctors may use their position to intimidate the nurse, leaving her feeling upset and angry. Furthermore, Perry (1993) argues that powerful groups like doctors, who determine the rules of clinical practice, sometimes abuse their power by the use of behavioural techniques (eg shouting), in order to stifle questioning of their decisions with regard to patient care.

However, Mackay (1993) comments that the expression of anger is affected by the position of a person in the hierarchy. For example, house officers do not show their anger to senior doctors, or senior nurses because their promotion is dependent on a good reference from the consultant. Mackay also suggests different socialisation within the two professions: doctors learn during their medical training not to criticise other doctors outside of their specialist area and they also learn that if a doctor does something wrong, he/she will be subjected to a private reprimand by the consultant, nothing is written down.

Nurses, on the other hand, are subjected to a much harsher disciplinary procedure because the nursing hierarchy is separate from the doctors' (Mackay 1993). For example, minor misdemeanors like using an abrasive attitude to a registrar who refused to visit a patient who was very ill are dealt with first by a verbal warning (Carol spoke to the nurse about her attitude but did not specify if this was a verbal warning). If repeated, such verbal warnings can lead to written warnings that may eventually lead to dismissal.

This difference, Mackay argues, especially when it extends to the silence of the medical profession towards what she terms maverick doctors, is a source of power. She suggests the rarity of doctors being struck off the General Medical Council Register can be accounted for by most doctors learning to rely on their colleagues not to be judged, or censured, unless there is evidence of grave misconduct. In contrast, nurses do not enjoy the same support because most of them are socialised into being aware constantly of this invisible threat of discipline for minor misdemeanours (see Janet's narrative in section 5.4). Mackay contends that many nurses attempt to hide their mistakes by keeping silent about them and this is supported by Kara's comments about another member of her group.

She told me about drug errors that she had done. Now that was something between her and I. There was no way that she would have stood up and said to the group because it's private you feel ashamed of something like that... people don't want to in front of people admit to being... negligent in some way which you are and I mean these are 2 drug errors. They were controlled drugs.

However, Mackay proposes that when someone in either the nursing or the medical profession breaks this silence, the whistle blowers are usually dealt with harshly. Two recent examples are the anaesthetist in Bristol who had to leave and work abroad because he spoke out about two heart surgeons whose techniques he thought were responsible for several children's deaths, and Graham Pink (discussed in section 6.2) a charge nurse, who was dismissed because he spoke out about the poor quality of care in an elderly care unit. On the other hand, Mackay contends that this system of control that governs nurses, where there is a lack of support and where minor misdemeanours are rarely tolerated, means that nurses may exhibit the behaviour of an oppressed group. Conflict *within* nursing takes place because they are unable to engage in conflict with those more powerful than they are (like doctors and managers to be discussed in section 6.2).

Carol's remarks reveal that despite this confrontation between the doctor and the nurse, she (the nurse) did get the doctor to return to the ward to instigate treatment.

Carol: I mean I know she (the nurse) can be a bit abrasive on the phone... so I think they sparked each other off... anyway she got him to come back and he decided she (the patient) needed a central line... but she arrested just as they put the central line in... and she died... it was a bit of a nightmare really ... it wasn't through lack of doing something. It was his thought processes were on a completely different track... you know he wished he had done other things because... they took bloods and... her potassium was 8.4 and her urine was zilch. ... I mean I felt sorry for him really because he really wasn't doing anything but he was going up the wrong path really... He's learnt a lot by the experience... but I asked him what happened at the post mortem and I could see he was still upset about it. I can see their (the doctors' problems) as well... but I had to talk to him because I said you know the nurses were wanting you and you shouldn't be shouting at them... but I did speak to him because he had a problem with this particular nurse and other people have said to me as well ... I know she can be a bit abrasive and I had to speak to her about that later ... this staff nurse she was very upset, very tearful... she could not understand why he had done nothing... he's a very good doctor but I think he'd be alright with you (identifies 2 students who are ward sisters)... it is very difficult depending on what level you are... but they (the doctors) do sometimes totally ignore what the junior staff nurses say and she was a very junior staff nurse, but she was right.

One of the issues here is Carol's attitude towards the junior staff nurse and registrar. Although Carol appears to sympathise with the registrar despite the fact that he did not implement treatment that may have improved/alleviated the patient's condition (his decision to put in a central line was too late to save the patient because the patient arrested during the procedure). On the other hand, she does inform him that he should not shout at the nurses when asked to visit a patient, whose condition in the nurses' view was deteriorating rapidly.

Carol however, does not reflect on why the nurse displayed an *abrasive attitude* and neither does she reflect on her critical attitude towards the staff nurse's angry exchange with the doctor. Walby et al (1994) contend that Carol may be exerting her authority over the junior nurse's behaviour towards a senior doctor because Carol may believe that part of her role is the monitoring of junior nurses. Perry (1993) argues that criticising the nurse's *abrasive* behaviour is one technique, used by those in a position of power, to ensure that the junior staff nurse learns to know her position in the ward-based hierarchy, hence ensuring a perpetuation of the status quo.

The dispute between the staff nurse and the registrar relates to the idea that the staff nurse knew the patient's condition was deteriorating and yet, was not satisfied with the doctor's lack of action because it did not improve the patient's condition. However, what Carol and the students do not reflect on, is why the nurses expected the doctor to treat a patient whose poor urinary output and high potassium blood level was possibly a consequence of her advanced heart disease (*she had a long history of cardiac problems*). Also, they do not reflect on the appropriateness of the doctor implementing a treatment procedure (like central lines) in a patient who was dying.

Walsh and Ford (1989) argue that most deaths are predictable and occur in patients who have usually suffered from a chronic disease (like the patient in Carol's narrative). It appears that the nurses, as well as the doctor, do not base their decisions on the patient's wishes because treatment took precedence. If the patient is to be empowered (discussed in section 5.1.3) to make decisions about her care, the patient needs to know the truth about her diagnosis and prognosis and then she can make choices relating to the kind of care she requires when her

death is inevitable.

This aspect about very ill and dying patients (discussed in section 5.2) is fraught with difficult and unanswerable questions and appears to remain a source of conflict between doctors and nurses (Mackay, 1993; 1995; Walby et al, 1994). One reason may be due to ethical dilemmas. Is it morally right to resuscitate a patient who is dying from cancer (like the patient in Lisa's story in section 5.2), or aggressively treat a patient by inserting a central line in a patient whose heart is failing? Elston (1993) argues that some doctors continue to treat such patients because they may perceive greater danger in non-treatment than in over-treatment. Nuland (1993) agrees, suggesting that clinical judgement based on the biomedical model often takes precedence over an ethical decision because subsequent review by other doctors, or consultants may lead to the accusations of poor judgement and negligence. Thus, it seems that the doctors may appear brusque and unwilling to listen to nurses because they fear the possibility that their medical colleagues may brand them as incompetent.

Mackay's (1993) study supports this notion that the nurse's perspective is not taken into consideration when making decisions about very ill patients, as well as substantiating the idea that the biomedical model takes precedence over the ethical paradigm. The reason, as argued by Mackay, may be because many doctors rate the doctor's clinical competence that is based on current scientific medical knowledge as more valuable than decisions based on ethics. Clinical successes, as pointed out by Mackay, are the things that are discussed when doctors meet socially in the dining room, not the way in which the doctor approaches and talks to the patients and relatives, or indeed the nurses (my emphasis). The result, as argued by Nuland, is that the more caring aspect of cure - in which doctors are able to project themselves into the place of the patient and relatives - in order to view the illness from their perspective, takes a secondary position to the biomedical model. This seems to be dependent on the position of the doctor in the medical hierarchy.

Mackay argues that the reason why that junior doctors (HO and SHO), in comparison to consultants, place attitude to patients and relatives as the second most important skill required by doctors, may possibly be due to the idea that they have more contact with the

patients than the consultants. The implication is that some doctors especially those in the more junior positions appear to be aware that maybe cure is inadequate, unless accompanied by care (Webb 2001). However, the view of many doctors is that decisions based on the ethical aspect are of secondary importance to decisions based on the scientific medical model (Mackay 1993).

When the patient died and the results of the post mortem were known, the staff nurse's judgement was proved to be correct. However, the students do not reflect on why the doctor would not listen to the nurse (this has been discussed in section 5.1.3). Perry (1993) argues that because the nurse is in a subordinate position to the doctor, this means that the staff nurse has no authority to change the patient's treatment and that the only option open to the staff nurse when the patient's condition deteriorated was to send for the doctor. Kendrick (1995) supports Perry's argument and contends that even ward managers whose positions are similar to those of consultants - as each heads a team and each is vicariously responsible for the care that is given by members of that team - are powerless with regard to treatment and diagnosis, as they have to await '*the legal prerequisite of doctor's orders before implementing care associated with such orders*' (p 246). This action needs to be taken, despite the ward managers being able to wield considerable influence concerning any difficulties involving the attitude/practices of junior doctors (Kendrick, 1995). Carol's narrative substantiates Kendrick's argument, as despite being able to speak to the registrar about his angry behaviour she still had to summon the doctor in order for treatment to be initiated.

On the other hand, the staff nurse, despite being junior, continued to challenge the registrar, even although he is a senior member of the medical profession because she seemed to think that the action/non action he was taking was not in the patient's interest. Walby et al (1994) propose that it is rare for nursing staff to confront doctors in the more senior grades of training posts such as a registrar. On the other hand, Walby et al's findings show evidence that nurses may willingly cross the professional hierarchy to challenge doctors if they believe that quality patient care is being compromised.

The other feature that the students do not reflect on, was Carol's view that possibly the registrar would accept the assessment of a patient's condition if carried out by a ward manager, but was unwilling to listen to a very junior staff nurse's evaluation. Perry (1993) contends that health professionalism is a hierarchy of power, in that different groups have differing perspectives according to their location and access to the decision making process. For example, the consultant and GP are at the top of the hierarchy because it is the consultant and GP who are legally responsible for the patient in hospital (consultant), or for the patient registered with the GP (Walby et al, 1994). Therefore, as a consequence of this responsibility the consultants and GPs enjoy a high level of autonomy.

Mackay (1993) and Walby et al (1994) however, point out that this autonomy is not so clear at the registrar, SHO and HO level because they are training to become either a GP or consultant. These doctors in training are aware that they are moving towards the responsibility of becoming either a GP, or consultant and so gain more autonomy as they move through the medical hierarchy. Whereas, as argued by Mackay and Walby et al, the nurse however skilled will never attain the same autonomy as the doctors because in comparison she/he does not have legal responsibility for patients.

The contemporary meaning of hierarchy relating to the health service is that each health care employee is arranged in a status, order and rank (Perry, 1993). Mackay (1993) argues that the way in which health professionals are organised as vertical hierarchies is one of the barriers to effective team working. It is also a pattern that may reduce the likelihood that a practitioner will respond appropriately and immediately to a patient's requirements because of the need to check changes with senior colleagues (Greenwell, 1995).

Snelgrove and Hughes' (2000) study supports the view that because doctors are at the top of the hierarchy, they are the only ones able to effect change in patient care: their research showed that doctors perceived themselves as being the key figure in the management of patients in that they diagnose the condition, outline a plan of care and advise the nurses how to carry out this treatment. Hence, as Perry would argue, since the staff nurse in Carol's view was in a junior position to the registrar the expectation upon her is to know his/her place and

not question the competence of persons of higher status.

A further aspect that the students and Carol do not reflect on is that power is not completely one-sided and that nurses according to Mackay (1993) may also wield power. For example, Carol (the ward manager) exerted power in that she was able to openly tell the registrar that he should not shout at the nurses because they wanted him to visit a comparatively young, very ill patient.

Gemma's narrative also, supports this notion that nurses do openly challenge doctors, but this pertains to a doctor not performing adequately. Gemma, a staff nurse, tackles the doctor herself. This contrasts with Mackay's (1993) proposal that the ward manager is the person who usually contacts the consultant if there is a problem with a junior doctor. .

We had a doctor who is a senior SHO and she's highly qualified but she's doing a lower job and every now and again she has to do the on call, and there are several factors... I think she is lazy... she's not used to - none of the doctors like doing the SHO job on gynae because they are back down to the lowest of the low. There is no one under them, they take blood, they do everything, they clerk them (the patients). Coming from medical or surgical SHO you know they've had skivvies running round, so, that's a step lower for her, but for her it's even a double lower step, but if she's on call she's never available to do the work that she should be doing. Apart from that she takes on the higher role as well, like she will do the forceps delivery, she will go to theatre and do the ERCP's. So she's doing the registrar's job as well as doing the SHO's job. If she was on call on the weekend, the patients don't get to see a doctor until, well she finished the ward round at a quarter to four in the afternoon and you know there have been people waiting to go home from 9 am in the morning, so, everyone was moaning like hell and I was getting really frustrated. I said right Monday I'm going to go and speak to the manager and tell her there's a big big cogwheel blah de blah, and then I thought well hang on a minute, I suppose I'd better tell F I'm going to complain about her. I sort of couched it in a slightly different way when I spoke to her about it, on the aspect of the fact that she's been put under stress to do both jobs and I think it kind of brought her up a bit short and made her think about what she was doing and certainly the next day she was very diligent in coming down and saying is there anything else I can do and everything. By Monday I'd calmed down and I said no I am not going to the manager, but it certainly helped. (Gemma)

The doctor in Gemma's story was a female and held a junior post in the medical hierarchy. Gemma's decision to tackle the doctor may have been influenced by the doctor's relatively junior position (Hughes, 1988; Allen, 1997) as well as the fact that she was female because

the findings from a study carried out in Norway (Gjerberg & Kjolsrod, 2001) imply that the doctor-nurse relationship may be influenced by gender as well as inexperience.

The results of Gjerberg & Kjolsrod's research, reveals that female doctors, especially the younger ones, complain that the nurses showed a lack of respect and confidence in their decisions. However, it appears that with increasing age the female doctors complained less about the lack of help from nurses. Gjerberg and Kjolsrod suggest that the reason for this difference is due to the notion that the older female doctors hold the higher positions in the medical hierarchy. Thus, there is an increase in the status difference between the doctors and the female nurses. The findings also showed that the women doctors used specific strategies to secure assistance from the nurses. For example, they made friends with nurses by actively courting them and they relied less on nurses by asking for less assistance than male counterparts. In addition, they attempted to be more efficient than male doctors by carrying out a nurse's request immediately and by asking the nurse's advice more often than male colleagues.

Paula's story supports Mackay's (1993) comments that senior nurses will contact the consultant if they are not happy with the decisions being made by a more junior doctor. Although the doctor concerned is a registrar, he is a locum registrar who would be less familiar with accepted practice within the maternity unit. Mackay contends that because locums are not part of the permanent medical staff, they tend to be treated with less respect by the nurses and often they are overseas doctors who have difficulty finding permanent posts.

Well I had a case and I went straight in and rang the consultant. We had a woman who was 22/23 weeks pregnant and she was having contractions and I went in to take over and she said she wanted some pain relief. Now we had an infusion going to stop the contractions. Now if we're going into the pain relief stakes obviously she was progressing and the infusion wasn't working. Therefore the thing to do would be to take down the infusion and accept that she was going to deliver but he didn't grasp this. He was the locum registrar on call for the night. He said well give her some pain relief and I said what will we do about the infusion and he didn't say anything. He said you can continue on that and I thought if we're continuing with that (the infusion) in the hopes of stopping the labour ... there's pethidine/morphine or whatever he wanted and I thought we're not going to do the baby any good. I wasn't happy just to take it on as it was... so I rang the consultant and got somebody

else to listen in to the conversation...you know it was the least favourite consultant you had to ring as always so that was okay. The next night I was on and another consultant rang and he said that I believe you were not happy with the care and that the registrar had some different ways of doing things. (Paula)

I know there are several situations that have happened on labour ward and the midwife in question perhaps hasn't agreed with what the doctor has suggested either it's against what the couple want and there's no clinical reason why something should happen and the doctor is intervening and saying that this could happen, that could happen and then having discussed it with whoever's in charge of labour ward said well right here you go, you go straight to the consultant. In different situations where you think something should be done and it's not being done, they're (the consultants) very good. I must admit they will always back you up. They may not always agree with what you actually say but they will give you the reasons why they don't agree, but they will always come and give advice (Betty)

What both Paula and Betty reveal, is their relationship with the consultants in their area of practice. Their comments appear to suggest that the midwives' views in relation to childbirth in the labour ward are taken into account. This may be because midwives have undergone further training in addition to their basic nurse-training course, thus reducing the gap in knowledge and experience between themselves and doctors. One of the factors that Mackay (1993) suggests may account for doctors not listening to the nurse's view is the difference in the educational traditions of the two disciplines. Traditional medical education involves a 5-year university-based academic/scientific course and a commitment to continuing education. In contrast, nursing has consisted of a 3 year nursing school-based vocational/practical training, undertaken by all the students within this study (to be discussed in section 7).

However, Sweet and Norman (1995) contend that the doctor's responsibility in defining people as patients and having legal responsibility for them continues to be a significant factor that influences the power relationship between doctors and nurses. In a similar vein, Porter (1991) argues that one of the significant factors in the maintenance of medical power is its control over diagnosis because for any health problem, action stems from diagnosis. The nursing profession has recognised at least implicitly the importance of diagnosis as a factor in professional power. The result has been the enthusiastic promotion of techniques like the nursing process (to be discussed further in section 6.2) that reflects a degree of diagnostic autonomy for nurses.

Another aspect of the doctor's role where the nurse's views may be considered relates to drug prescribing.

We have a lot to do with anti-emetics and chemotherapy patients. You just get the house officer who doesn't know anything about chemotherapy really hasn't got a clue and you're telling them what to write down. You know you have to tell them how to spell it what dosage and how frequently to give it. (Abigail)

Abigail's comments substantiate research undertaken by Allen (1997) where the findings show that the nurses influence drug prescribing. However, Allen suggests the reason why these nurses were included in decisions regarding drugs may be that many doctors came from overseas and were a transient workforce, in comparison to the nurses who had trained locally and for whom staff turnover was low. Therefore, doctors frequently sought nursing advice about drug dosages and nurses routinely requested specific drug prescriptions for patients. Furthermore, nurses often questioned junior doctors' prescriptions, if they differed from standard medical regimes with which they were familiar. Allen contends that because the nurses were familiar with the organisation, its rules and operations, this enabled the nurses to have some power over the junior doctors.

Other research carried out by Hughes (1988) and Aksel Hn Tjora (2000) reveals nurses participating in the decision-making process. Hughes' study into nurses' decision-making influence in a casualty department indicates that the nurses were responsible for categorising patients, for history taking, for observation and for indicating the likely course of treatment (eg suturing, plastering, admission) before the patient was seen by the doctor. There were situational factors that contributed to the nurse's promotion of power. Firstly, the doctors required help from the nurses because the number of admissions was large and the patients' complaints too clinically ambiguous. Secondly, the high turnover of medical, as opposed to nursing staff in the department meant that the younger, inexperienced doctors relied on experienced senior nurses for assistance and advice. Lastly, many of the doctors came from the Indian subcontinent and because recognising social cues is an important part of casualty work, these doctors were reliant on the nurse providing advice. However, the doctors had the final responsibility for diagnosing the patients that is telling the patient what is wrong with him/her.

Asel Hn Tjora's (2000) study explored the work of the nurses who staff Norwegian emergency, medical communication centres (AMK - similar to NHS direct), independently from doctors. These nurses had contact with the doctors through the use of a telephone and they acted as the intermediary between the patient and doctor. He concludes that the nurse's work involved autonomous decisions with regard to screening, evaluating and diagnosing. Thus, because of their co-coordinating role, there were times when the nurses managed the doctors, in the sense that they filtered the information that the doctors received and controlled their involvement with particular patients. Many of the doctors, the nurses were dealing with were inexperienced doctors, or hospital doctors working on call to get extra income. Thus, it would appear that the nurse's management of doctor's work becomes more visible, when experienced nurses interact with doctors with little local experience, or little experience of any kind (this is supported by Abigail, Gemma and Paula's comments).

The other important aspect in this research is that the nurses found the doctor-designed Index for Medical Emergency Assistance (NI) a deficient tool for guiding the nurse's decision. The reason, according to Asel Hn Tjora, is that it failed to take into account the nature of the nurse's real-world decision-making that is based on interplay between professional and personal knowledge, experience and common sense, as well as support from colleagues and collective learning. However, there are moves by the doctors to implement a compulsory use of the NI by the AMK nurse, which according to Asel Hn Tjora, may be an attempt to increase their control of the nurse's autonomy in practice.

Titchen's (2000) and Binnie and Titchen's (1999) action-research study into the development of patient-centred nursing reveals that prior to the introduction of their research, the doctor-nurse relationship on a medical ward was very similar to the one that Stein et al described (1990) - in that the nurses were no longer prepared to be cast as handmaidens and believed that they should work in a collaborative partnership with doctors. However, the nurses on the medical ward commented that it was their own lack of confidence and skill within the relationship, as much as the doctor's reluctance to change that denied them the status they wanted. By the end of the study, the nurses took a more active part in the decision-making

process with doctors, by acting on the patient's behalf in some very difficult circumstances. For example, during the ward rounds, the primary nurse would ensure that the consultants as well as the medical students he was teaching at the bedside included the patient in the session. She/he would encourage the doctors to explain aspects of care to the patient and to ensure that the wishes of the patient were included in the discharge process. Some of the doctors also, voiced favourable comments concerning the way in which the nurses were participating in decisions concerning patient care.

In contrast to this theme of nurses participating in the decision-making process, Lisa's comments support Mackay's (1993) contention, that although nurses train the newly qualified HO the power may rebound later: once these same doctors have familiarised themselves with the organisation, they may assert their superior position over the nurses who 'trained' them.

To begin with when the doctors commence the nurses tell them to sign this and do that and do this and after three months they come on the ward as if they know it all and you've taught them it all.

Lucy's remarks substantiate the argument that some doctors perceive nurses as subservient. However, Lucy's action supports Walby et al's (1994) claims that as an experienced ward manager she is willing to tackle the inexperienced junior house officer in front of his colleague and a more senior doctor (registrar). This is because she did not like the idea that he stated that nurses are subordinate to doctors and implied that pouring out the iodine for the doctor was an inferior task to be carried out by nurses and not doctors.

I think I told you about my experience with that particular team when they admitted a patient to the unit who was ventilated and I was bagging the patient when they came in, they wanted to put a central line in and there were 3 doctors 2 chaps and 1 female. They'd got their pack out. I had it all on the trolley. The female doctor tipped the iodine out and one of the house doctors said 'Ooh A's playing at being nursie. So I said 'what does that mean? Playing at nursie, what does that entail?' ... He said 'Ooh er, er, I don't mean anything. I just meant she's being subservient. So I said 'Oh do you consider a nurse to be subservient then? Then the nice registrar said 'No no we don't think that at all do we? We don't think that at all, no do we? We don't'. [laughs] red to the top of his hair but I thought he wouldn't have said it if he didn't.. um... anyway he looked up and he winked at me the house officer, so I said 'That's a wink for nursie to make her feel better'. He was just, really he was mortified but he wouldn't have said it if he hadn't actually thought it. It has actually gone round the hospital because one of the doctors witnessed it and I was very furious.

This doctor's perception of the tasks that doctors expect nurses to perform, equates with Walby et al's (1994) findings, in that some doctors expect nurses to perform menial tasks, such as setting up trolleys for medical procedures and clearing away clinical debris, besides tidying up (e.g. clearing away dishes and mugs that doctors have left behind). On the other hand, the registrar supported Lucy when she challenged the house officer. Walby et al (1994) contend that the registrar crossed the professional boundary to support Lucy against the house officer because the HO is in a subordinate position within the medical hierarchy and showed a lack of respect towards Lucy, who as a ward manager holds a senior position within the health care team.

The second aspect that Lucy does not reflect on is why the doctor openly stated that nurses were subservient to doctors. Perry (1993) argues, that the reason why the doctor views the nurse as subservient is because the socially constructed care/cure distinction results in nursing care being viewed as subordinate to medical cure. Some doctors, according to Perry, tend to expect nurses to clean up the mess after them because nursing care is viewed conveniently as an extension of the female role in the family that is accorded low value in the market place. Adshead and Dickenson (1993) agree with Perry that the reason why doctors may view the nurse as inferior can be attributed to the perception that medical cure is superior to nursing care, a perception rooted in socialisation during their medical training. They suggest that doctors are socialised during their training into viewing their work as having more intrinsic value than nursing, partly through role models who perpetuate the view that nurses are there, as the doctor's handmaiden.

Theresa expresses surprise when one of the new GP's who is a part time senior partner in the practice asked Theresa to explain the nurse's role within the practice.

Surprisingly we have a new senior who's part-time, and just this week - she's only been there for 3 weeks - she said I must come and speak to you about what you do and she went through everything that I did in the practice and said what do you do when this happens and she was really interested in what I did and I thought, well I thought two GP's both of them just started, their approach was completely different and I thought well maybe it's because of the male macho image, I'm not going to ask a nurse. I just don't know, but I have a bit more autonomy of course, I do most of the work myself, and if I'm not sure what to do I refer them back to the GP, I learn through two years of working in general practice you don't speak to a doctor about a patient you just send them to them, they don't really want you to give your

opinion for them, they have to think about it themselves and then decide.

One of the issues raised in Theresa's account is her perception that her general practitioners (GP's) are not really interested in listening to nurses' opinions about patients, preferring to make their own decisions in relation to patient care. Whilst nurses do have opinions, they are not encouraged to express them in the workplace.

The second issue that Theresa and the students within the reflective practice group do not reflect on, is why some doctors do not encourage nurses to voice their opinions. Perry (1993) argues that doctors are not likely to value nurses' opinions because medical cure is in an elite position in comparison to nursing care. The consequence, Keddy et al (1986) contend is that in order for patients to continue to believe in the supremacy of the doctor's ability, so the patient must not see anyone disagree with the doctor's judgement. Thus, nurses are not encouraged to build up relationships with patients, because as argued by Perry (1993), nurses might inadvertently criticise the way in which the doctor is treating the patient.

The third aspect that Theresa raises, but does not reflect on, is why she does not deal with patients' problems as they arise. Instead, Theresa advises patients to make an appointment with the doctor. Theresa's remarks seem to reflect the paternalistic view (discussed in section 5.2), in that in her opinion the doctor is the best person to deal with problematic decisions relating to patients because he (the doctor) is the expert. Thus, Theresa's view suggests that she's internalised this care/cure dichotomy as much as the doctors have, that supports Freire's argument that the dominated group tends to absorb the cultural myths of the dominator.

The last issue highlighted within Theresa's story relates to autonomy. She states that she has some autonomy because she carries out most of the work. The implication is that she has a choice in how she organises her workload, but does not have the autonomy to make clinical decisions because any problematic decisions with regard to patients she refers back to the doctor (if I'm not sure what to do I refer them back to the GP). However, Theresa and the students within the reflective practice group fail to reflect on the meaning of autonomy and its implications in relation to clinical practice.

Ford and Walsh (1994) argue, that nurses are not autonomous practitioners because they do not have the freedom to question decisions made in relation to clinical practice, or have the choice of doing things differently, or to assert the primacy of caring above the medical model of cure. Therefore, because nurses are subservient to doctors (Perry, 1993; Ford & Walsh, 1994; Kendrick 1995), they lack the power to influence clinical decisions. Becky (section 5.1) and Pat's stories (section 5.2) do not reflect on the idea that because nurses lack the power to influence clinical decisions in relation to patients they do not have the freedom to provide care for the patients in the way that they would like. For example, Becky was unable to relieve her patient's pain whilst Pat's patient underwent CPR instead of dying with dignity.

Ford and Walsh (1994) contend that because nurses are powerless and because they are mainly females in a patriarchal society, thus they are an oppressed group. Freire (1970; 1985) cites several consequences that happen when one group dominates another and these may apply to the position of some nurses with regard to doctors. Firstly, the dominated group (nurses) absorbs the cultural myths of the elite (doctors) as well as their values. In addition, nurses adopt the doctor's hierarchical structures, but lack the power and resources of the elite (doctors). Thirdly, as a consequence of the adoption of medical culture, the dominated group imposes rigid rules and regulations upon its members whilst simultaneously constructing a '*silent society*'. Fourthly, when the dominators express their views the dominated listen because they have no voice of their own. Lastly, the dominated group echoes the dominator's culture whilst at the same time utilising techniques that silence the members of the dominated group should they question decisions (Freire, 1970; 1985).

The students' accounts substantiate some of Freire's (1985) views. Nurses have little or no voice in the decision-making process because the doctors tend not to listen to what a nurse has to say about the patient's condition (this aspect has been raised previously in sections 5.1, 5.2 and 5.3). Furthermore, nurses have little control in the decision making process when the patient requires analgesia because the nurse has no authority to prescribe adequate analgesia. That is solely the responsibility of the doctor (discussed in section 5.1). Also, when the doctor fails to discuss resuscitation procedures in conjunction with the patient, despite the patient's death being inevitable, the nurse usually has no option but to instigate CPR in the

absence of a not for resuscitation definition being written in the patient's notes. The nurse is unable to make the decision not to resuscitate because the consultant may criticise her lack of action on the basis that he (not the nurse) is responsible for making the decision not to resuscitate the patient (see Lisa and Pat's accounts in section 5.2).

Besides nurses having no control in decisions that affect patient care, Janet's narrative (section 5.3) reveals one technique (shouting) that the doctor may use to prevent the nurse from questioning the doctor's reluctance to implement treatment procedures to a patient who was dying from long-term heart problems. In addition, Kara's (section 5.3) consultant displayed an unpleasant manner that achieved the aim of silencing Kara because she did not continue to assert that her evaluation of the patient's rectal contents was correct. These socialisation techniques matches Freire's contention that the dominant group (doctors) tends to utilise techniques that silence the subordinate group (nurses).

However, this traditional view in which nurses entirely lack autonomy and power and are oppressed is a simplistic picture because, as has been discussed, some nurses do have the power to influence patient care. For example, Gemma was able to discuss with the doctor how she (the doctor) could possibly manage her workload more effectively, in order for patients to be discharged earlier in the day. Paula and the midwives in the labour ward seemed able to achieve the care they wanted for maternity patients, by contacting the consultant for advice and support, whilst Abigail influenced the doctor's decision when prescribing anti-emetics for patients undergoing chemotherapy. In addition, research by Benner (1984), Hughes (1988), Porter (1991), Allen (1997) and Aksel Hn Tjora (2000) reveal that expert/experienced nurses use their power to participate in the decision making process with doctors whilst Titchen's (2000) and Binnie and Titchen's (1999) research shows that nurses are able to use their power to gain a more collaborative partnership with doctors where they participate in the decision-making process whilst developing a patient-centred nursing service.

Foucault's perspective on power and knowledge may provide an explanation as to why some nurses are empowered/not empowered to participate in the decision-making process and

change/not change the way in which they carry out their care. Sawicki (1991) contends that Foucault's ideas of power differ from those of traditional views as individuals, or groups do not possess power, rather they exercise power. There are many examples in this study that reveal this power being exerted (like the consultants in Kara and Becky's narratives as well as the maternity patient in Janet's narrative to be discussed in section 5.4). Secondly, traditional models conceptualise power as primarily repressive, while for Foucault it is primarily productive. Lastly, power for Foucault does not emanate from a central source (eg from top to bottom) rather it is diffuse, operating in varying directions. Thus, for Foucault power is everywhere, because a person does not have power, rather they only exercise it (Clarke, 1983). However, Foucault (1975) suggests that this power both limits and produces knowledge and that a discipline is an important force in maintaining power and limiting, or producing knowledge. For Foucault this is achieved through examination, normalising judgement and hierarchical observation.

Lupton (1994) explains that the Foucauldian perspective on power is closer to the idea of a form of social organisation by which social order and conformity are maintained by voluntary means. For example, both the doctor and the patient subscribe to the belief of the importance of medical testing, constant monitoring and invasive or embarrassing investigative procedures in the interests of the patient (Lupton 1994) Thus, according to Lupton, the patient voluntarily gives up the body to the doctor's or nurse's gaze because that is what people are socialised to expect. Therefore, the Foucauldian perspective suggests that the medical encounter comprises productive, rather than coercive power relations. Medical dominance is necessary for the doctor to take control in the medical encounter, in order to fulfil the expectations of both the patient and the doctor. Lupton contends that from the Foucauldian view detachment, reserve, responsibility for the patient's well being and an authoritarian stance needs to be maintained by the doctor. According to Lupton, the notion of patients being empowered to take control makes little sense, because such a change in the relationship calls into question the reason why the very encounter exists. Annandale (1998) argues that at the heart of the Foucauldian perspective is the view that medicine no longer controls through exclusion, or repression, but by inclusion and normalisation. Thus, because power is embedded in all social relations and practices, this appears to mean that it is

virtually impossible to dislodge (Annandale, 1998).

On the other hand, the assumptions within the Foucauldian stance may explain how nurses may be empowered to enable change to take place. Hennemann (1995) proposes that according to Foucault, nurses are able to change their relationship with doctors to a more collaborative approach because those who are governed either directly, or through resistance to power, can exert power. Thus, shared power through collaboration means that nurses have the power to alter the status quo through evaluating the traditional doctor/nurse relationship, because there is a need at a societal level for a more coordinate approach to health care (Heinemann 1995). Furthermore, as theories are potentially oppressive, the role of the nurse is to question the familiar and accepted rules and rituals and recognise that there are multiple methods of enquiry. Henneman argues that in order for nurses to become empowered so that they may contribute fully to the decision making process, they need to recognise that they are no longer limited by traditional definitions of science. Power relations, according to Heinemann are not fixed and that alternative ways of knowing are now recognised as legitimate forms of investigation.

Norsen et al (1995) contend, however, that for nurses to have a successful collaborative partnership with doctors requires co-operation, assertiveness, responsibility, communication, autonomy and co-ordination. Co-operation involves power sharing that is based on knowledge and expertise in which there is mutual respect for each professional's views. Whilst assertiveness ensures that the nurse is able to express his/her views with confidence. Responsibility refers to accepting accountability for views expressed and decisions made, whereas autonomy ensures that each professional is empowered to carry out their plan of care within their respective scope of practice. Co-ordination means that each practitioner has a clear understanding of each discipline's defined boundaries and competencies that reduces misunderstandings. Thus, the professional most qualified to do so addresses issues.

As well as the nurses not reflecting on possible reasons as to why they had no power to influence clinical decisions concerning patients, the students do not reflect on why the medical profession is more powerful than the nursing profession that results in the precedence of the medical scientific model over the nursing model. Hagell (1989) contends

that the reason for the unequal status between nursing care and medical cure may be attributed to the view that empirical medical knowledge that originated from positivism is created by and for male interests. Therefore, Hagell argues that because males have the power to validate this positivist knowledge, it is deemed to be legitimate and as a consequence is superior to nursing knowledge. However, Carpenter (1993) argues that nursing knowledge is perceived as inferior to medical knowledge because, as pointed out by Oakley (1984), nursing work is the result of gendered oppression and as a consequence is seen as invisible.

On the other hand, Kendrick (1995) contends that although there are limitations to this scientific model based on Descartes' view of Cartesian dualism, in which the body and the mind are split from each other, humankind has benefited. He points out that if medical knowledge had remained generic, oncology would never have existed because it is only through medical specialism that the pathology of cancer has been reduced to the intricate physiology of the cell. Thus, it is possible as argued by Kendrick, that Descartes' perspective provides a valid reason for the importance of the medical model because medicine's main aim is to explore the disease process and do everything that is possible to achieve a cure.

Returning to the theme of the reasons why doctors have more power than nurses, it appears that this dominance can be traced to the division of labour (Kendrick 1995). Gaze (1991) proposes that because nursing is a predominantly female profession which was founded during a period of male dominance - the Victorian era, thus, the early image of the nurse embodied the Victorian ideology as it related to womanhood. From its inception nursing has always been closely linked to *femaleness* (Jolley, 1995; p95) and according to Hunter (1988 quoted in Jolley, 1995; p95) had its origin in the home where nursing was seen as a natural part of the mother/housewife role. In contrast medicine, consisting mainly of males, embodied complementary Victorian values, emphasising the man as the natural head of the family and the female as subservient and economically dependent (Walsh & Ford, 1989). The consequence of this gender difference is that because nursing is perceived as an embodiment of the housewife/mother role, nursing according to Meleis (1985) conjures up an image of servitude, sacrifice and altruism. Walsh and Ford (1989) point out that this results in the

nurse accepting the authority of the doctor.

Oakley (1974) proposes that the Victorian attitudes that arose within our culture during industrialisation in the late 19th century was a result of the culturally determined sexual division of labour and that the latter shaped the relationship between the nursing and the medical profession. In other words, Oakley (1985) proposes that nurses are socialised into their subordinate position and the findings from this research appear in part to support this assertion (see Carol and Kara's narratives section 5.3). On the other hand, feminist theories encompassing a wide range of views about women's place in society are linked by the common view that women are an oppressed group within a male-dominated society (Annandale, 1998; Jolley, 1995; Ford & Walsh, 1994). Feminists contend that the gendered division of labour is not the result of some natural progress associated with the rise of science, but is the result of a series of political, power-based struggles (Stacey, 1988). The consequence of this gendered work is that nurses, who are predominantly female, are controlled by forces such as doctors, who are predominantly male and who have greater prestige, power and status (Freire, 1985). Ford and Walsh (1994) argue that currently there is ample evidence to show that nurses are an oppressed group, in that nurses, according to Maslin-Prothero & Masterton (1999), lack autonomy, accountability and control over the scope of their practice.

The findings from this study (see Becky, Lisa and Pat's remarks in sections 5.1 and 5.2) support the argument that nurses lack autonomy. These nurses did not appear to have the freedom to care for patients, as they believed they ought, such as alleviating pain and allowing a patient to die with dignity and respect. Although Lisa and Pat may instigate resuscitation without the doctor's permission, they are not responsible for deciding which patients are not for resuscitation – that is the doctor's prerogative. Furthermore, the patient's views as to whether he/she wishes to be resuscitated appeared not to have been sought. The nurse's assessment of the patient is not believed by doctors (see Lisa and Zara's, comments in sections 5.2 and 5.3) or acted upon (see Becky, Pat and Carol's narratives in sections 5.1, 5.2 and 5.3) whilst other doctors view nurses as subservient to them (see Lucy's comments in section 5.3).

On the other hand, there are instances when the nurses in this study do influence doctors (see Gemma and Abigail's narratives in section 5.3), but this appears to be related to the inexperienced and more junior members of the medical profession. This influence seems to be on an informal basis that involves advising the doctor about drug prescribing and requests for a doctor to make decisions that patients can go home in the morning, rather than leaving this decision to the end of the day, when the doctor has completed her work. Some of the midwives' comments (see Paula and Betty's remarks in section 5.3) suggest that the consultant appears to support and advise them if they are unhappy with the way in which the registrar is dealing with a woman during labour. However, Lisa's comments reveal that once the inexperienced and junior doctors have familiarised themselves with the organisation, they may assert their superior position over the nurses that trained them. It appears that nurses do not have the control and responsibility over certain aspects of care, like not being able to prescribe a more potent analgesia for their patient, not having the authority to decide which patient is not to be resuscitated, or which patients are to be discharged, as well as not being able to decide whether an endoscopy is a suitable intervention in a patient who the nurse believes has a heart problem. The result is that nurses are unable to practice autonomously.

5.3.1 Professional Power: the division of labour

The second aspect that the students appear not to consider is the difference in the balance of power between the two professions and how this constrained their practice and resulted in friction between the nurse and the doctor over aspects of patient care. Walby et al (1994) maintain that currently the consultant has ultimate responsibility for the patient in hospital and the GP has responsibility for the patient's treatment outside of hospital, whereas the nurse does not have ownership of the patient. This difference in the power relationship can be traced through the disparity in the development of the two professions. Despite the fact that the development of the medical and nursing professions are closely linked, it is the medical profession who has an established and prestigious place in the health care system (Perry, 1993).

The provision of a privileged status for the practice of medicine gained ground when the Medical Registration Act 1858 laid the foundation for the current organisation of medicine (Hardey, 1998). It was an important piece of legislation because the Act set up the General Medical Council (GMC) that remains responsible for the monitoring of educational and professional standards (Hardey, 1998). The Act granted doctors a monopoly on medical practice and granted them important powers of self-government (Walby et al, 1994). Thus, in comparison to nurses, the doctors organised themselves into a professional group before state intervention in medicine made the state a major employer of doctors, as well as creating control over their market situation.

Hardey (1998) contends that when the National Health Service (NHS) was established in 1948, it played a significant role in consolidating the dominance of medicine by placing the profession at the centre of public policy so that

Complete medical authority remained sacrosanct (Klein, 1984; p14).

GPs remained as independent contractors to the health service and consultants gained generous salaries; merit awards and the option of combining NHS work with private practice (Klein, 1984). Annandale (1998) argues that once in place medical power seemed intractable and clinical autonomy meant that decisions about patient treatment were totally in the hands of the consultants.

Walby et al (1994) contend that nurses attempted to achieve a similar state-sponsored form of closure. However, Rafferty (1996) argues that because nurses lacked the right to vote, they had to depend on male proxies to argue their case. When The Nurses' Registration Act was passed in 1919, it did not give nurses the same control over their profession as doctors had over theirs. The act provided a registration of nurses based on broad training experiences and driven by cost considerations. The knowledge base of registered nurses related to a range of practical skills to be performed at the patient's bedside (Williams, 1980) under the direction of a doctor (Hagell, 1989). Nurses did not gain autonomy and as a result nursing was typified as a relatively low paid female occupation (Hardey, 1998). The consequence of their lowly

status, as pointed out by Hardey, resulted in nurses not being involved in the debate about the creation of the NHS. Furthermore, the nurses were not consulted during the implementation of the Griffiths report in 1985 (Davies, 1995). The reason why nurses were not present at the negotiating table in 1948 was because Bevan did not consider them as experts and they were perceived as subservient to doctors. Also, Bevan believed that nurses would automatically follow doctors if the doctors were persuaded into the NHS (Denny 1999). Griffiths, on the other hand ignored the nurses because he did not regard them as important in the decision making process (Davies, 1995).

The implementation of the Griffiths Report in 1985 resulted in nurses losing their automatic representation at senior levels and destroyed a career structure that had been exclusively available to nurses (Walby et al, 1994)). Nurses were eligible to apply for general manager's post but as Levitt and Wall (1995) point out only a few nurses applied for the posts and very few were appointed. The reasons are twofold. Firstly, Strong and Robinson (1990) argue that nurses were not educationally equipped to compete with doctors and administrators for senior management posts. Secondly, nurses tended to take a humanitarian view relating to resources issues, instead of the management ethos of efficiency.

The main objective of general management was to make doctors more accountable for their decisions (Denny, 1999) but this appeared to have very little effect (Annandale, 1998). Therefore, further controls were introduced under the 1990 Community Care Act (Denny, 1999), despite vehement opposition from the British Medical Association (Annandale, 1998). In order to increase the doctor's financial accountability, clinical directorates were introduced and although nurses were eligible to apply for these posts, in practice the vast majority of clinical directors appointed were medical consultants (Denny, 1999). Annandale contends that despite these changes, it appears that the doctors' clinical autonomy has not been significantly undermined because medicine's move into management means that they support the doctors' control of clinical practice.

However, Annandale - who bases her argument on Friedson's (1994) study - proposes that the challenge to the doctors' power and domination differs at the level of medicine's corporate

body compared with individual practitioners. At the collective level doctors remain firmly in control of the key factors that confer autonomy, such as control over training and the right to practise and the right to monitor practice standards. It is at the level of individual practitioners that doctor's powers are being challenged. Annandale argues that the divisions within the medical profession are intensifying. The medical profession has always been hierarchical, but it is the current restratification that has resulted in opportunities for GPs who historically enjoyed less power and status than senior hospital doctors – although they enjoyed a high degree of clinical autonomy (Annandale, 1998). For example, Denny (1999) argues that the implementation of the proposals within the 1997 White Paper (The New NHS Modern and Dependable) meant that GPs would form a collaborative relationship with community nurses during the development of primary care groups (PCGs). These PCG's would control most of the NHS budget within their area. Denny maintains that in comparison to nurses GPs are the more important group because as Kenny (1998) contends, the health minister gave in to pressure from the BMA and agreed that when the PCGs were introduced there were to be only two nurse representatives on the PCGs, in comparison with seven GP representatives and a GP in the chair. North's (1998) argument is that once again, nurses were frozen out of collaborative partnerships with doctors

Annandale maintains that this restratification has meant that some doctors have increased their autonomy and dominance, but there are those doctors (many women, for example) whose position of relative weakness are exacerbated. In other words, the power positions, such as clinical directorships are the preserves of white male doctors (Annandale, 1998) whilst the gender-based inequalities that have historically characterised medicine are heightened. This is because women doctors' work in non-consultant posts and in less prestigious specialities such as elderly care (Annandale, 1998; Elston, 1994). Hardey (1998; p71) states that

Under the impetus of second wave feminism, medicine was identified as a key example of the patriarchal exclusion of women.

There are historic echoes of this statement in the 1858 Medical Registration Act that allowed women to register as a practising doctor, yet did not permit women to enter universities (Walby et al, 1994; Hardey, 1998), so women had to train outside of the United Kingdom. Even then, Hardey notes, if women did obtain their medical credentials outside of the UK their application to register met with vehement opposition from male colleagues. Since the 1970s there has been an increase in female medical students and although currently women form half the entry into undergraduate medical schools (Walby et al, 1994) only 17% of women doctors are consultants and these are in areas such as anaesthetics, paediatrics and radiology (Annandale, 1998). Elston (1994) reveals that in 1990 there were only 16 female consultants working in the more prestigious areas such as surgery and cardio thoracic surgery.

It can be deduced that the medical profession, as argued by Annandale, averts threats to its dominant and autonomous position by a process of restratification in which some members of the profession gain more power and dominance at the expense of others eg females. From a pluralistic perspective, it can be concluded that in comparison to nurses, it is the doctors' objectives that prevail in conflicts over key political issues (Maslin-Prothero & Masterton, 1999). This supports the feminist view that nurses' subservience to doctors is the result of political, power-based conflict.

Historically, nurses have struggled to become a self-governing autonomous profession with some control over practice (Walby et al, 1994). Since the 1970's there has been an increased intensity for professionalism. This has been done through the development of nursing theories, primary nursing, changes in the concept of professional practice as depicted in the UKCC code of practice, the implementation of P2000 and an evidence base for practice.

There are a variety of opinions as to how successful the nursing profession has been in obtaining their objectives (Walby et al, 1994). Davies (1995) argues that the profession has adopted strategies pioneered by the doctors before them whilst Witz (1992) contends that the nursing profession's success is only partial because of the doctors' control over key aspects of nursing eg prescribing (see Becky's story in section 5.1). Hardey (1998) suggests that the

profession's success applies to the registered nurses only. This has been obtained, according to Hardy, at the expense of other women, who have become low paid health care assistants. They were introduced to fill the gap left by the nursing students, who gained supernumerary status as a result of the implementation of P2000. The consequence of this skill mix arrangement is that a core of registered nurses are increasingly taking on the supervision of health care workers, who deliver the majority of 'hands on care' to patients (Walby et al, 1994). The health care assistants are constrained to those areas where there is a significant amount of routine bodily care eg elderly care (Hardey, 1998). Denny (1999) suggests that by creating a pool of partly qualified workers (NVQs) who are undertaking what was considered nursing work, for lower salaries may result in undermining the professionalisation strategy of nursing.

It seems that similarly to the medical profession, restratification in nursing means that some nurses stand to gain more than others (Annandale, 1998). The implementation of the clinical grading pay system in 1988 reinforced the idea of an elite in nursing (Carpenter, 1993). Maslin-Prothero and Masterton (1999) argue that nursing is becoming more specialised along disease-related parameters in that specialist nurses are employed to care for patients/clients with particular medical conditions eg specialist nurse in diabetes/Parkinson's/respiratory diseases etc. Annandale (1998) contends that one professionalising strategy that appears to contrast with holistic care is the development of a cadre of highly, technical, orientated, advanced nurse practitioners (ANPs). The debate, Annandale argues, focuses on whether nurses are willing to undertake procedures such as venepuncture and the willingness of doctors to take responsibility for overseeing the nurse's performance (this is to be discussed in section 6.1). Restratisation within the nursing profession means that an elite nucleus of nurses has been developed at the expense of others within the professions. This elite core, similarly to doctors, may gain more autonomy because, according to Annandale, the nurses have undergone this internal restratification in order to further their professional status.

The question that still remains relates to the subordination of nurses to doctors' dominance. Despite the fact, that through professionalisation, nursing has attempted to clearly define the divisions between professional nursing care and basic care which, according to Baxter

(1988), may result in the creation of a white, middle-class elite, Hardey (1998) maintains that nurses remain subordinate to doctors because Carpenter (1993; p124) argues that in most instances nursing

Will involve less of a direct challenge to medical power than an attempt to reform it, a renegotiation of traditional patterns of subordination and a claim for greater responsible autonomy within it

In other words, nurses remain subservient to doctors because they appear to redefine professional nursing as consisting of the technical aspects of care that used to be the domain of junior house officers in the hope of raising the professional status of nursing. Thus, nursing has stratified along similar lines to the medical profession, but at a subordinate level.

In the next section, who controls the decision to induce a mother will be explored in more detail to reveal how the dominance of the doctor defines the boundaries of the midwife's practice and does not allow the mother to be empowered to make an informed choices.

5.4 Controlling inappropriate practice

It has been discussed in section 5.3 (see Carol's remarks) that some nurses may challenge the doctor if she perceives the patient/client as not receiving the care that the nurse expected. The following extracts reveal Janet's confrontation with a consultant obstetrician. Janet seems to believe that the consultant's decision to induce a mother at 38 weeks instead of at full term (40 weeks) was inappropriate because of the mother's previous obstetric history coupled with the fact that the mother's pregnancy was following a normal progression.

Janet's narrative (in appendix 3 because of its considerable length in comparison to other students' stories) reveals several issues that the students, the facilitator and Janet fail to reflect on. The first aspect relates to why the consultant capitulated to the mother's demands despite admitting to Janet that he would have preferred to wait a further week before making a decision to intervene (extract 9; appendix 3).

The consultant's remarks reflect a paternalistic stance (discussed in section 5.2), in that he is the best person to make the decision to induce the mother. This paternalistic attitude needs to be seen in the doctor's socially constructed dominance (Perry, 1993). It is the doctor, not the nurse who has the power, autonomy, expertise and knowledge to make clinical decisions (discussed in sections 5.3 and 5.3.1). However Janet states that

They (the doctors) are practicing defensively because they'll say if they force a woman and sort of say 'No I'm not doing this damn section you've got to go for a vaginal delivery' and something goes wrong... and you know, they come into hospital well and if they go out of hospital anything other than well with an infant, that's anything other than well... they want to know the reason why, and in a lot of cases what they actually do is in defence because of the risk of litigations.

The doctor's decision, as viewed by Janet, may be legally based because of the fear of litigation. The current climate, in which consumer demand (Hardey, 1998) and in which the medical elite monitor the rank and file are significant features within the health care system (Annandale, 1998). This means that individual doctors are accountable for their decisions, with regard to monetary costs and satisfactory patient outcomes (Annandale, 1998). The result is that doctors may engage in defensive practices such as ordering certain expensive procedures eg electronic foetal monitoring, for legal, rather than clinical reasons because they fear disciplinary action or a court case (Annandale, 1998). On the other hand, Pratten (1990) contends that improvement in the safety of technological procedures has resulted in the doctors' reluctance to do nothing. Pratten argues that there is a subtle influence in obstetrics, to vindicate the doctor who intervenes in the course of a normal pregnancy and that by implication exposes his colleague to condemnation, for non-intervention when a baby dies (as in the Wendy Savage case, 1986).

The second issue not reflected on relates to why Janet views the consultant's decision as risky. The reason is based on Janet's past experience (extract 6; appendix 3). When Janet questions the consultant's decision, he tells Janet that he will go ahead with the induction and will wait and see what happens. It seems that he is willing to give increasing amounts of prostin based on how the mother progresses during the induced labour (extract 7; appendix 3). The consultant's remarks support Inch's (1982) argument that the medical model results

in the use of technological intervention '*just in case*'. Furthermore, the fact that the mother required three doses of prostin and was very near to undergoing a caesarean section (extract 13; appendix 3) supports Inch's contention, that by disrupting the normal pregnancy pattern means that further intervention may be required to ensure a satisfactory outcome. The key issue within the consultant's answer to Janet's question is that because of the doctor's socially constructed power base (discussed in sections 5.3 and 5.3.1), the consultant has the power and autonomy to make risky decisions concerning clinically based care.

The third feature relates to why the students did not reflect on the perception that the consultant did not provide the mother with information about the risks (extract 5; appendix 3) of the induction procedure. This procedure may have resulted in the mother having a caesarean section, despite the mother's claims that she did not want another caesarean section (extract 1; appendix 3) The issue here concerns empowerment that Taylor (2000) defines as the process of giving and accepting power in order to liberate people (like nurses) from their oppressive circumstances. Whilst Mason et al (1991) contend that empowerment is concerned with the equitable distribution of power in order for people (like the maternity patient in Janet's narrative) to participate fully in the decision making process. However, Miller (1976; quoted in Ford & Walsh 1994; p26) argues that men (like the consultant) view power as a scarce commodity to be competed over in order to gain as large a portion as possible. Once this power is gained, Miller contends that the power is to be defended and preserved as well as being extended so that the power may be used over others (like nurses and patients).

It is likely that because the consultant views his position as more powerful than the mother, hence, he decided not to inform the mother of the risks involved in an induction procedure. This paternalistic attitude (discussed in section 5.2) that is a result of the doctor's socially constructed power base (discussed in sections 5.3 and 5.3.1), means that because the consultant tends to view his knowledge and expertise as superior to the mother, thus, he does not see the importance of discussing the risks involved in the induction procedure. One of the results of the precedence of the medical model being utilised in obstetric care is that the routine administration of technical interventions like an induction during labour appears to

be common practice (Pratten, 1990).

Betty: We had this patient from A... and on the page that's for labour document... is a consent form and at the top it says that this must be completed and signed by all women when they are admitted to the labour ward, and basically it said that they consent to any procedure, oh god, which is deemed to be necessary during labour apart from a caesarean section... I said to her 'Have you seen this?' ... So she said 'Oh yes' ... she said 'If they want to put a drip up or something like that'. I said 'is that what they said to you?' I said 'It's not just putting a drip up' ... she doesn't know because she's never had a baby before, so she's never been through the system... I was absolutely staggered.

Janet: They do not have to sign any consent for an induction... you can walk in for an induction. You're given a sheet of paper describing what will happen in an induction and by walking in and lying on the bed they write on their admission form admitted for an induction.

Janet and Betty's remarks support Pratten's (1990) contention that the scientific viewpoint results in mothers agreeing to consent to technological interventions, like induction procedures that are not based on the mother's individual requirements. Therefore, it appears that the individual needs of the mother are sacrificed to the medical model of care that has been defined by the medical profession (Pratten, 1990).

The mothers also, do not appear to have full knowledge of the risks involved in an induction process. Giving information about what happens during the procedure is not in itself empowering (Ford & Walsh, 1994). Ford and Walsh argue that telling the mother what will happen during an induction allows her to predict what will happen. On the other hand, giving information does not concede control to the mother because she has no control over the levels of prostin to be given during the induction procedure. As discussed previously (in section 5.1) doctors determine the amount of prostin to be administered because they have control of prescribing drugs.

The fourth issue that the students do not reflect on concerns why Janet viewed informing the mother of the risks of the induction as problematic. It was obvious to Janet that the mother was unaware of the risks concerning an induction (extract 5) whilst the mother was quite pleased about the induction because to her it meant that she would achieve her objective of not progressing with the pregnancy to full term.

Janet believes that

Basically what she (the mother) was doing, she was increasing the risk to her baby for her own comfort and well being and if I'd actually said that to her, she'd probably say don't be ridiculous

Janet reveals that she could have sought advice from her colleagues but the reason she did not consult them was because she believed that one of them might insist that she tells the mother about the hazards, involved in the induction technique (extract 8; appendix 3). It seems that Janet was unwilling to impart information concerning the risks because this may have resulted in the mother losing faith in the system (extract 8). Also, Janet believed that by explaining the dangers at this late stage in the pregnancy may be more harmful because *It may shake her confidence in herself to cope with it (the induced labour) because that can affect the outcome of labour as well.*

It appears that Janet regarded the mother's emotional state as important, whilst the consultant's actions seem to substantiate Pratten's (1990) argument that because of his positivist stance with regard to this mother's pregnancy, then by implication the consultant appears to have ignored the subjective experience of becoming a mother.

Part of Janet's problem related to the notion that the consultant exerted a paternalistic attitude (extract 9; appendix 3) in that the medical profession in inverted commas was held up there as being the ones that know. The other part concerned the idea that because the consultant had not given explicit permission for Janet to inform the mother of the risks, hence Janet decided not to go behind the consultant's back, in order to give details of the risks involved in an induction procedure. The reason is that if the mother decides not to go ahead with the induction, then Janet's head is truly on the block (extract 11; appendix 3). The implication is that Janet's action could be seen as disobeying a superior.

Walsh and Ford (1989) argue that usually management supports the medical staff if the nurse does not comply with the doctor's decision. Although Janet has not discussed her dilemma with her superiors and the consultant has not overtly told her that she cannot inform the mother of the risks, these abstract authorities, according to Perry (1993) are as powerful and

real as their physical presence and exert a striking influence on the care given by the nurse. This is reflected in Janet's story because instead of fully informing the mother of the risks, she writes her concerns about the consultant's decision to induce the mother early (extract 12) in the mother's notes.

Janet's decision not to tell the mother the truth may be due to the unwritten medical rule that the nurse must only tell the patients the same story that the doctor has given (Walsh & Ford, 1989). Mackay (1995) supports this notion that nurses tend to remain silent and do not express their doubts to the patient even in the face of what must seem to the nurse, at times, as unacceptable medical decisions. The reason for this silence, according to Mackay, is because the nurse believes that maintaining the patient's trust in the doctor's competence and knowledge is important, as he/she is the person responsible for carrying out treatment. There are many reasons why nurses tend to support the doctor (eg training, socialisation and their traditional relationship with doctors) but one reason, as argued by Mackay may be that some nurses are afraid of incurring the wrath of the doctor, especially the consultant. Mackay argues that when nurses have been humiliated or have witnessed other people being humiliated, they tend to learn to be quiet. Thus, when nurses like Janet remain silent (Janet does not inform the patient of the risks involved in an early induction) Mackay contends that this action tends to reaffirm the power of the medical profession.

Another reason may be that as Janet works in close conjunction with the consultant she may not wish to risk further conflict that may result in a deterioration of their relationship. A midwife in Taylor's (2000) study supports this assumption. For instance, the midwife complained about a GP's difficulties and unsafe practice in inserting a catheter for an epidural anaesthetic that did not provide adequate pain control for the maternity patient. This resulted in the doctor refusing to talk to the midwife and led to deterioration in the doctor-nurse relationship. The midwife reveals that management ignored her complaint about this GP and despite other midwives being present and muttering amongst themselves about the ineptness of this particular GP, they did not support the midwife when she complained about him. Management intervened on her behalf - as the result of another midwife's similar complaints about this GP. However, the midwife's perception was that while her relationship

with the doctor became superficially cordial, he continued to be allowed to carry out epidurals, despite the midwives complaints about his incompetence.

This finding - that nurses tend to mutter amongst themselves rather than challenge the doctors - is supported by Mackay (1995) who contends that nurses are vociferous in their assertions that they want their patients to have quality care, yet in practice rarely confront doctors about their poor judgement, clinical techniques and over-treatment of very ill and dying patients.

Walsh and Ford (1989) argue that because nurses defer to the doctor, this results in the nurse being forced to break her professional code and conspire in misleading the patient. The issue of professional accountability is raised within the reflective practice group

Carol: I just wonder where you stand in a sort of duty to care... really that you haven't actually told her... I mean if something goes wrong... the midwife never told me that this would happen... could they not say if you've expressed your worries you should have done something about it... I just wonder where you stand in that situation to be honest that's what we're all afraid of now.

Janet: Are you in breach of your code by omission by not speaking to her?

The Code of Professional Conduct (UKCC, 1996; p8) states that

In exercising professional accountability... whatever decisions you take and judgements you make, you must be able to justify your actions... and it is no defence to say that you were acting on someone else's orders

Janet withheld information that she knew should have been given to the mother and this substantiates Walsh and Ford's (1989) contention that withholding information breaches the professional code. However, Janet does weigh up the advantages and disadvantages of explaining the risks at this late stage in the mother's pregnancy. Janet justifies her actions based on her judgement that it would be more harmful to tell the mother the truth. Rowden (1987; quoted in Hoppin, 1995; p5) argues that the master-servant relationship in English law decrees that the master is responsible for the actions of the servant if the servant is working in accordance with policies agreed by both of them. The implication is that as trusts (master)

agree to care for the patient and select staff (servant) to carry out that care, hence it is the employing authority who is responsible for the negligence of any practitioners who fail to give reasonable care (Hoppin, 1995). Thus, if nurses are seen not to act in the best interests of their clients (UKCC, 1996; p9) they would be asked to account for their actions by the employing authority.

On the other hand, Dimond (1993) points out that there is an implied legal term within the nurse's contract that he/she will obey the reasonable orders of the employer. Walsh and Ford (1989) question whether this includes obeying a doctor's order to withhold information. This presents another dilemma in that the nurse by not telling the truth breaks her professional code but by disobeying the doctor's order risks being disciplined. Perry (1993) argues that when nurses voice their concerns about unmet patient's needs they are severely criticised. For example, Graham Pink (Faugier, 1991) was disciplined for voicing his concerns about the standards of care in an elderly care unit, whilst Webb (1987) cites an American case where a nurse was disciplined for providing information about alternative therapies to chemotherapy that the doctors had decided upon.

The last feature that the students do not reflect on relates to a point raised when one of the group members in response to Janet's narrative points out that

It's very difficult that when it's a doctor that's made a decision that you don't agree with to go back to a patient and say because they don't trust you in the end because they'll always believe what the doctor has got to say and so they end up not trusting you

The reason the mother will believe the doctor is because in comparison to nurse/midwife, the doctor has high status (Perry, 1993). Walby et al (1994) argue that the basis for the doctor's superiority (discussed in 5.3.1) lies partly in the acceptance of medical ways of thinking and the prominence of medicine as a scientific approach to knowledge that permeates throughout society. Furthermore, the construction of this medical science operates not only at the level of beliefs and concepts, but is firmly rooted in a solid set of social institutions because medical knowledge is secured through the universities and legitimised by the state (Hardey, 1998; Walby et al, 1994; Pratten, 1990). Therefore, it can be deduced that this notion regarding the superiority of medical science has gained not only credence as a result of the development of

scientific innovation and technological knowledge, but, is reinforced by the wide publicity given to procedures such as organ transplants and in vitro fertilisation techniques (Pratten, 1990).

Medical science on the other hand, results in a snowballing effect on the development of technological interventions (Ford & Walsh, 1994). Ford and Walsh argue that each new invention, (whether it be the development of new surgical procedures that were previously impossible or new drugs) produces a live patient requiring more intensive nursing care, dependent upon more and more sophisticated medical science. Therefore, this burgeoning of technological intervention substantiates Miller's (1976; quoted in Ford & Walsh, 1994; p26) argument that male power involves extending the power base.

Within these higher technological areas a more equal partnership between doctors and nurses has developed (Ford & Walsh, 1994). Ford and Walsh and Mackay (1993) contend that doctors value the judgement and knowledge base of nurses because it is founded on the close hour-by-hour working relationship that is lacking on the general wards. The establishment of this equal relationship reflects the doctor's scientific stance because Ford and Walsh argue that it is the nurse's technical and biomedical expertise that is valued by the doctors, rather than expertise in caring. This is supported by Snelgrove and Hughes' (2000) research where the doctors stated that they discussed ECG readings with nurses on the coronary care unit as if they were medical colleagues (discussed in section 5.3). Henderson (1994) contends that this knowledge of ECGs is not powerful to the development of the nurse-patient relationship because the nurse is unable to consider the social and emotional aspects. Therefore, according to Henderson, this technical knowledge reduces the power of the nurse in relation to caring and is only powerful in promoting communication with the doctor that is deemed meaningful by the doctor.

Childbirth is a normal part of a women's life (Pratten, 1990), so the question to be answered is why doctors have claimed control of pregnancy and childbirth. This aspect was not discussed within the reflective practice group sessions but is explored in the next section.

5.4.1 The conflict between midwifery and obstetric knowledge

Traditionally childbirth was the domain of women because experiential knowledge handed down through generations of women allowed some women to act as midwives (Leap & Hunter, 1993). However, the medicalisation of childbirth (Pratten, 1990; p41) as Hardey (1998) argues, developed in conjunction with the advent of scientific knowledge and as a consequence various implements such as forceps were introduced to facilitate childbirth. This provided an impetus for more men to become involved in midwifery. DeVries (1993; p133) contends that the development of delivery by forceps was the *technological break-through* that led to the decline of midwifery in most western nations including the United Kingdom.

The establishment of the GMC (see section 5.3.1) allowed the men who were practising midwifery to set up the Obstetrical Society (Hardey, 1998). Hardey proposes that midwives attempted to retain their autonomy and existence, but the medical profession confronted the midwives and used a number of techniques to extend their power. For example GP's campaigned in order to gain formal control over all aspects of pregnancy. Although the hospital-based doctors supported the midwives, they sought to confine the midwives' activities to normal births. Hardey maintains that this strategy served the interest of the doctors, because the birthrate far exceeded the supply of doctors. Thus, most of the women who were poor used midwives in preference to doctors. This relegation of midwives to normal births meant that doctors could deliver babies in those mothers who had the monetary means. Hardey contends that the doctors' male power and their positivist knowledge base (see section 5.3.1) was wielded through the control of abnormal births and through the Midwives 1902 Act, which stated that midwives, similarly to the general nurses, were to be formally trained. However, this instruction was largely controlled and delivered by doctors (see section 5.3.1).

It appears that the creation of the NHS in 1948 removed the economic barrier that kept many high-risk, low-income mothers out of hospital, besides removing the cost differential between midwives and doctors. GP's were paid for obstetric cases whether or not they delivered the

baby (Sullivan & Weitz, 1988). Pratten (1990) argues that it is a legitimate belief that the increased use of advanced technological and pharmacological monitoring has significantly contributed to a reduction in maternal and perinatal mortality and morbidity. This belief resulted in a move towards the centralisation of maternity services in large obstetric hospitals (Pratten, 1990). The result was that by 1981, 94.2 per cent of all births were hospital deliveries (Squire, 1986; quoted in Pratten, 1990; p43). Midwives followed the move and became confined largely to the hospital, where they were under greater medical control (Robinson, 1989). The assumption is that technology lessens the risk to both mother and baby. Therefore, the safest place to give birth is in a hospital, where the necessary expertise (doctor) and equipment is at hand. This notion may not be justified because Tew (1995) argues, that interventionist techniques during the management of birth may actually increase the risk to some infants. Tew also suggests that the fall in maternity and neonatal mortality and morbidity rates may be due to the improved general standard of health of the population. Furthermore, Tew contends that the central issue is not safety but professional self-interest of the doctors. By encouraging the use of technological interventions, the doctors maintain their medical domination over midwifery (Hardey, 1998). Furthermore, these procedures support the efficient running of maternity units rather than the needs of the women (Oakley, 1993).

The Wendy Savage (1986) case where the debate involved at least four fundamentally significant issues related to the social handling of childbirth, highlighted the self-interest of her four male colleagues as well as identifying the reasons why they, in contrast to Wendy, believed in interventionist childbirth. Oakley (1989) contends that the first issue related to the promotion of an uncritical association between safety and medical authority. The result is the notion that the safe delivery of a baby may only be achieved when supervised by obstetricians in a hospital setting. The second aspect concerned control in that because childbirth is defined by medicine, so it is doctors who control childbirth and not women (Savage, 1986). Thirdly, Oakley contends that male, obstetric consultants are convinced that because obstetric medicine represents science, it is considerably more powerful and has contributed more to its success, despite the fact that routine technological interventions are not based on the evaluation of different approaches, or strategies, in relation to childbirth. Finally, the conflict brought into question the gendered division of labour itself because

women give birth and the obstetrician is usually male. Oakley maintains that usually most professional, high achieving women absorb the ideologies of their male counterparts. However, Pratten (1990) argues that Wendy Savage was unique, in that in contrast to her male colleagues, she believed in the women centred approach to obstetrics in which there is as little intervention as possible that is consistent with safety. Thus, Savage accepts that childbirth is a part of women's life and so the obstetrician's role is supportive, rather than a controlling one. Furthermore, she worked to take antenatal care to women through community based, rather than hospital based services (Pratten, 1990). The issues raised by the Wendy Savage case centres on who defines and thus controls pregnancy and childbirth (Pratten, 1990).

The Winterton Report 1992 (Hardey, 1998; p74) that represented the concerns of pressure groups such as the National Childbirth Trust highlighted the disquiet that related to the medicalisation of birth. The reason was because doctors rendered childbirth as an abnormal and unnatural event (Pratten, 1990). In response to a select committee's criticism of medicalised, hospital services (Hardey, 1998), the report *Changing Childbirth* (DOH, 1993; quoted in Hardey 1998; p74) suggested a women-centred approach to maternity care. This report proposed that maternity services should move to the community and that there should be an emphasis on the continuity of care for maternity clients. Hardey (1998) contends that this report enabled midwives to reassert their sphere of autonomy by identifying the midwife-client relationship as fundamental to their expertise, because continuity of care demanded an ongoing relationship between midwife and client. It was envisaged that through this partnership between client and midwife, so decisions about the place and form of care could in theory be planned at an early stage. Thus, the midwife acts as a mediator in the client's access to childbirth services (Hardey, 1998). However, Hardey maintains that the inequalities of power between the midwives and doctors remain because it is the doctor who is responsible for defining which pregnancies are low risk. The consequence, according to Tew (1995), is that midwives have full responsibility in only a minority of pregnancies.

De Vries' (1993) cross cultural study of midwives argues that the reason why doctors are more powerful than the midwives is that by redefining childbirth as a hazardous event so the

doctors gain power because they can reduce the risk and uncertainty through intervention. The midwives on the other hand, are present during a mother's pregnancy and at low-risk births, but they do not alter the course or reduce the impact of childbirth (De Vries, 1993) Unlike doctors the midwives are restricted from using a number of medical technologies (Reid, 1989; quoted in DeVries, 1993; p142). De Vries contends that doctors gain prestige and power because they manage high-risk situations, whilst midwives are ultimately accountable to the doctor because the care they give is palliative. Janet's remarks relating to her expectation that the consultant would intervene in the pregnancy when the mother was full term also, supports De Vries' contention that because midwifery in the United Kingdom has gained legitimacy by affiliating with technological medicine, so midwifery care is similar to medical care.

It seems that the consultant's actions based on scientific knowledge, in which he decided to perform an early induction, not only redefined a normal pregnancy as hazardous but undermined the partnership between Janet and the mother that Janet had built up over a period of time. For example, the consultant did not inform Janet of his decision and when she found out via the mother, Janet perceived this action as unexpected. This was because she had been explaining to the mother that the consultant would not make a decision until the pregnancy was full term. Thus, it is possible that the consultant's actions substantiate Perry's (1993) argument that he was using the power of his position to make the rules as he went along, with the expectation that Janet would not challenge his decision.

Janet: It's the fact that the goal posts keep being moved and you're spending 9 months telling someone well this is what it's going to be like and this is what's going to happen to you and they'll go and see the doctor and he'll just say oh no that'll be ok... I said to her which is what I normally say to most of the girls that have had a previous caesarean – they'll say to you do I have to have a caesarean next time? We say no, if the caesarean was done for foetal distress unless it was a very obvious disproportion problem where the pelvis is basically much too small for the size of the baby... then you say in the majority of cases no you're likely to have a perfectly normal delivery if that's what you want... I fully expected him (the consultant) to say well we will wait until you are at least term, you know we're not going to induce the baby early... I think it was going against everything you've formally been trained and understood to be safe. You spend your whole time everybody saying to you, you must practise safely... and then suddenly here's somebody... trying to do something that goes against everything you've been told.

Despite the fact that the outcome was a satisfactory one in that the mother had a vaginal delivery (see extract 14) – although induced rather than spontaneous – Janet still remained concerned about the fact that the consultant

Had not discussed with her (the mother) the possibilities of ending up with an emergency caesarean ... and why we were sort of taking extra care, which in the light of the day we were because of the scar and everything and that there was a risk ... we were inducing this baby early and that increased the risk and if she was prepared to accept that risk.

The implication appears to be that Janet, in comparison to the consultant, recognised the importance of telling the truth as an important aspect of midwifery care. This confirms Hardey's (1998) suggestion that currently midwives undertake aspects of obstetrical care eg advice and support that GP's and obstetricians do not have time for. On the other hand, Perry (1993) argues that as Janet carries out care that the doctors do not wish to engage in, that is the hidden agenda because the care that Janet gives serves the interest of the doctors.

Similarly to Janet, the request by Theresa's GPs that the nurses carry out registration checks on all new patients who register with the general practitioner regardless of their health care needs, confirms Perry's (1993) argument that routine practices such as registration checks is an example of the hidden agenda that serves only as an invisible, economic incentive that benefits the medical profession and not the patient. For example, when a new patient who has been diagnosed as having terminal cancer makes an appointment to register with the general practitioner, Theresa recognises that it would be inappropriate to carry out a registration check, in which the patient's blood pressure height and weight are recorded. Therefore, Theresa does not complete a registration check and her remarks imply that she does this without informing the doctor. Instead, she appears to bend the rules and discusses the important issues surrounding the patient's imminent death. Perry (1993) contends that Theresa uses this behaviour to get the work done in an allocated period of time.

I did a registration check on a person the other day and we've got a format at work which you're supposed to fill in all this criteria about their height, weight, blood pressure.... and you know one of the other practice nurses said to me what are we doing with that information? I said the information's going on the computer and if they [the doctors] meet their target they get reimbursed. So it's not a question of the doctors going to help the patients specifically on the information that we gained and this chap came for a registration check and I didn't do any of that at all because it was completely inappropriate...and I felt alright about doing it because.... at this particular time he'd been told 3 weeks ago that he

was going to die from cancer and what was the point.... there were other sort of more important things to talk about. (interview).

Summary

Despite some students challenging doctors' decisions (eg Janet in section 5.4), the findings from this chapter reveal that the students appear not to reflect at the critical level because they seem unable to recognise how medical power constrains their practice. The students do not acknowledge that historically and politically doctors have attained a powerful position in relation to nurses (discussed in section 5.3.1) and that this socially constructed power base of the doctors is possibly perpetuated through socialisation. During medical training doctors learn to view their medical scientific knowledge base as superior to nursing knowledge, as well as being socialised into the perception that nurses are the doctor's handmaiden (Adshead & Dickenson 1993).

Besides the students not recognising that doctors are possibly socialised into the belief that their knowledge is superior to that of nurses, the students do not acknowledge that they themselves may unwittingly perpetuate this subordination through collusion and silence. For example, Carol (see section 5.3) seemed to be more understanding and supportive towards the registrar than the staff nurse, despite acknowledging that the registrar's medical assessment of the patient, in comparison to the staff nurse's, was incorrect. Although in private (in the consultant's office) Janet (see section 5.4) challenged the consultant about his decision to undertake an early induction in a mother who had previously undergone a caesarean, in public she remained silent by not informing the patient of the risks involved in an early induction. This public silence, argue Mackay (1995) and Perry (1993), is a source of power to the doctor because nurses may send out the message to the patient that there is no conflict of interests and that she/he shares the same perspective as the doctor in the treatment and care of patients.

Thus, as Mackay has argued, the needs of the patient become secondary to the perpetuation of the power base of the doctor because nurses learn not to undermine doctors' competence in front of patients, despite the doctor making (as in this case) what the nurse considered an

unacceptable medical decision. However, both Janet and Carol are in senior positions in the nursing hierarchy and so they would have quite a lot of contact with the consultant (in Janet's case) and the registrar (in Carol's case). Therefore, they may have wished to prevent further conflict by being sympathetic towards the doctor (Carol) or by remaining silent (Janet) because as discussed previously (see section 5.4) the nurse-doctor relationship may deteriorate when individual nurses challenge doctors about their poor practice (Taylor 2000).

The students seem unable to recognise that another reason why this subservient position continues is because some doctors, especially those at the more senior levels of registrar and consultant, use specific techniques like ignoring the nurse's assessment of a patient's pain level (see Becky's story in section 5.1); shouting (see Carol's story in section 5.3); being personally unpleasant (see Kara's narrative in section 5.3); or holding medical knowledge up as superior to the nurse's knowledge (see Janet's story in section 5.4) as a way of socialising nurses into their subordinate position. These techniques, if used in public may tend to stifle the nurse's questioning ability and reduce her/his confidence so that she/he may be unwilling to offer her/his opinions. Furthermore, nurses may internalise these techniques to socialise other nurses into their position in the hierarchy (see Carol's story in section 5.3).

As well as the students not recognising the reasons why doctors have achieved this power base and how this is continued, the students appear unable to identify the results of this medical power on their practice. For example, the students are unable to acknowledge that because the medical model takes precedence over the nursing model, especially in the hospital setting, so some students like Theresa and Zara appear to have internalised the medical model. For instance, Theresa views the doctor as the expert (paternalism) whilst Zara appears to base the patient's complaints of pain on the medical model as well as behavioural aspects (see Zara and Theresa's narratives in sections 5.1.2 and 5.3).

Furthermore, the students are unable to recognise that this labelling of patients, according to their behaviour - in which the uncomplaining patient (see Becky's narrative in section 5.1) receives attention whilst the aggressive patient (see Jessica's comments in section 5.1.3) is ignored - does not meet the individual needs of the patient. Distancing themselves from the

patient through the application of labels does not increase nursing knowledge because in order to learn skilled judgement requires knowledge of the patient as an individual. The students seem unaware of how other ways of carrying out care like patient-centred care (discussed in section 5.2) and primary nursing (to be discussed in section 6.2) may address the needs of the patient as an individual, as well as increase the autonomy of the nurse and her/his knowledge of how the patient views his/her illness experience.

The last aspect that the students are unable to identify as a source of the doctor's power is the doctor's sphere of authority. The doctors substantially determine the workload of the nurses as in comparison to the nurses they have the power to admit and discharge patients, as well as to determine the numbers and type of patients to be admitted, their length of stay and what tests and observations are to be carried out (Mackay, 1993; 1995; Walby et al, 1994; Perry 1993). The students appeared unable to recognise that because the doctor was responsible for specific aspects of care like prescribing drugs and deciding which patients were not to be resuscitated, this impinged on the nurse's autonomous actions. For example, Becky was unable to alleviate her patient's pain because the doctors would not prescribe a more potent analgesia, whilst Lisa and Pat were unable to ensure that their patients died with dignity because they required the authority of the doctor to decide if a patient was/was not for resuscitation.

It appears that the students do not acknowledge that medical power, apparently perpetuated through the socialisation process, results in their failing to recognise that developing knowledge through their practice requires them to use their power; to form a collaborative relationship with the doctors, in which power is shared. Through this power sharing process there may be mutual acknowledgement of and respect for each professional's views and opinions as well as recognition of each professional's limitations. By collaborating with the doctors, the nurse's views may be heard and the nurse may gain autonomy. As a consequence the nurses may attain empowerment, in order to carry out a plan of care based on the patient's individual needs.

CHAPTER 6

THE ROLE OF THE NURSE

The role of the nurse has its origins in both the religious orders and the Victorian era (Rafferty, 1996). Nightingale introduced a system of nurse education at St Thomas' Hospital in 1860, whose aim was primarily concerned with ensuring a steady supply of conforming obedient, uncritical mainly female employees (O'Brien & Watson, 1993). A further aim of this educational system was to produce a nurse whose work was essentially practical, that was informed by medical knowledge and could be achieved with limited resources (O'Brien & Watson, 1993). This view of the role of the nurse was extremely powerful, because it reflected the class and gender (discussed in section 5.3) divisions. The bedside nurse matched the servant class, whilst the matron and ward sister equated with the middle, or upper middle class. The bedside nurse's duty was to obey and comply with all orders from the ward sister, matron and doctor (Jolley, 1995). Palmer (1983) contends that the result of Nightingale's perspective was that a relationship was established that placed nursing in a subordinate position to both the doctors (discussed in section 5.3.1) and the hospital administrators.

The approach to nursing care that evolved was a regime that emphasised a strict hierarchy of tasks, in which the performance of practical tasks were carried out at set times, in order to instill obedience (Maggs, 1983). Thus, task-centred care dominated hospital nursing because it fitted well with the class system in Britain (Hale et al, 1996), as well as efficiently organising a transient, student labour force that moved frequently through various hospital wards (Proctor, 1989). The essence of this approach was that it operates within a hierarchy of skills, within a clinical team that may consist of trained (RGN) semi-trained (student) and untrained (nursing auxiliary) employees (Keen, 1995). Qualified nurses directed untrained and trainee staff to carry out a specific task for all patients (Walsh & Ford, 1989). This resulted in tasks being defined as basic, or technical (Keen, 1995). For example, the basic tasks of washing, feeding and recording temperature, pulse and blood pressure would be carried out by the junior student nurse/auxiliary nurse, whilst the qualified nurse or senior student would give injections, execute the drug round (technical tasks) and the ward sister

would accompany the doctor on his ward round, or deal with administrative aspects.

Walsh and Ford (1989) cite several disadvantages of this task centred approach. Firstly care was fragmented because nurses might only see the patient for a few minutes, whilst taking their temperature, pulse and blood pressure readings. Hence, communication was reduced and psychological and social problems were not considered. There was no scope for individual originality because nurses carried out a series of ritualised tasks that Chapman's (1983) research revealed were not always performed. Lastly, decisions about care were often based on the opinions of the nurse in charge, whilst the patient's views were rarely considered. Research by Lelean (1973), Wright (1974) and Jones (1975) revealed other problems in that nobody was identified as responsible for care outside the prescribed routine and individual nurses did not have the authority to adapt standard procedures to the needs of the individual patients.

During the latter part of the 20th century, the nursing profession has attempted to develop its own knowledge base, separate from that of the doctors, through the importation of nursing theories (Riehl 1974; Roy, 1980), the nursing process (Walsh & Ford, 1989; Porter, 1991) and primary nursing (Ford & Walsh, 1994), from America. Carpenter (1993) contends, that these imports emulate medical professional practice through individual nursing histories, diagnosis and care plans, as well as attempting to *intellectualise* (Carpenter, 1993; p122) clinical nursing. In other words, redefining nursing as intellectual, rather than manual labour, as well as placing nursing care on a more rational individualised basis, may be viewed as an attempt to mark out a sphere of occupational independence from other health care workers (Carpenter, 1993; Walby et al, 1994). Individualised care, rather than organisation of care by tasks, is integral to the new nursing in which patients are treated as partners, rather than receivers of care (Dickenson, 1982; Walsh & Ford, 1989; Salvage, 1992; Carpenter 1993).

Walsh and Ford (1989; p142) state that

The aim (of individualised care) was to provide care relevant to the individual patient's needs, which acknowledged that the patient was a human being with a mind of his/her own who had to be seen as part of the social setting.

The two other aspects central to new nursing, was the notion that experienced nurses should be involved in basic tasks, whilst the patient should be an active partner in care with the nurse as advocate (Hale et al, 1996). Thus, this individualised approach to care encompassed the idea of holistic care. This approach considered the patient as a whole person (De la Cuesta, 1983). Paramount to this patient centred approach to care is the nurse-patient relationship. Binnie and Titchen (1999) propose that in patient-centred care, the nurse recognises the value of each patient's individual way of perceiving and experiencing the illness process (discussed in section 5.1.5).

However, Witz (1994) argues this new nursing that embraces a people-centred, rather than a task-centred approach, appears to advocate a carative route forward, rather than a curative one. This means that if the enhanced nursing role (carative route) is to be favoured over the extended curative role, nurses need to renegotiate several changes. Witz argues, that in order for nurses to make judgements and explain the patient's needs, they require a body of relatively abstract nursing knowledge. In addition, Witz proposes that nurses need to claim back the core tasks of primary care as the nurses' special province and renegotiate those elements of medical authority that mitigate against practitioner autonomy in the planning, delivery and evaluation of nursing care (like prescribing drugs). Witz contends that if nurses attain these changes, the new nursing may be viewed as a dual closure strategy, in which the exclusionary dimension creates a division of labour in caring: diagnostic autonomy concerning care in illness and in health becomes the privilege of a few surrounded by lesser skilled care workers (the health care assistants). The usurpationary dimension as perceived by Witz, would enable nurses to claim from the doctors certain areas of decision-making as '*the new nursing*' relates to demarcation and power relationships between doctors and nurses on the one hand and nurses and health care workers on the other, thus changing the definition of the core of nursing work. This new nursing presents far more of a challenge to medicine, because of the notion of the partnership between nurse and patient and the translation of this patient-centred care into practice through experimental nursing development units.

Ford and Walsh (1994) argue that despite nurses, educationalists and managers embracing these new ideas like primary nursing, the evidence is that these potentially valuable

innovations are being accepted, without nurses questioning their usefulness. Thus, Ford and Walsh (1994) contend that this unthinking acceptance of new innovations may lead to a ritualistic approach, in which the nurse carries out care unthinkingly. Therefore, the aim of this chapter is to examine if the students within this study approach care in a ritualised and routine manner because this does not encourage or develop reflective ability.

6.1. Extending The Scope of Professional Practice

During a reflective practice group session, Sophie reflects on nurses performing cannulation techniques that used to be the domain of junior doctors (HOs and SHOs). She reveals the conflict that may occur between those nurses who prefer to extend the scope of their practice (UKCC, 1992), by undertaking technical tasks and those who find that it impinges on their nursing role.

Sophie; Because we're an admission ward we used to have a lot of problems with the doctor taking blood putting cannulas in post op and things like that so they decided that the nurses do the cannulation. So there are about 3 'E' grades and 2 'F' grades that have got their cannulation course now. But the problem is that we're only supposed to do it if it is really necessary, like if the doctors do not come from theatre or go into clinic again... but now we've got 2 'E' grades who just do it any time, who just do it for the doctor... and they doctors) expect us to do it (cannulation) all the time. I've tried to talk about it... say you must not do it when the doctors are roaming around doing nothing just for the sake of pleasing the doctors... but there's still this particular one (staff nurse) and she said she's quite aware that what she is doing is wrong but she still does it... When the patient is admitted... they will need ECG's and the doctor should do that when he comes for these admissions. But by the time the doctor comes somebody else (the nurse) has already done the cannulation for them (the doctor)... what is so annoying is that they (the doctors) expect to come in and admit a patient who has already been cannulated and had their ECG done. (extract 1)

However, Sophie is reluctant at times to cannulate because

If you call them (the doctors) and say can you come in I've got three cannulas that need to be done... I'm busy at the moment. I've got my own work to do. One said to me I'll do two and then you can do one... and I said I'm not doing one I'm busy. I've got my own work to do. This shows that the doctors now think that because so and so does it why shouldn't I do it as well. (extract 2)

The response of the group members is

They'll (the nurses) run off to do a cannula and it stops them doing something else... the priority has got to be nursing care... you find the drug round being done at some ungodly hour because they've stopped put it (drug trolley) away to take some bloods... they're desperate to get their 6 assessments in.

You get the very enthusiastic nurse who just cannot wait to take on the doctor's tasks. They're really enthusiastic about that but get them to change a patient who is wet in bed and that is when they are not interested.

I think that what annoys me is that many nurses who do cannulation... whether they're absolutely necessary or not during the hours that the doctors are around... are often the ones that can be found sitting at the desk when there's people with full urine bottles sitting in their beds. Those tasks are too lowly for them.

Sophie's story raises several issues that the students fail to reflect on. The first aspect relates to why qualified nurses in Sophie's clinical area at E level and above were selected to carry out cannulation techniques. This is due to the implementation of the clinical grading system in 1988 (Carpenter, 1993) that perpetuated the traditional hierarchical system because each nurse is allocated a grade, according to the duties he/she performs.

Sophie's narrative also, supports the hierarchical issue. Perry (1993) argues that the competence of a nurse is determined by his/her superior, hence, those nurses who are graded at E level and above are the only qualified nurses chosen by their superiors as being able to competently carry out cannulation techniques. The implication is that there is a hierarchy of technical tasks because qualified nurses at D level are allowed to carry out a drug round, yet, are not considered competent enough by their superiors as being able to cannulate. Pat's remarks also support this notion that the more technical aspects of care like central lines are dealt with by nurses on the higher grades of the grading system.

Pat; I have my named patients but if there's any patients with hickman lines in... or if there's any acutely ill patients... I'm probably the only person on the shift who can deal with those so I'm popping and out to those patients. So you're restricted to what you can do

The second issue the students do not reflect on is why some nurses prefer to execute cannulation, ECG techniques and take bloods, rather than care for the patient's elimination needs. One reason for this enthusiasm may be that some nurses seek the approval of doctors,

rather than develop their own potential (Kalisch & Kalisch, 1977). This is supported by Mackay's (1993) study, as the doctor's view of the good nurse is one who does not pester the doctor to undertake tasks that are within the nurse's area of competence. Therefore, it is possible that the nurse undertakes these technical tasks, in preference to emptying urinals, in order to attain a good working relationship with the doctor, as well as the avoidance of conflict (discussed in section 5.4).

Lawler (1991) however, contends that some nurses prefer to undertake these medical tasks like cannulation, in preference to emptying urinals and changing an incontinent patient, because the latter are perceived as lowly and dirty tasks. The reason may be that these aesthetically distasteful tasks are equated with women's work - dealing with such intimate aspects as changing an incontinent patient is analogous to the mother changing a baby's nappy (Lewin, 1977 quoted in Kendrick, 1995; p 243). This women's work is not considered as valuable as medical technical competence, like cannulation, that reflects the male image of objectivity (Kendrick 1995).

On the other hand, Freire (1985) argues that because nurses are the subordinate group, so they absorb the cultural values (discussed in section 5.3) of the doctors who are the dominant group within the health care system. Thus, it may be that some nurses are willing to perform these technical duties. This may be due to the idea that medical knowledge that incorporates technology is the cherished custom of medical practice and this technical expertise is valued most by doctors, rather than expertise in caring (Ford & Walsh, 1994). Ford and Walsh suggest that this internalisation by nurses of medical values (discussed in section 5.1.2 and 5.3) and knowledge results in some nurses believing that technical competence (cannulation and taking blood samples) is the aspired aim of nursing practice because it may bestow on them a higher status. The students' remarks provide evidence that some nurses internalise medical values, in the hope that by attaining the characteristics of the powerful they too may become powerful (Harden, 1996). However, Freire (1985) contends that power (discussed in section 5.3 and 5.3.1) may be used in such a way that the subordinate group internalises the dominant groups ideology and hence, unwittingly participates in their subordination that becomes part of their collective personality. Thus, by taking on tasks like cannulation means

that nurses are internalising their subordination, because these technical tasks that used to be the domain of junior doctors are now executed by nurses under the direction of the doctor (Ford & Walsh 1994).

Sophie; We all go to the doctors to get practice, say can you come in and supervise ... and teach me... now you can cannulate the doctors want you to do it for them... they (the doctors) say you wanted me to be there when you wanted to learn how to do it. Now you can do it you don't want to do it but it's not only not wanting to do it but I think to do it when you've got your own duties.

The third aspect that the students do not reflect on is why these tasks that originally were the domain of junior doctors are being delegated to nurses. Walby et al (1994) argue that advances in medical technology and calls for a reduction in the junior doctors working hours has led to a reassessment of the tasks that nurses undertake. The less skilled and onerous technical tasks have been delegated to nurses (Walby et al, 1994). However, Hardey (1998) contends that one of the reasons for nurses undertaking these tasks may be that nurses, in comparison to the doctors, are always present on the ward. Janet's remarks support Walby et al's (1994) contention that doctors find cannulation an exacting task because nurses, like doctors, find executing cannulation techniques demanding and time consuming.

Janet: Because we are taking on the role of the doctors so much of the time like cannulation because let's face it it's not easy sometimes cannulating a patient. You know the few times I have done it I've sweated buckets beforehand... it can be time consuming especially if you have somebody who's shocked... that hasn't got good veins to get at... but if you have a patient who's elderly and things like that it can take a lot of time.

The UKCC (1992) endorse this delegation of technical tasks because the modification of the code was precipitated by the demands to reduce the junior doctor's hours (Walby et al, 1994). Hardey (1998) asserts that this change in the code means that nurses are to be trusted to act within their professional competency, instead of having to gain certificates to undertake tasks like the giving of intravenous drugs. These modifications help legitimise the nurses' claims on professional status (Hardey 1998) because by undertaking these technical tasks nurses extend their scope of professional practice and also, gain prestige. Furthermore, replacing a rule bound approach to the delivery of care, with one orientated to individual judgement brings nurses closer to the medical profession (Hardey, 1998). Hardey however, argues that this subcontracting means that although nurses perform these technical tasks, it is the doctor

who has control of the task. For example, the doctor tells the nurse which patient is to be cannulated and prescribes the intravenous drugs that are to be administered, as well as determining which patient's are to have blood samples taken.

However, Perry (1993) argues that the reason why doctors have transferred these tasks to nurses is because doctors who are in a higher position than nurses, trade off their routine work, like cannulation, to lower status groups like nurses. This is one hidden method used by doctors to socialise nurses into carrying out work that they perceive as a simple routine task, but remains under the control of the doctors (Perry, 1993). The consequence of nurses accepting technical tasks that used to be the remit of junior doctors means that this extended role has resulted in the dirty tasks, like emptying urinals being assigned to a lower status group (health care assistants). This has created a division between those who give care at the bedside (health care assistants) and those who have extended their role into executing technical tasks (registered nurses), as well as socialising the health care assistants into their lowly position within the health care system. This delegation of tasks perpetuates the traditional task approach to care, in which nursing care involves a hierarchy of skills, hence, resulting in certain types of activities like cannulation being more valued than responding to a patient's elimination needs. Carpenter (1993) argues that this delegation of tasks often referred to as skill mix may result in a reduced number of qualified nurses in the future because of the increasing amount of care being transferred to the health care assistants. Furthermore, the registered nurse's role becomes supervisory in that he/she directs untrained staff to deliver the care and this is endorsed by the UKCC (1992) that state that

Health care assistants must work under the direction and supervision of ... registered practitioners... registered nurses must remain accountable for assessment, planning and standards of care and for determining the activity of their support staff.

On the other hand, Perry (1993) contends that because nurses are expected to carry out the basic task of changing an incontinent patient, as well as executing a technical task, such as cannulation, thus, the nurse's role comprises routine physical activities and technical competencies. The consequences of this task approach to care is that nursing care becomes ritualised, in that nurses fail to consider if the care given is based on the needs of the patient

(Ford & Walsh, 1994). For example, Becky (ward manager) states that

You can't sort it (the patient's pain) out because you haven't got enough nurses on the ward and there are lots of other things to distract you... I think if the ward was less busy really because we have got 11 acute admissions and 2.5 nurses and doctors and consultants ward round and they go round 11 patients and you haven't got the time to spend... sit down and discuss it (the patient's pain) with other people.

Becky's view is, that because she had to accompany the doctors and the consultant on a ward round as well as having too few nursing staff meant, that she did not have enough time to discuss the pain her patient was suffering. Her remarks support Walsh and Ford's (1989) contention that the doctor's/consultant's ward round is a ritual that serves no useful purpose, because, Becky's contribution, in which she stated that the patient's pain was not being controlled effectively was dismissed by the registrar and the consultant as unimportant (see section 5.1). Perry (1993) argues that the consultant's ward round is part of the hidden agenda that is used to serve the interests of the doctor, because, it is not openly acknowledged as an essential part of the nurse's role. However, Mackay (1995) contends that the ward round protects the status of, and the respect given to the doctor, because the nurse often acts as the interpreter between doctor and patient, as well as ensuring there are no disruptions. Thus, Mackay suggests, the nurse acts as an attendant in which her skills, knowledge and experience are not on visible display, because the doctor takes the leading role in making decisions about patient care.

6.2 The Care/Cure Differential

The last feature that the students fail to reflect on is why the doctors do not listen to Sophie when she complains that she has her own caring duties to perform (see extract 2 in section 6.1) and why technical tasks impinge on the standard of care given to patients.

Sophie; We have a lot of complaints about the nursing care we give...from the community, from the rehabilitation wards, because we transfer our patients to the rehabilitation ward 72 hours post operatively and we've had a lot of complaints... due to doing drips.

The reason why the doctor in Sophie's story does not listen (discussed in sections 5.1, 5.1.2 and 5.3) to her complaints that she is unable to execute cannulations because she is busy and

has her own work to do, relates to the notion that technical tasks are viewed as more important than nursing care. Medical cure that is based on scientific knowledge is perceived as superior to the practical non-scientific, non-technical activity of nursing care (Perry, 1993). Maslin-Prothero and Masterton (1999) argue that this lowly opinion of nursing care may be attributed to the fact that nursing is viewed as a natural extension of the female role in the home (discussed in section 5.3). Therefore as nursing work is linked with womanly virtues, this legitimises caring as low status (Perry, 1993; Kendrick, 1995). Perry suggests that as a result nursing is labelled and undervalued in the health care system as a type of domesticated personal service, because nursing is associated with the low opinion society has acquired in relation to caring that, as pointed out by Annanadale (1998) the feminists argue is socially constructed.

Despite, the students' narratives revealing that some nurses view technical tasks as more important than nursing care, some of the students disclose that in their view nursing care is of greater value than technical competencies.

I refuse to take bloods when we're too busy. I just phone the doctor and say you need to come and take some bloods because we haven't got the staff all the time... I don't mind taking on new roles. My priority's got to be nursing care but some people won't do that won't say they can't do it.

I like being with the patient. I know people say that you're with the patient when you're giving them an IV but you're only there for two seconds and then you're gone.

I don't feel I'm using my nursing skills doing a drug round really and the IV's... I think it's not being able to talk to patients.

Although the students highlight being with and talking to the patient as the enjoyable aspects of nursing care, they do not reflect on what constitutes care. If nurses are to develop a knowledge base separate to that of doctors, nurses need to define the caring aspects of nursing, because as argued by Ford and Walsh (1994), knowledge is power.

One of the difficulties about creating knowledge based on nursing care is that the concept of caring is difficult to define (Smith, 1992). Also, the concept of care has been largely missing from nursing literature until comparatively recently (Dingwall et al, 1988). Ford and Walsh (1994) argue that caring is not unique to nursing because men can care as well as women,

besides other health care workers like health care assistants and as contended by Walby et al (1994), doctors also lay claim to the notion of care.

In fact, Engelhardt (1985) argues that there is no conceptually significant difference between the professions of nursing and medicine in caring for patients. Leininger (1985) also implies that caring and curing are intimately related because she proposes that caring is an essential aspect of any curative process. However, Webb (2001) argues that the interpersonal relationship between nurse and patient is recognised as being a distinctive aspect of nursing care (discussed in section 5.1.5). Appleton (1993) contends that patients need care and help and it is when the nurse responds with sincere, genuine and authentic concern that the patients are able to have faith in the decisions they make, because the nurse has enabled them to feel confident about themselves. Moreover, Appleton suggests that nurses need to synchronise multiple ways of knowing with a variety of knowledge bases, in order to transcend the mechanical performance of technical skills (like cannulation), so that nursing becomes a profession and not a skilled trade.

Yet, Lupton (1997) contends that nurses may be unable to claim that patient-centred care and the nurse-patient relationship is unique to nursing, because doctors are being encouraged to be reflexive actors in the doctor-patient encounter. Lupton points out that currently doctors are being urged to encompass the application of expert biomedical knowledge, as well as develop a collaborative relationship in which they view each patient as an individual, with the express purpose of eliciting the patient's emotional state. However, nurses are in the unique position of being able to form a relationship with patients, especially in the hospital setting, because in comparison to doctors their work is confined to one ward and the care they provide is on a continuous 24 hour basis (discussed in section 5.3).

Graham (1983) makes a distinction between 'caring for' and 'caring about'. The former denotes doing or tending whilst 'caring for' indicates a relationship that comprises feelings. For example, Freda's remarks support Graham's description of 'caring about' because, through the formation of a relationship with the patient, Freda is able to anticipate when the patient needs to release his grief about his lost toe. In addition, she accepts that his emotional

response is appropriate. However, James (1986; quoted in Smith, 1992; p6) contends that observing emotions like grief may be painful to watch and difficult to respond to, because they do not match the standard ideas of workplace skills.

Freda: I had a diabetic man and he had lost his toe. He was trying for weeks not to cry. Anyway I brought him into the treatment room and I said look you're allowed to cry you are allowed to feel really desperate about this... and he sat down and he had a really good cry he nearly had me in tears as well but he said I just feel so much better...

Paula and Abigail also, reveal that forming a relationship requires skills.

Paula: I think it's very exhausting for a midwife if you're looking after someone all day long... home confinement... if you're with them for hours on end and you are really emotionally and physically exhausted... it is very difficult because there are lots of time in the labour when nothing's happening and you have a conversation with someone all day in their house... it takes quite a lot of skill to do that, sort of build up a rapport.

Abigail: Talking about conversations, I mean for chemotherapy because I sometimes have to sit next to them (the patient) for 2 hours while I'm waiting for this stuff to go in and I do run out of conversations sometimes. I find it's alright if they've got children there's always safe conversations there... if they're a different age group... it's quite a skill in itself just making small talk... if that's what they want or judging what they want to talk about or whether they don't want to... we see patients for 6 months to a year so you get to know people really well because some come in every week for a year... then you form quite a relationship with them and their family that come with them, so that's really nice but there again it's very intense... they've got serious illnesses

Paula's statements highlight the emotional and physical exhaustion that the midwife feels when supporting the mother through childbirth and her feelings are similar to those expressed by the nurses in James' (1989) study, who work in the hospice setting. The nurses who care for dying patients and their families, find that the demands of coping with emotions such as anger, frustration, helplessness and despair results, in the nurses viewing their work as hard as physical and technical work (James, 1989). Furthermore, James contends that because the management of emotions is difficult work that requires effort and the giving of oneself, hence, she refers to care as an act of labour. On the other hand, this emotional work that is as problematic as technical tasks is not so readily recognised and valued as medical cure work (James, 1989; Perry, 1993).

Paula's narrative discloses the value of discussing the emotional aspects of childbirth, because this is likely to have an adverse effect on a mother during her childbirth.

Paula: Well I must admit... when I go round to see them (the expectant mother) I talk to them (the partner) as well because... I've had the experience where the partners have been very frightened about their wife having a baby at home... because when it comes to the crunch and they're (the partners) very stressed then that can reflect on the woman so we sort of talk through that... and I have known people who've gone into hospital they've (the mothers) really wanted a home delivery they've gone in because their partners have been so worried about it (the birth).

In addition, the following story provides support for Paula's view that the partner's anxiety can create difficulties for the mother during the labour process, besides revealing the rapport that needs to be established between the mother, midwife and father of the baby.

Paula: I went out to a home delivery at 3am... I was on call that night... you see she (the mother) wasn't anybody I knew... but knowing the midwife who'd been seeing a lot of her (the mother) ... I'd spoken to her (the midwife) a lot... she (the midwife) had gone through the fact that she (the mother) may find it a distressing situation and that she may need to go into hospital but she decided to have (a home birth)... her partner had decided that this was not going to be painful if you use massage and they decided not to (have the baby in hospital)...

However, when Paula arrived at the house the mother was

Literally crawling up the wall she was really uncomfortable. I arrived and somehow she relaxed a lot more and her husband said oh as soon as you walked in the door she sort of relaxed... but the woman was so distressed... very distressed and I examined her and she was hardly dilated at all and I knew it was going to be a long labour. It was her first baby. I knew she was not coping well, so I discussed it (going into hospital) with her and eventually she went in quite easily she went in she was quite happy for me to make that decision. Her husband got her in the state in the first place... he was so stressed... she had obviously read lots of books and hadn't absorbed anything... she thought the only thing she'd need in labour was deep massage... and that would be enough for her pain relief and when it was much stronger than she thought and she wasn't dilating... it completely threw her... and I said have you got any paracetamol... she had no paracetamol... she didn't even have a hot water bottle I didn't just immediately get in there and take her off to hospital... I was very nice to her... and she had to have it accelerated. So she wasn't a person who was suitable for a home delivery.

From these students' narratives, it can be seen that the emotional aspect of caring, as well as being important in the building up of a relationship is also, a valued component of the health care needs of patients, mothers and their relatives.

These students' stories support research by Botorff et al (1995) and Gammon and Mulholland (1996) whose findings reveal that the provision of comfort through increased proximity (eg Abigail stayed by the patient's side whilst he/she underwent chemotherapy) and information (eg it is possible that Paula talked to her maternity patient about the pros and cons of having a hospital birth) play an important part in helping patients, to cope with the illness and giving birth experience. Furthermore, Freda and Abigail's remarks support Appleton (1993) and Perry's (1993) contention that ill people need and respond to care. Whilst Abigail, Freda and Paula's narratives support the humanistic aspect of care which Hagell (1989; p226) suggests

Stems from the lived experience of nurses as women and as nurses involved in the caring relationships with their clients.

Besides supporting Smith's (1990) contention that caring involves emotional labour, the students' reflections also, substantiate Perry's (1993) assertion that this person centred care is time-consuming and labour intensive. However, Perry (1993) and Smith (1990) argue that as a consequence of the nurse's low status, this caring and emotional aspect of their work, like supporting a patient whilst undergoing chemotherapy, or a mother going through the process of childbirth becomes invisible. Thus, because much of nursing care, like comforting gestures is regarded as a natural feminine response hence, it is not noticed.

Reed and Proctor (1993) and Kendrick (1995) on the other hand, contend that because the majority of nursing work incorporates sordid tasks, such as dealing with faeces, vomit, urine, blood and sputum, as well as dealing with death, pain and physical disfigurement, thus, these issues are not discussed in public. Furthermore, Reed and Proctor (1993) argue that these latter characteristics serve to make nursing care invisible. This invisibility, according to Perry (1993), perpetuates the dominance of the doctor's scientific perspective, as well as marginalizing nursing, despite nurses being central to medical practices. For example, when important political health care decisions are taken (discussed in section 5.3.1), it is the doctors' views that take precedence over nurses. Thus, it can be seen that because the nurse is viewed as subservient to the doctor hence, the emotional aspect of the nurse's caring role is viewed as invisible and unimportant, in relation to the doctor's scientific and technical, rational perspective.

However, some student's stories reveal that they have internalised the doctor's curative medical model that prevents them from considering how the emotional aspects may affect the way in which a patient responds to their illness. For example, Lucy's narrative reveals that she derives some of her ideas from the positivist view because she bases the assessment of her patient's chest pain (see Becky and Zara's stories in section 5.1 and 5.1.3) on the notion that there is nothing physically wrong with him.

Lucy; I've got a gentleman at the moment who came in with chest pain which I don't think is anything cardiac wise... and he's decided he can't cope at home on his own because his wife's got ovarian cancer and she's dying. Basically there was no-one saying that he had to go home and look after her... she's in hospital... but he just decided because he was going home on his own he couldn't cope... and there's nothing physically wrong with him... it's just a mental thing... because the day he's supposed to be going home he got more chest pain so therefore he had to stay in more and you don't know how much of it is totally real and how much of it was anxiety because he thought he was going to have to go home and cope on his own... I mean I haven't personally sat down and spent time talking to him... I mean we have had social work involvement with them (this patient and his wife) and occupational therapy assessments... He could probably do with it (time spent talking to him) but if it's just time and effort into going into all that (his anxiety about his wife's impending death)... who is going to be responsible for doing that does it come down to us nurses to make time apart from all the physical tasks we've got to do to actually put aside some time on a busy morning sit down and talk to him about his emotional needs as well. How do you fit in the sort of length of time it takes to talk to somebody in depth about these sorts of problems when you're getting somebody saying can you come and answer the phone to you because somebody wants to speak to you on the phone.

Besides not recognising that Lucy bases her assessment of the patient's pain, on the medical model, in that there needs to be a physical cause for pain, the students do not reflect on how labelling affects the way in which nurses carry out care. Lucy labels (discussed in section 5.1.3) the patient's pain as just a mental thing and due to anxiety. Moss (1988; quoted in Ford & Walsh 1994; p191) contends that these labels may adversely affect the nurse's perception of the patient, because the nurse tends to carry out care typical of the label that is based on the nurse's attitudes and beliefs, rather than on the needs of the patient. Consequently, Lucy does not believe that the patient's pain is totally real.

The other aspect that Lucy does not reflect on is how the wife's impending death may affect the patient's complaints of pain, because in her view undertaking physical tasks and answering the phone takes precedence over the discussion of the patient's emotional needs.

Walsh and Ford (1989) argue that routine tasks, like answering the phone require no thought and fail to address the patient's needs, as well as being a characteristic of the nurse's oppressed status (discussed in 5.3). Thus, the assessment of the patient's pain that is based on the curative medical model means that the patient's discharge is dependent on the outcome of further technical investigations and occupational assessments as Lucy says.

Well we'll go through the usual investigations just to check things one more time that if his chest pain is not of cardiac origin and then go and investigate into why it might be gastric in origin or whatever and eventually ... somebody saying go home.

Gemma and Holly's narratives provide the second example of how the internalisation of the positivist perspective may affect patient care.

Gemma; Her operation was booked a couple of weeks beforehand and it was cancelled because we said to the manager that there was no way that we can cope with somebody who was unstable who is a threat to themselves who is on the second floor. We haven't got the staff so they actually cancelled her.

However, the students within the reflective practice group, fail to reflect on how labelling affects the care that this patient receives. For example, because the nurses on the gynaecological unit label the patient as *unstable... a threat to herself*, hence, they feel that there was no way that they could cope with caring for this patient who was to undergo an operation on a gynaecological unit situated on the second floor. As discussed previously in section 5.1.3, this labelling of the patient reflects the scientific medical model that depersonalises and objectifies the patient (Carpenter, 1993). Thus, the nurses view the patient's behaviour as typical of the label and fail to look at the patient as an individual. The result was that the patient's operation was cancelled.

Also, the students fail to reflect on how Holly's labelling the patient's behaviour as *variable and typical of her pathology* affects her view of how this patient should be cared for. Using behavioural, diagnostic and pathological labels reflects the doctor's positivistic perspective (discussed in section 5.1.1). One of the characteristics of this viewpoint is that diseases of the body can be separated into smaller units of study (Davey, 1992). If Holly is using this scientific stance, then this probably explains her view that only nurses who are trained (have the expert knowledge) in diseases of specific parts of the body (eg psychiatry) are able to care

for patients with a mental disorder. This paternalistic perspective (discussed in section 5.2) possibly clarifies why Holly thought a psychiatric nurse was needed to care for this patient's behaviour, whilst an in-patient on the gynaecological unit. In other words, the psychiatric nurse is the expert.

She (the patient) has a history of cutting her arms, severe overdoses, jumping out of windows, smashing windows; she broke her ankle a few times. Her mental state is so variable one minute she'll be on five minute observations, the next minute she'll be on leave and its typical of her pathology that this will occur... I was most concerned that a section 3 patient was sent without a nurse escort. You can't be faced with that responsibility. We (the psychiatric unit) were responsible for her (patient's) behaviour and we had more of a duty to care for her... I was most concerned that our hospital sent her down without a nurse escort she was accompanied (from the psychiatric unit to the gynaecological unit) by a psychiatric nurse.

The students also, do not reflect on the notion that Gemma's statements represent the positivistic stance, because she assesses the patient's recovery in gynaecological and behavioural terms.

She was very good she had her operation... her recovery was done; the catheter was out... in fact she was quite stable with us.

When nurses adopt the doctor's medical model, emotional aspects (discussed in section 5.1.1) are not considered important (Davey, 1992). Thus, it appears that this patient's emotional needs, relating to her impending operation and its subsequent cancellation, as well as the reasons why she was reluctant to return to the psychiatric unit were not addressed. In addition, when nurses evaluate the patient's health care needs using the scientific framework, then the holistic approach to care as advocated by the UKCC (1996) is not considered.

The second issue that may affect care and which the students do not reflect on is the unthinking application of procedures. Ford and Walsh (1994) argue that one of the consequences of the nurse's low status in the health care hierarchy is, that they are socialised into following orders from above, without thinking too carefully about their meaning thus, leading to ritualistic practice. Binnie and Titchen's (1999) and Johns and McCormack's (1998) studies support this notion, that nurses are socialised into unthinking behaviour. They argue that because nurses have been socialised into carrying out task-orientated care, ward

routines and procedures, this results in nurses not recognising that they have the power to influence the way in which care is given. Holly's belief that procedures that inform nurses how to use restraining techniques on patients in the psychiatric unit may be used on a patient who has a mental illness and is being cared for in a gynaecological unit is an example, of ritualistic thinking.

Holly; She (the patient) was going out of a six bedded locked ward for an operation... she was on section 3 of the mental health act ... and the section papers will have been transferred with the patient

Gemma; that means nothing to me... How do you stop her when you haven't got the staff to hold onto her? We're not trained in restraint... I think even if you'd had a psychiatric trained nurse sat right next to her once she'd decided to go what could a psychiatric nurse do?

Holly; There's lots of procedures, there's nothing difficult... I think it might have been useful to have specific guidelines because you predicted that she may well say I'm going to go then you should have known that if this happens, this is what you do ... ABC... you do not let her leave the building, you contact someone from Z and wait until someone arrives.

What Holly and the students fail to reflect on is, if the nurses on the gynaecological ward could use restraining techniques to prevent the patient from leaving the ward. Restraining techniques can only be used if the patient's mental state poses a danger to herself, or other people (Dimond, 1990). Therefore, if the nurses on the gynaecological unit had attempted to keep the patient on the ward and denied her the right to discharge her, this could have been viewed as a breach of the professional code of conduct (UKCC, 1992).

The students also, fail to reflect on how the sectioning of a patient may influence her care, whilst an in-patient on the gynaecological unit. Although Holly provides some information about sectioning, she does not say why the patient is sectioned.

Holly; Section 3 is for treatment. It is a six monthly section that is renewed every 6 months. It is put in place for 6 months then another 6 months and then yearly and it allows you to do certain things but not everything. But it certainly allows you to keep them (the patients) on the wards... it's very interesting because I feel we're at fault because we know the risks.

Dimond (1990) states that patients are admitted under section 3 of the Mental Health Care Act (1983) because; treatment is likely to alleviate a deterioration of the patient's mental condition. Furthermore, section 3 means that the patient does not have the right to refuse treatment for her mental condition but, the patient has the right to discharge herself from the gynaecological unit, despite being sectioned, because that is her right by statute and common law (Dimond, 1990).

The last feature that the students do not reflect on is, how management imposes its objectives on nurses. Despite the staff in Gemma's story raising disquiet about the safety aspects in relation to this patient, the managers ignored the previous concerns that the staff mentioned and decided that the patient could be admitted for her operation.

Gemma; There was a big hoo ha and the ward manager and the next manager up had to go over to the psychiatric unit and meet who ever it was ... and the outcome of that was that she was coming down without an escort and if we had a problem we had to ring Z and they would perhaps be able to send someone over in due time if she was unwell.

The managers did not discuss the reasons for their decision with the staff that would be caring for this patient and neither was any specific information given to the nursing staff, concerning how to deal with problems specific to this patient's unpredictable mental state. In addition, the implications of Section 3 of the Mental Health Act was not discussed. The information that was provided was, on a need to know basis, in that the nursing staff could contact the staff at the psychiatric unit if difficulties arose. Thus, management expected the nursing staff to care for this patient, on the basis of this knowledge. Perry (1993) contends that ignoring the concerns of the nursing staff, besides providing information on a need to know basis and dismissing the nurses' grievances as insignificant and not as an organisational problem are all techniques, utilised to socialise nurses, into adopting care based on managements' needs and not care as it ought to be practised.

Freire (1985) argues that one of the consequences of being an oppressed group (discussed in section 5.3) means that the ward nurses do not have control of resources and as a consequence they cannot cope with challenge. For example, the nurses on the gynaecological unit do not have control of the resources to determine staffing levels. Thus, similarly to the

nurses in Walby et al's (1994) study, the nurses on the gynaecological unit define the limits of their responsibilities (like saying that they are unwilling to care for a patient with unpredictable behaviour), instead of challenging management's organisational responsibilities, with regard to how they determine staffing levels on the unit. Walby et al (1994) argue that nurses defensively mark out their responsibilities, in order to resist being overwhelmed with work

Judy's story provides further support for this feature that management use hidden techniques to obtain their objectives. However, the students do not reflect on how those in management may use the power of their position to make the rules as they go along. For example, management introduced mobile epidurals, without prior discussion with the midwives who would be caring for these patients. Furthermore, management did not consider the notion that the midwives had no information on how to care for patients with mobile epidurals and neither did they realise that the introduction of these mobile epidurals increases the midwives' workloads. Also, management did not recognise that when the maternity unit was busy, the midwives would be unable to provide individualised care to those mothers with a mobile epidural. Thus, it seems that because midwives, as argued by Perry (1993), are in a subservient position to management, they have to obey the changing orders of the day, unless as Judy's details imply someone has the courage to point out the disadvantages of these rules.

They (the management) do spring things on us. For example mobile epidurals they decided all of a sudden, we're going to have mobile epidurals, none of the midwives had any information on it and the community midwives say oh don't worry its very similar to the normal epidurals. What you just need to do is this this and this. Now that really wasn't the case because with the workload all of a sudden there were three women walking around with these mobile epidurals. We knew that if we became really busy that you couldn't give them one to one, which is actually what you need. So it was stopped. You know someone had the courage to say right we're not doing this. There's no proper protocol and it was stopped overnight.

Estelle's narrative also, highlights this aspect that management decisions affect individualised care. From Estelle's story, it appears that management has implemented rules autocratically, without considering the effect these rules will have on the care of the maternity patients. Furthermore, management has not consulted the midwives and as a result,

there is a lack of support to enforce these rules from some of the midwives. Sullivan and Decker (1985) contend that these autocratic managers who make decisions alone, rather than ask the staff's opinion first, tend to be more concerned with task accomplishment, than with the midwives who have to ensure that these rules are implemented. In addition, Estelle's narrative supports Walsh and Ford's (1989) contention that these rules and regulations may actually be harmful, because there is no rational basis for them, as well as management failing to realise that quality care is dependent on care that matches the individual mother's changing needs in an effective way.

On the other hand, Estelle's remarks support Perry's (1993) contention that the midwives are charged with the responsibility, to carry out the orders of management, without knowing the reasons why, as well as lacking the power to influence important decisions relating to modes of practice. Perry (1993) argues, that management's values equate competence with behaviour that supports the rules. Thus, some of the midwives in Estelle's area of practice who adhere to management's rules, as argued by Perry (1993), are socialised into basing their care on management's objectives, rather than focusing their care on compassion and an individualised approach to care.

We've got a running battle at the moment with visiting in the evening... but there are certain midwives unfortunately bang on the door at half past eight. All visitors go now. As far as I'm concerned there is no actual reason for that so long as you see them safely out of the building or there's somebody like the porters to let them out. If they come in late or their wife's upset or they just want to stay what is the harm? I will strongly go against my colleagues and I will say no you don't have to go. Sit down I'll make you a pot of tea. You stay as long as you like... if people deliver and it's quiet as far as I'm concerned... if there's an empty bed or a single room and he (the partner) wanted to sleep in a chair. That's fine so I do things so long as they're safe and I'm not flouting any policies and I'm not endangering anybody. I will do it for the patient... There's lots of silly little things like you're supposed to have only one person in the delivery room. Well why? You know we're not a main unit with lots of doctors so it's not overcrowded say grandma wants to come in and mum wants to come in well there's no problem with that... and other midwives will say oh no you must not have other people in as well... just because somebody says so in a blue dress (ward manager) or a manager says it's got to be done like this does not necessarily have to be as long as you have reasons and so long as you're safe... the feedback I've had is that the patients will say to me I'm human some of them aren't human so I've learnt humanity.

On the other hand, it appears that Estelle's narrative supports Foucault's assumption (discussed in section 5.3) that power, when exerted by the individual may be productive. For example, Estelle is willing to use her power to defend the mother's right to decide how many people she wants to support her during the birth of her child, as well as defending the mother's right to have her partner stay after visiting hours, if the mother is upset, or if the mother's partner is unable to visit during the allocated visiting times. Thus, Estelle gains autonomy that results in the mother being empowered to choose whom and how many people she would like to stay and support her during the birth process. This understanding of the mother's need, for support, during and after her labour supports Titchen's (2000) view that saliency and involving the relatives is an important part of patient-centred care. Saliency has been described by Benner (1984), as the situation where certain aspects appear to stand out as more or less important, whilst Titchen identifies saliency as knowing what is important from both the nurse's and the patient's point of view. Therefore, Estelle saw that support from the relatives during and after the mother's labour was more important to the mother, than adhering to rules that did not take into account the mother's individual needs.

The other aspect to be considered in Estelle's narrative is her view that she had learnt humanity, besides the maternity patients perceiving her as being human. Titchen (2000) proposes that human represents the nurse as a person whilst, for example, being refers to the human attributes of kindness tenderness and patience, besides the existential ones of being there, being available and being close. Therefore, it seems that Estelle and the maternity patients assume that Estelle's humanity represented the little things, such as making a cup of tea for the mother's partner and allowing the maternity patients' partners to stay outside of visiting hours. This attention to detail is supported by Binnie and Titchen's (1999) research, in which the patients and their relatives appreciated the little things, like playing tapes of favourite classical music to a dying mother and recording that Fox's Glacier mints were a passion, on an aphasic husband's care plan.

Returning to the theme that managers use their power to increase the nurse's responsibilities and devise rules and regulations that have no rational basis in relation to patient care, Sylvia's story reveals another example of how decisions made by managers affect patient

care.

Well it's about this man on the ward, this 91-year-old man. He was supposed to be discharged back to a rest home because he can't manage on his own very well. So they said he had to go but then some of us said you know it's unfair on this man to go where he doesn't know anybody. I don't think he really wants to go but he's not all that good at debate, he's not confused as such, but you know old age he can't really express himself because he was so depressed and he was so closed.....he's sad they're moving him...he'd been living on his own in a flat with his wife...that's why like he was grieving, leaving his home on admission and then going back to a different place with his wife.....Unfortunately the wife died before his birthday..... the wife's death was sudden..... You know they haven't got any children. I told the ward manager that I think it's not right for us to discharge him now...At least keep him in until after the funeral...He'd been with us for about a month... at least he'd been used to us on the ward... we'd done so much for him and I think this is where he really needs us and normally we'd be there for him.... somebody would be able to go with him to the funeral.... Well she [the ward manager] was trying to be defensive because she said this decision has been made and why should you say that he couldn't go or something? We discussed this with the social worker and she agreed with me about...postponing his discharge to the rest home... I just think it's unfair really. Well they're not really pushed for beds. We have about 2 patients that were on the ward...they'd been admitted as social admissions. One of them the district nurse couldn't cope with this lady...and the question is where's our psychological support? You know we only tend to concentrate on the physical aspect and this man needed psychological care for his grieving needs...Sometimes if a patient's supposed to go home and there's deterioration in their condition, they postpone the discharge. So it is the same thing for this man, so why can't the nurses decide ...I just think that someone should be there to support him... at the funeral

What the students do not reflect on is, the ward manager's autocratic stance in relation to this patient's discharge. Sylvia is a staff nurse, working on an elderly care ward and this means that the medical influence is greatly reduced in discharge decisions (Walby et al, 1994). In addition, because the discharge planning is undertaken by the nurses, the ward manager and nursing staff are in a position to delay discharge, if they do not think the elderly person is ready for discharge (Walby et al, 1994). However, it appears that the ward manager did not consult the nursing staff about this patient's suitability for discharge, despite the patient being allocated to a primary nurse (see Sylvia's extract 2 at bottom of page). It seems that the ward manager has adopted a paternalistic stance towards this patient, because the decision to discharge him appears, to have been taken without consulting the patient and neither has the patient's grieving needs been considered.

Smith (1994) argues, that the negative attitude that modern society has about elderly people is reinforced within the health care system. Nurses meet elderly people who are sick, frail, or cognitively impaired and this supports the negative image (Smith, 1994). The consequence of this attitude, according to Smith (1994), is that often nurses adopt a paternalistic stance towards the elderly patient.

The second issue that the students fail to reflect on is the notion that Sylvia's area of practice has possibly not implemented primary nursing correctly.

We do primary nursing but you know on night duty you tend to look after everybody. I did talk to the nurse looking after this man and said you are the one looking after this man you should be able to have a say in his care...the primary nurse...they do make decisions on the patient's care but they're still responsible to the ward manager...and she's just been promoted to an E grade. (extract 2)

Primary nursing incorporates the concept that each patient is allocated to a nurse who is responsible for the care provided, for the duration of the patient's stay in hospital (Manthey 1980; Thomas & Bond, 1990; Binnie & Titchen 1999), as well as patient empowerment (discussed in section 5.4) being an important aspect (Ford & Walsh, 1994). However, Ford and Walsh (1994) argue that if the primary nurse is the key planner and giver of care, then the traditional hierarchy of health care assistant, staff nurse, ward manager no longer applies, because the vertical hierarchy is flattened. The authority is devolved from the ward manager to the primary nurses, in which each has the same amount of authority, shares decision making with their colleagues, practises patient-centred care and has autonomy (Binnie & Titchen 1999; Ford & Walsh, 1994).

Sylvia's comments also, reveal that a hierarchy still exists, because the ward manager became defensive, when Sylvia voiced her concerns about the timing of the patient's discharge. In addition, it is the ward manager who directs the primary nurse as to what care is to be carried out, because the ward manager maintains responsibility for decisions taken, with regard to patient care. Thus, the primary nurse responsible for this patient's care had no autonomy (discussed in section 5.3) to make decisions, or participate in the decision making process, with regard to his discharge. Furthermore, the ward appears not to practice patient-

centred care, because the patient's grieving needs had not been addressed and neither had an assessment been considered of whether the rest home was a suitable place for him to be discharged to, now that his wife had died. The original decision to relocate this elderly couple to a rest home had been taken in conjunction with the social worker, before this gentleman's wife died unexpectedly.

Sylvia; They (the social worker) did the assessment before the wife died... they showed them round or something... that's all.

Theresa's remarks support this notion that when changes in the way in which nurses approach care are implemented, these are not fully understood. For example, Theresa equates care plans with protocols.

We've got to devise a protocol for giving people malaria injections so that means the GP and the nurse sitting down... sorting out the nursing problems and sorting out the doctor's problems so that we've got a protocol which we can then use... which is just like a care plan isn't it really?

Theresa's perception of care plans that form the written aspect of the nursing process substantiate Walton's (1986), Porter's (1991), Sheehan's (1991) and Hurst et al's (1991) findings that nurses have not internalised the nursing process. Protocols are not the same as a care plan, because a protocol comprises written rules of how to do something (eg give malaria injections) in a certain order, whilst a care plan is a written record of a problem solving approach to caring for patients, in which care is planned and assessed, according to the individual patient's needs, besides acknowledging that the patient is an individual human being who needs to be seen as part of the social setting (Walsh & Ford, 1989). On the other hand, Walton (1986), Pearson & Vaughn (1986), and Roper et al (1981) propose that the adoption of the nursing process was introduced to professionalise and improve nursing practice. The nursing process, according to Walton (1986), requires high levels of understanding and conceptualisation. One of the reasons why nurses have been unable to implement this type of nursing may be due to their lack of knowledge base.

However, the students and the facilitator fail to reflect on why nurses do not fully understand the concept of the nursing process. Walsh and Ford (1989) argue that in 1977 the General

Nursing Council (GNC) advocated that the nursing process should become the prevailing philosophy for the organisation and delivery of nursing. The GNC also proposed that the nursing process had to be implemented in all teaching areas, in order for them to be approved for training by the GNC (Walsh & Ford, 1989). Walsh and Ford contend that the consequence of this authoritarian style that characterises nurse management meant that the concept was introduced without proper preparation. Hence, it is doubtful, if many educationalists and managers fully understood this radical move from task-orientated care to individualised patient care (Walsh & Ford, 1989).

Judy's view supports Walsh and Ford's (1989) argument because she says

Midwifery is changing and we have been behind a lot because... like the nursing process we never had to do that, now that's been implemented on the general side for years... only now it's being implemented in our notes and there's been no teaching on it nothing. All of a sudden you get a new set of notes that have been devised and there you've got your care plans your evaluation and all of that and all of a sudden you're supposed to be inspired on how to do this properly... so it's things like that we're really lacking.

Abigail's narrative also, substantiates Binnie and Titchen's (1999) and Walsh and Ford's (1989) contention that without adequate preparation, nurses fail to internalise new concepts like nursing development units.

Abigail; We're open from 8am to 6pm... the only thing that we don't do in the day that is medically orientated... turns out to be mostly things like chemotherapy and blood transfusions and you know support for that type of thing ... but we do things like liver biopsies and bone marrow biopsies and endoscopies... bronchoscopes and there's quite a lot of investigative stuff... but we've had this fund running for 3 years because its the nursing development unit but at first it was really awful because we didn't know what we were supposed to do... I mean they said you can be a unit here's all this money. Of course they kept coming down wanting to see what we were doing with all this money so it's taken a while to get our feet off the ground but now it's great, we've got a research group co-coordinator who does all the analysis all that type of thing he's not a nurse he's an archaeologist ... we're doing (the research) mostly about chemotherapy and the side effects that's the main project that we are doing but we've also done other things like staff satisfaction, yes that's been interesting.

The students do not reflect on the important characteristics of Nursing Development Units (NDUs) or Nurse Led Units (NLUs) and how these may raise the status of nurses. NLUs not only undertake research into the quality of nursing care provided (Pearson, 1988; Binnie &

Titchen, 1999; Titchen, 2000), but also are responsible for enabling nurses to gain autonomy (discussed in section 5.3) over an area of practice, in which they can develop nurse-patient relationships that are distinct and separate from doctor-patient partnerships (Wiles et al, 2001). It does not appear that Abigail's area of practice is a NLU, as the nurses do not have autonomy over an area of practice, because the patients in the unit undergo technical, investigative procedures that are organised by the doctors. Thus, it is the doctors who control the admission/discharge of patients and direct the nurses as to what drugs are to be given, during chemotherapy and which patients are to undergo a blood transfusion. Furthermore, the research that is being conducted is based on the technical, rational perspective, because the main study concerns the side effects of drugs used in chemotherapy. .

Hardey (1998) argues that these nurse led units - where nurses act autonomously, are responsible for discharging patients and share care with patients - fail to change the relationships between the primary nurse and the patient. For example, each primary nurse works within a team of associate nurses and health care assistants who undertake the domestic and basic nursing tasks (Salvage, 1992). Hence, Hardey contends that the primary-nurse/team relationship is similar to the traditional doctor-nurse relationship and as a consequence, the primary nurse/patient partnership reflects the traditional doctor/patient relationship. Furthermore, Hardey proposes that it is the power relationship between doctors and nurses that is redefined, because in a nurse led unit, care takes precedence over cure and knowledge is developed and based on the patient's holistic needs. Therefore, doctors are relegated to cure, under the guidance of nurses who represent the patient's interests (Hardey, 1998). However, Hardey argues that this development of nursing as a profession in its own right, in which nurse led units have been created, has been opposed in the main by doctors who saw their role as being regulated to a residual role.

The consequence of nurses gaining power is that conflict occurs with the doctors (Keen, 1995). Witz (1994) argues that the reason why some NDUs have attracted overt medical opposition is, because, doctors view the one-to-one relationship between the primary nurse and her/his patient, as a reflection of the traditional one ascribed to doctors. Yet, Witz (1994) contends that doctors do not oppose those NDUs where the nurse (like Abigail)

extends his/her role, by taking on tasks traditionally done by doctors, such as administering chemotherapy drugs and supervising the whole blood transfusion. The reason is due to the assumption that the nurse's developing autonomy does not pose a threat to the doctor's power base.

The closure of the nurse led unit in Oxford in 1989 was partly due to opposition by doctors (Pembrey & Punton, 1990). In Keen's view, this was because the doctors viewed the nurses' autonomy relating to patient care, as a threat to their power base, in that the nurses in this unit acted autonomously, admitting and discharging patients – the usual domain of doctors (Keen, 1995). Witz argues that this led to the doctors failing to refer patients, as well as displaying reluctance to provide emergency cover. The unit closed despite successful patient outcomes and costs that were comparable to other wards (Keen, 1995).

Besides the students failing to critically discuss the characteristics of nursing innovations like care planning, primary nursing and nursing development units, the students do not reflect on the reasons why nurses do not seem to understand these nursing developments. Maeve (1994) contends that one of the consequences of trying to raise the status of nursing is that the nurse theorists have created a theory practice gap and the result is the development of two different classes of nurses and episteme. The nurse theorists according to Maeve (1994) occupy the elite group and the care they espouse relates to knowing that, whilst the bedside nurse whose clinical knowledge concerns knowing how, inhabits the lower echelons of the profession. Schon (1983; 1987) described these two worlds, as that of the academia, or the high hard ground and the world of practice, as the swampy lowlands. Maeve (1994; p10) succinctly describes these different worlds as a representation of the

Theory-practice gap... and can be characterised as the differences between classes and as a difference between esteems, or 'knowing that' versus 'knowing how'. The elite in nursing clearly occupy the high hard ground and possess a great deal of knowledge about 'that'. The working class of nurses populate the swamp and possess a great deal of knowledge about 'how'.

Maeve (1994) contends that this theory practice divide means that the nursing bureaucracy have claimed and assumed for themselves, the guiding role for the profession, whereas the bedside nurse is not in the same position to demand the same privilege. Perry (1993) argues

that this professional caring versus the work ethic, results in nurses against nurses. For example, there is contention between the two classes of nurses, because the practitioner may associate nurse theorists/educationalists with the ivory towers (Meleis, 1985; p43) of education and research. Thus, the practitioners may believe that because the latter have been divorced from practice for many years, so their espoused theories deal with what ought to be, rather than what is in reality (Meleis, 1985; Loughlin, 1988; Garbutt, 1995). Therefore, because the knowledge base posited as the core of nursing does not meet the reality of practice (Greenwood, 1993) and because the bedside nurses are so entrenched in the traditional methods of caring, so they may be confused by and hostile to the creation of new theories (Biley, 1991).

Hagell (1989) and Pearson (1992), on the other hand, contend that the presence of the theory practice divide is because scholarly nursing that comprises research has espoused the positivistic model of science, with its associated language and paternalistic attitude (Meleis, 1985). For example, the routine application of problem solving, care plans that reflect a linear model of nursing care (Ford & Walsh, 1994) and the reduction and categorising of the phenomena (models of nursing) that are encountered in nursing, create problems (Pearson, 1992). The difficulty is that theory is portrayed, as an accumulation of facts that may be used by practitioners when required and thus, encourages the nurse to separate theory from practice (Pearson, 1992).

Pearson (1992) supports Maeve's (1994) argument that the knowledge the nursing scholars use bears no relevance, usefulness, or relation to practice. However, Pearson's (1992) view is that this sophisticated, scientific knowledge inadvertently undermines the many faceted values that practitioners use in practice. In order for practitioners to know nursing, Pearson (1992) contends that nurses need to move away from the traditional narrow horizon of the scientific mode, to a more action orientated view, in which nursing theory is derived from practical experience that aims to transform and seek collaboration that leads to development, as well as re-examining and reformulating concepts in the clinical situation.

Besides the students failing to reflect on why these different approaches to care have been introduced during the latter part of the 20th century and why nurses have failed to internalise these changes, the students fail to reflect on how the management changes that have taken place throughout the 1980's and 1990's, within the NHS have affected their role as nurses.

6.3 The impact of Health Care Markets

Since the beginning of the 1990's the NHS and its future has dominated the political agenda and its difficulties represent the wider process of economic and social restructuring that has affected health-care organisation internationally (Annandale, 1998). Lash and Urry (1987) argue that the NHS has changed from a 'Fordist' model derived from the organisational methods and assumptions of mass production and notions of a mass health care 'product', to a post-Fordism associated with disorganised capitalism: specialisation, niche provision, flexibility, uncertainty and priority given to consumers (Hardey, 1998). These changes are based on the view that the NHS was costly and inefficient, besides incorporating within its structure, clear evidence of a stultifying bureaucracy that was organised to fulfil the aims of professionals (doctors), rather than concentrating on the provision of quality care to patients (Annandale, 1998). The concept behind these political changes was to create competition, through the introduction of a quasi-market market (Annandale, 1998) in which knowledgeable consumers (patients/clients) would use their disposable income to purchase services (health care) that give value for money (Denny, 1999). The NHS trusts (producers) of these services compete to give the consumer what they want, at a price that maximises profit and the outcome of this market is efficiency (Denny, 1999). In other words, the idea was to create a health care system that would provide a cost-efficient, consumer-led quality service (Annandale, 1998; p202).

Hardey (1998) argues that these quasi-markets are very complex and inherently artificial, in that it is hard to identify either the market, or the producer, or the customer. Despite the rhetoric, the patient is not the customer, because according to Annandale (1998), it is the GP and health authorities/ PCGs (Primary care group discussed in section 5.3.1) who purchase care from provider units. In addition, there are financial constraints because the money that is

allocated to the trusts is centralised. However, the way in which it is spent is devolved to the trusts (Walby et al, 1994) that determine their own management structures, employ their own staff and set their own conditions and terms of employment (Annandale, 1998). Besides these financial restrictions, there are yearly financial duties, that the DoH (Department of Health) imposes on each trust, such as earning a 6% return on assets, breaking even and staying within their external financing obligations, as set by government (Annandale 1998).

These financial constraints affect patient care, as trusts attempt to achieve these financial aims. Gemma and Holly's (see section 6.2) discussion provides an example of the problems that may arise when two separate competing trusts are involved in the joint care of a patient who is undergoing a gynaecological operation, but has a psychiatric disorder.

Gemma; The assumption was that Z's staff felt she was well enough to come down unescorted and therefore wouldn't need extra care...I felt they didn't send a nurse because it was due to lack of money.

Thus, the reason why the psychiatric unit was reluctant to provide a nurse to care for the patient, whilst an in-patient in the gynaecological unit may be due to the idea that the contract does not cover the extra cost incurred. Similarly, the gynaecological unit may have been disinclined to supply extra nursing staff to care for this patient's specific needs, because they wish to minimise costs.

Gemma; We can't get the staff when we're down in numbers, let alone get extra staff on the possibility that all the time the patient is here we might need someone to sit on her

Gemma's remarks fit in with the changes within the NHS, where the idea that registered nurses who are an expensive commodity (Walby et al, 1994) need to be kept to a minimum in order to be cost effective.

In comparison, Sylvia's narrative, not only supports Hardey's (1998) argument - that at the heart of the government's argument was the notion that patients do not have sufficient knowledge to make appropriate decisions about their healthcare - but reveals the financial constraints that affects decisions made, with regard to patient care. The reason why Sylvia's patient may not have been given the choice of other options, like the provision of care in his own home may be due to the notion that it was too expensive, besides the patient not

realising that other care options were available. Annandale (1998) argues that Griffiths reduced social security benefits, for residential care/care in the community, to a basic level and the local authorities social services departments have to pay the balance on a needs assessment basis. Therefore, it is possible that because this elderly gentleman had no relatives to act as his advocate, or help with his care in his own home, hence, the cheaper option was the provision of residential care in a rest home. This fits in with government policy, because as argued by Annandale (1998), local authorities have a statutory duty to use 85% of their government funding, to buy private sector (residential and domiciliary) care. In addition, the reason why the social worker may have agreed with the nurses about keeping this patient in hospital for a few more days may be due to the idea that the local authority social services department may save money, at the expense of the hospital trust. Whereas, the ward manager may have been keen to discharge this patient to the rest home, because of the efficiency ethos of the NHS that measures the output of a hospital based on the increased throughput of patients and high bed occupancy rates (Walby et al, 1994).

The students reveal other consequences of this efficiency ethos. For example, one student refers to the increased throughput of patients as a *conveyer belt*, whilst another student highlights the problems that arise, when there are no beds to treat patients who have been admitted for operations.

I think it's difficult because we... must treat these patients, get them out, get the next patient in, but you don't cover everybody's psychological needs as well... everything's gone. This patient's better now, out, next one in, like a conveyer belt really, the bed's never empty before there's somebody else booked to go into it these days.

I had a chap in for a bilateral hernia repair... I mean he'd been cancelled three times just because there were no beds... and to go and tell him three times. He said I had my pre-med last time.

In addition, these efficiency beliefs has led to trust managers examining the roles of health care professionals, to assess whether some of the work may be executed by someone less qualified (Denny, 1999), because a comparable service may be delivered at a lower cost (Annandale, 1998). This is because in order to procure contracts, the costs of the services

must be as low as possible, if trusts are to succeed in gaining them (Keen, 1995). This has implications for qualified nurses, as trusts seek to get value for money from nurses who are expensive (Walby et al, 1994).

The result is that nurses are being asked to accept additional tasks that were once the responsibility of junior doctors (eg. cannulation see Sophie's narrative section 6.1), whilst health care assistants are charged with the delivery of basic, nursing care at a lower cost. In addition, Annandale (1998) argues that the nurses in the clinical area, like staff nurses and health care assistants are being requested to take on these extra responsibilities, with limited resources. In other words, nurses are expected to be flexible, because they need to respond to the increasingly, diverse pattern of consumer (patient) health care needs (Annandale, 1998), yet, it appears that this flexibility is a hidden, problematic feature of post-Fordist health care (Witz, 1994). This is because managers are increasing the nurses' duties, without a subsequent increase in staffing levels (see Gemma, Judy and Sophie's comments section 6.1 and 6.2).

Furthermore, the following remarks from students who were present during Sophie's discussion on cannulation (see section 6.1) support Perry's (1993) contention that this flexibility means that nurses are used as general carers, because they fit the spaces, where one technical job ends and another begins

When you are on nights that's (performing a cannulation) quite appropriate because you can't wake up the doctor and say can you come in and cannulate at 2o'clock in the morning.

They're not employing phlebotomists on a Sunday morning and the nursing staff are expected to go round and actually take 15 or 16 people's blood in the morning.

However, this flexibility that is a characteristic of the changes within the NHS reflects Lash's (1994; p120) reflexivity in which the *winners* (doctors and management) progress at the expense of the *losers* (nurses).

Another result that affects nurses has been the introduction of new wave (Walby et al, 1994) management. Traditionally, the Fordist approach to management represented a clear

hierarchy of command, in which the tasks of the health care workers were narrowly and tightly controlled and was characterised, by the creation of specialised sub-occupations (Walby et al, 1994). For example, when doctors considered a task had become routine they sought to transfer it (usually to nurses). If nurses resisted this transfer, or the task was seen to be too simple, or too technical to be the responsibility of nurses, this work was contracted to a specialised group (like phlebotomists who can take bloods) for less money than the nurses/doctors (Walby et al, 1994).

In comparison, new wave management means that managers of clinical directorates emphasise the nurses' accountability for the patient's satisfaction outcomes and the quality of care given (Annandale, 1998). Annandale (1998; p247) argues that, while on the one hand this may enhance the nurse's autonomy, it may also generate a climate of fear, as she reveals that nurses report

A need to 'watch your back' or as one sister more graphically put it 'cover your arse'

Walby et al's (1994; p97) findings support Annandale because they state that

The responsive, flexible, autonomous, multi-disciplinary team dreamed of in the aspirations of the 'new wave' managers becomes a wary, inflexible group of staff defensibly marking out the limitations of their responsibilities.

Annandale contends that the reason why nurses are apprehensive is, because they are concerned that they may be disciplined and so the nurses ensure that any concern about patient care, or progress, or complaint, however minor, is documented and reported to others, to show that they have followed the correct procedures (see Becky and Janet's stories section 5.1 and 5.5).

A further reason why nurses may be increasingly anxious about the threat of being disciplined, may be due to the notion that they are being pressurised by management who imply that there is a risk that the nurse may face disciplinary procedures, if a patient complains about nursing care, or if the patient puts in a financial claim for malpractice (Annandale, 1998). Besides facing intimidation by management, nurses also face a threat from patients who are becoming increasingly aware of their rights (Annandale, 1998). Annandale argues that this sense of intimidation from management and the patient may

generate high anxiety and the nurse's confidence may be undermined.

However, it is mainly doctors and not nurses who face medical negligence claims, because Annandale contends that consumerism in health care may be less to do with enhancing the power of consumers and more to do with placing the consumers at the centre of the market led system, as a means of restraining the power of doctors, by holding doctors accountable for their actions through the rights embodied in the Patient's Charters (1992; 1995). If patients feel that their rights and expectations are not met, then the patient can complain and this has led to a significant increase in the number of medical malpractice cases during the 1990's. For example, health authority spending in relation to clinical negligence increased from £53 million in 1990/1, to an estimated £155 million in 1994/5, amongst fears that individual health care authorities/trusts would be unable to pay, because they had to pay the first £300,000 of any claim, with the DoH picking up the rest of the bill (Annandale, 1998). Furthermore, it appears that the most significant rise in claims for medical malpractice related to obstetrics (Annandale, 1998). However, in 1995 the DoH created a new Central Fund for clinical negligence in England that is open to all trusts and means that they can be reimbursed for 80% of the damages and legal costs for outgoings over £10,000 and up to £5,000,000 (Annandale, 1998). Annandale argues that this Central Fund's pooling arrangement is likely to develop future incentives, so that trusts will create effective management and claims monitoring.

On the other hand, it seems that there is little evidence that the NHS reforms have made any positive difference to patients (Annandale, 1998), or to nurses, because the students in this study reveal that their responsibilities are increasing, but with no subsequent rise in the number of staff employed. Quality of care and patient centred care that is incorporated in the government's Patient's Charter (DoH, 1992; 1995) appears to have been sacrificed to the cost cutting exercises of management who wish to achieve value for money (Keen, 1995). For example, Bevan and Stock (1991) argue that skill mix reviews usually result in cheaper, less qualified staff replacing more expensive, better qualified nursing staff, despite studies revealing that higher nursing grades provide a better quality of care (Keen, 1995).

It seems that basic nursing care has reached the political agenda (DoH, 2001) and this is due to the notion that the government is to help nursing home residents with their fees, by paying for care that is given by a registered nurse (Royal Commission on Long Term Care, 1999). Scott (2001) argues that there appears to be some confusion over what constitutes nursing need, because the government has redefined nursing to exclude personal care like bathing, feeding and attending to elimination needs and so a charge will be made for this care.

Although some nurses have labelled personal care as simple, routine and nonessential (MacAllister, 2001) nevertheless, Scott (2001) contends that it is an essential aspect of nursing that enhances quality care. Carrying out personal care enables the nurse to assess the small, but important changes that occur in the patient's condition, as well as providing an opportunity for the nurse to establish a relationship (see Abigail, Paula and Freda's narratives in section 6.2) that facilitates an understanding of the individual, patient's health care needs (Scott, 2001; MacAllister, 2001). Therefore, MacAllister (2001) argues that despite the idea that personal care provision may not be considered prestigious, it has a potent impact on the patient's, health care experience and hence, it is essential that personal care is carried out under the supervision of a registered nurse. However, Keen (1995) argues that nurses need to deliver direct personal care, because supervisory duties and carrying out technical tasks prevents the nurse from gaining experience that is crucial to the development of the nurse's assessment and decision making skills.

The last aspect to consider is the original aim of the changes within the NHS that was to give priority to consumers (Hardey, 1998), as well as curtail the power of the doctors (discussed in section 5.4). These changes appear to have little effect on patient choice, or the doctor's collective power (Annandale, 1998). Annandale argues, that because capitalism has been restructured from an economy, in which people transform raw material into mass-market goods, to a flexible economy based on the production of knowledge and information, new areas that may be exploited are developed and these differ markedly from any previous spheres.

One area for exploitation concerns health care, because it is viewed as central to the current risk society (Annandale, 1998; p18) hence, the risks to health - like nuclear, chemical and genetic factors, mysterious viral infections, contaminated food as well as smoking, diet and exercise appear to threaten the very existence of society (Annandale, 1998). As a consequence, power is decentralised from the state to medicine that is a specialised division of labour (Annandale, 1998).

This restructuring of capitalism has meant that the individual person's way of living (lifestyle) is linked very closely to the techno-economic-sub politics (Beck, 1992; quoted in Annandale, 1998; p18) of medical industries and health institutions that utilises a market strategy that profits from risk. Annandale contends that these risks generate new economic markets, like filters for pollutants and nicotine patches to help the individual give up smoking, as well as vitamin complexes that enhance nutrition in a society that digests an enormous amount of chemically infused fast foods. In addition, the rapid development of cosmetic surgery and new medical technologies like silicone breast implants, amniocentesis, electrical foetal monitoring and induction procedures (see Janet's narrative section 5.4) instead of reducing risk may create further risks (Annandale, 1998).

The decision to undergo cosmetic surgery remains with the individual, because he/she has the choice and freedom (empowerment) to make the decision. This reflexivity (Hardey, 1998; p16) in which the individual makes health care choices based on knowledge gained from an array of expert information, under conditions of risk and uncertainty, can create considerable anxiety (Annandale, 1998). However, Annandale argues that reflexivity may increase health awareness, whilst Shilling (1993) contends that making the individual person responsible for his/her healthy lifestyle tends to draw attention to the notion that the formation of a dynamic self-identity focuses on the healthy body that represents modern society.

Hardey (1998) argues, that because current society emphasizes healthy living through the media, this has created a niche for medical knowledge, with the result that medicine remains a powerful presence in both public and personal life. On the other hand, Annandale and Hardey argue, that the downside of this self-control over health related behaviours draws

attention away from the problems that poor housing and poverty may have on a healthy lifestyle. Despite the idea that an economy constructed from self-control and responsibility may be profitable (eg. diet industry, health clubs), it needs to

exist alongside the economic mandate to consume market-offered goods, as immediate gratification is portrayed as a source of stress reduction and emotional and physical well being. (Annandale, 1998; p20).

In other words, capitalism is in the process of being restructured, where social class and family decline in importance, to the current society, in which health is viewed as vital to the individual's well being hence, perpetuating the role of medicine in both public and personal life. This modern society presents new opportunities and a set of constraints that are partly defined by ideas relating to risk and uncertainty, where problems about lifestyle and self-identity may be solved by choosing options concerning healthy lifestyles, because these are promoted through the media, as essential to the establishment of successful relationships and employment opportunities (Hardey, 1998).

Summary

The findings from this chapter reveal that the students do not appear to reflect at the critical level, because they seem unable to recognise how medical and management's power, as well as policies constrain their practice. Firstly, they do not explore the reasons why they are being asked to take on such tasks as cannulation, neither do they recognise that these tasks extend their technical skills without enhancing the nurse-patient relationship, nor extending their care knowledge base. Secondly, they fail to recognise that the grading system has led to a perpetuation of the nursing hierarchy that leads to nurses, on the higher grades, being recognised by their superiors as the only ones competent enough to carry out cannulation, or care for central lines (see Sophie's narrative in section 6.1). Thirdly, they do not explore the reasons for accepting these tasks, nor that the result of their accepting them is that basic nursing care (that is an important part of the nurse's role and learning experience) is gradually being allocated to health care assistants. They fail to acknowledge that the consequence is that registered nurses are increasingly being asked to act in a supervisory role hence, reducing their contact with patients (see Sophie's story in section 6.1). In addition, the

students do not recognise that the reason why some nurses prefer to do these tasks is that cannulation – a technical task considered by some nurses as high status – legitimises the view that emptying urinals is low status and associated with a ‘natural’ extension of the mother role. Also, the students fail to explore the notion that they are continuing their subordination to doctors, by taking on these tasks that remain under the control of the doctors.

Despite some students revealing that they enjoy the caring aspect of their role more than executing technical tasks (see Abigail, Paula and Freda’s stories discussed in section 6.2), as well as commenting that it takes skill to form a rapport with the mother during labour (Paula’s story), they do not appear to recognise the importance of these caring actions and neither do they explore the contentions surrounding the concept of care, or the reason why their care is not valued. They fail to explore the idea that because the care they give is perceived as almost invisible, of low status and analogous to a mother’s role, so their care is not valued.

In addition, the students are not aware that the reason why primary nursing and nursing development units were introduced was to raise the nurse’s status and to attempt to develop a knowledge base separate from that of the doctors. Furthermore, because of their lack of awareness of the purpose of the NDUs and primary nursing, the students are unable to critically evaluate these changes. They appear unaware of the notion that when nurses take the curative route within the NDUs, in which the nurses gain autonomy, this may result in overt opposition from doctors. This is because the nurses in the NDUs undermine the traditional doctor-nurse relationship, through gaining the power to practice autonomously, that reduces the doctors to their curative role. Also, the students do not recognise that doctors do not challenge nurses when they extend their role, by relieving doctors of their more routine medical tasks (like cannulation), because they do not threaten the power base of the doctors.

Sylvia, Gemma, Holly and Lucy’s narratives reveal that the medical model of care is widely used. However, they fail to explore the idea that this is possibly a characteristic of the dominated group. Furthermore, they do not appear to recognise that because doctors are in a

dominant position, hence, nurses adopt the doctor's culture (discussed in section 5.3). They appear unaware that this domination leads to some nurses basing their care on medical and behavioural labels, resulting in misconceptions about how a dying wife may affect the husband's complaints of chest pain (Lucy's story in section 6.2). Neither do the students address the grieving needs of an elderly patient (Sylvia's story in section 6.2). Furthermore, the students do not recognise that their socialisation into their subordinate position is also a feature of groups that are oppressed.

The students also, appear unaware that those in positions of power use hidden techniques, like expecting nurses to carry out orders without knowing the reasons why (Estelle's narrative section 6.2), or providing information on a 'need to know' basis (Gemma's story section 6.2), in order to achieve management's aims and perpetuate the status quo. The other aspect the students do not recognise is that they are perpetuating their subservience, by not questioning these rules and rituals. In addition, they appear unaware that acting as an attendant on the ward round (see Becky's comments in section 6.2) serves only the interest of the doctors and does not further the nurse's skills, or knowledge, because the doctor leads the ward round.

The last feature that the students fail to recognise is how the changes in the NHS affect patient care and the concept of client autonomy, because the changes during the 1990's were accomplished in order to create an efficient, equitable, consumer-led, quality service. Although the students' narratives raised the issue of cost saving exercises (discussed in relation to Gemma and Holly's narrative and Sylvia's story in section 6.2) the students failed to explore the reasons for certain categories of patients gaining more power over the decision making process than others. For example, Janet's maternity patient requested an early induction (see section 5.4) that was granted, whilst Gemma's patient (see section 6.2) who had a psychiatric disorder and Sylvia's patient (see section 6.2) who was very elderly and did not communicate well did not attain effective outcomes of their individual, health care needs. This supports Hardey's (1998) contention that certain patients who do not have the knowledge, or skills to articulate their needs are not empowered to make choices about whether to be discharged home, or to a rest home (Sylvia's patient see section 6.2), or in the

case of Gemma's patient to a psychiatric ward. Neither do the students recognise that other categories of patients, like maternity patients, are empowered to make choices as to where to have their baby delivered, besides having the advantage of a one to one relationship, with the midwife during a home birth (Paula's story section 6.2).

The students appear unaware that they have the power to influence the way in which care is given (see Estelle's story in section 6.2). In addition, the students fail to explore the notion that the reality of the modern NHS is that it does not provide a consumer-led and equitable service for all patients and neither do they examine the idea that the NHS supports Lash's reflexivity, in which the winners (certain categories of patients like some maternity clients) progress at the expense of the losers (certain categories of patients like elderly and psychiatric patients). Furthermore, the students do not explore the notion that collective, medical power is increasing whilst nurses are sacrificing their caring aspects to the lower paid, health care assistants that is part of a cost cutting exercise by management.

CHAPTER 7

LEARNING THROUGH REFLECTIVE PRACTICE

As has been discussed in the previous two chapters, the students' reflections on practice reveal that nurses are socialised into a subservient position to doctors and managers. The consequence of this oppressed status means that the students have internalised medical ideology (Freire, 1985), as well as being socialised into carrying out nursing care that serves the interest of the doctors and managers (Perry, 1993). This tends to influence the students' reflective ability, because they do not examine how this oppression that is socially constructed has constrained the way in which they carry out care. Besides doctors and managers socialising nurses into their subservient position, nurse education also represents a powerful vehicle for the socialisation and transmission of a culture (Rafferty, 1996). Therefore, this chapter will focus on how nurse education, as well as other factors, like the nurse's oppressed status, may influence the group process as a method of facilitating reflection, as well as how these aspects affect the students' learning ability.

7.1 The Problems/Advantages of the Empowering Properties of the Group Process

The description of the group process (discussed in section 4) reveals that it was self-directed, in that there was no agenda for the type of clinical topics to be reflected on at these group sessions. Therefore, when the students met for one hour every other week during term time, it was the students who determined the type of clinical aspects that were to be discussed during these group meetings. The role undertaken by the facilitators was non-directional and non-confrontational hence, allowing the students the freedom to develop reflective ability at their own pace. The aim of these empowering (discussed in section 5.4) seminars, in which the power relationships were shared between the students and the facilitators, means that the students could discuss patient care/dilemmas in a safe environment, in order to experiment and take risks (Ford and Walsh, 1994).

Taylor (2000) argues that if students are to learn from reflection, they need to explore the power relationships in their practice areas, so that through collaborative processes they may attain informed consciousness about the positive social and political changes that are required, in order to provide nurses the freedom to practice what they consider ideal care. Furthermore, Ford and Walsh (1994) contend, that an empowering education that permits nurses to become active participants in their own learning, may aid the promotion of caring to a position of primacy, that results in caring becoming a health care issue. This may enable nurses to move away from routine and ritual care (discussed in section 6.2) to patient centred care (discussed in section 5.1.4), where the patient is empowered to make choices, with regard to his/her health care needs (Ford and Walsh, 1994).

Hatton and Smith's (1995) research reveals that an empowering education does not always result in the transformative process. Their study shows that despite reflective strategies being used throughout a three-year degree course 60-70% of the students reflected at the descriptive level only. The move to a critical level as argued by Lumby (1992; quoted in Lumby, 1998; p94) requires

Much more in terms of process and facilitation, since it is here that transformation links reflection and revisioning. When we revision, we 'see again', revising previous assumptions and identifying possibilities never imagined. We become aware of the multiple perspectives of events and actions, the historical and socio-political contexts in which they are located. This is when the known becomes part of the knower, the observed becomes part of the observer and the interpreted becomes the interpreted.

Lumby (1998) contends, that the reflective process is not inherently transformative, but comprises several complex layers that the students need to progress through, in order to reach the critical level of reflection.

7.1.1 The Student's Perceptions of the Purpose of Reflective Practice

Schutz (1967) proposes that each individual member needs to be clear about the aims of the group, in order for it to be effective in achieving change. The students' comments reveal that their notion of the purpose of reflective practice does not equate with those at the critical level of reflection (discussed in section 3.1.2), in which learning through reflection enables

the students to develop critical awareness of the social, political, cultural and historical causes of their oppression (Taylor, 2000). For example, some students view the purpose of reflective practice as reflecting on a situation/event that has either gone well/not well, or a retrospective act in which errors are focused on, in order to see how they could rectify the mistakes, or deal with situations in a different way.

Carol; You're just reflecting on how you practice basically and whether you can do things better or whether you should have done anything differently.

Sylvia; I think reflective practice you can say ... what you learnt from it whether it's right or wrong and if it's wrong you want an improvement next time.

Glaze (1998) argues, that simply examining an event/error/problem to see how the latter could be dealt with in a different way is far removed from the ability to become critically conscious through reflection on practice. Besides this retrospective view of reflective practice, some students suggest that the purpose of the group was to share ideas/experiences. On the other hand, some students' comments equate reflective practice with an informal gossip, or buzzword, or a known concept that is formally named reflective practice.

Theresa; Reflective practice is... to share ideas with other people. It makes you... think that I'm going along the right lines. Their wavelength is the same as my wavelength. We're on the same sort of lines so that's a good marker.

Judy; I thought it was quite useful that you could actually discuss things that you couldn't actually discuss at work... because you got the group members' opinions on it and how they might react to situations or just to see if they were on the same wavelength.

Abigail; Reflective practice like this group has gone on informally since nursing ever started. You know that we talk at coffee, we talk with our friends, how you reflect on things and that's how knowledge is passed on. You know people will say something has happened on the ward... or whom did what and then you learn. That's how its always been really

Claudia; I think you do reflective practice all the time... I think it's something that nurses do all the time... but not in such a formal setting.

Lisa; To me reflective practice is something most nurses do anyway. You can be driving back from work... and something pops up in your mind and something might have occurred at work... and you come home and you ponder on it and how you can improve it. I think it is recognised that it has always been there.

Estelle; It was quite a new buzzword when we started

Kay; Reflective practice is just another buzzword in nursing. I thought it was another trend. It wasn't going to stay the course and in another couple of weeks another buzzword will come along and we'll be off reflection onto something else. I think that nursing is changing so much now that everything becomes a buzzword.

The reason why the students tend to have misconceptions about the purpose of the reflective practice group is likely to be due to their socialisation into their subordinate position by both doctors (discussed in section 5.2) and managers (discussed in section 6.2). The result of this oppression is *false consciousness* (Taylor, 2000; p139), in that the students do not examine why they continue to accept the power relationships in their work place, because they either go unnoticed (Taylor 2000), as some nurses accept that they are unable to change the power relationships.

As well as nurses being socialised into their subservient position, the nurse education system tends to perpetuate the socialisation of the nurses into their oppressed state (Freire, 1970). For example, this notion of a correct way of dealing with situations that matches other student's ideas of the right method to use when solving problems, reflects the traditional nurse training that these students undertook, as well as embodying their oppressed status (see section 5.2). Ford and Walsh (1994) argue, that nurse training is characterised by the ability to perform tasks correctly and efficiently, whilst the nurse's oppressed status results in conformity and obeying orders, in order to survive. Abigail's idea that knowledge is gained through an informal chat supports Roth's (1989) contention that learning in the practice area means that information is attained through word of mouth. Ford and Walsh (1994) propose, that this passing on of knowledge does not allow the student to have control, or a sense of ownership of this knowledge. However, Roth (1989) argues that this emphasis on learning in the practice area means that the knowledge gained is not based on a theoretical framework and it also socialises the student into learning specific behaviours.

Theresa; I mean... on the wards that's where you learnt all your information from really... you learnt in school... a bit of anatomy and physiology... you didn't... do the nursing of patients until you were out on the wards really... and then it was whatever the standard of the ward sister was that you worked with.

Gemma; My training was medically orientated and I tended to think of patients by their medical diagnosis. We weren't actively taught to think for ourselves.

Jessica; I suppose I did feel I had to respect authority... and be subservient to doctors.

Becky; At the beginning of my training... you bowed to the consultants.

Lisa; Certainly, one of the things that I did find in the reflective practice group was the god like awe you held the consultant in.

Carol; Well I can remember the rigidity bit and the fear of the sister

Betty; Injustice, bullying from the old senior staff... it made me determined and tough. You... had to face a lot of things very quickly... hard work long hours, death, disease.

Theresa's view supports Roth's (1989) argument, that the apprenticeship training of nurses emphasised practical bedside skills, whilst Gemma reveals that she learnt to base her care on the scientific medical model (discussed in section 6.2). The result is that Gemma tends to refer to patients by their medical diagnosis. This supports Carpenter's (1993) contention that labelling (discussed in section 5.1.3) patients means that the nurse considers the patient in a detached and unemotional manner, that is characteristic of the scientific medical model.

Jessica, Becky, Lisa and Carol's statements support Perry's (1993) contention, that one aspect of the hidden agenda in nurse training is the socialisation of students into acquired deference to authority figures. Betty's comments show the techniques (injustice, bullying) used to ensure that students learn to know their place in the ward hierarchy (Melia, 1987; Smith, 1992). Binnie and Titchen (1999) argue that a significant factor in ensuring the perpetuation of a non-challenging and non-participative culture was fear of the ward sister. The nurses in their study appeared to be afraid of challenging the established order, despite

no apparent justification for this fear. However, Perry (1993) argues that because nurses are the oppressed group (discussed in section 5.3), they are vulnerable to abuses of power like injustice and bullying.

The result of this social learning is that nurses acquire the status mentality that corresponds to their subordinate place in the health care hierarchy (discussed in section 5.3); hence, existing inequalities are perpetuated. Kay's description of how she was treated on the ward, by nurses more senior to her, also, reveals the humiliating techniques used to socialise her into her subordinate position within the ward-based hierarchy.

Kay: The discussions about teamwork... made me understand a lot of things that happened during my training... I was made to feel very insecure not just during my training but afterwards when I worked in units within the hospital. They (the nurses) thought they were superior and they kept their knowledge to themselves. They did not welcome outsiders... it was very difficult. It was almost like an initiation. You had to battle through these daily emotional onslaughts from people who thought they were superior to you, laughed at your mistakes... discussed your mistakes and weaknesses between themselves but didn't do anything to alleviate them... they expected you to fall into line straight away.

Perry (1993) proposes that this humiliating behaviour, like laughing at a junior nurse's mistakes and not providing Kay with the knowledge to alleviate mistakes, is part of the hidden agenda, that the more senior members of the nursing staff use to socialise junior nursing staff into their lowly positions within the ward hierarchy.

In comparison to viewing reflection as sharing ideas, Claudia, Lisa and Abigail reveal the idea, that reflective practice is not a new concept and that they have always reflected or are reflecting continually. Their extracts show evidence of knowing through tenacity because they truly believe that they are reflecting (Kerlinger, 1986). Vaughan (1992; p4) argues that problems are created when a nurse adopts notions, like I know I am reflecting, because I have always done it like that consequently, I accept it as true. The reason, according to Vaughan, is because this knowledge is being accepted without questioning whether it is correct. The reason for Claudia, Lisa and Abigail's views may be due to the idea that their prior experience of nurse training socialised them into believing the facts they were taught were true.

Carol; You believed everything the sister said at one time rather than questioning.

On the other hand, Ford and Walsh (1994) contend that why Claudia, Lisa and Abigail may not question their view of reflective practice may be because nurses are in a subordinate position within the health care hierarchy (discussed in section 5.1.3). Hence, they are socialised into following orders that inhibits a questioning attitude. This passivity and submissiveness, as argued by Meleis (1985), does not encourage debate that is required for learning through reflection on practice.

Kay and Estelle refer to reflective practice as a buzzword. One possible reason may be that they equate reflection with the plethora of new innovations (like the nursing process and primary nursing that are discussed in section 6.2) and consequently may distrust the belief that it will improve patient care (Auld, 1992). Furthermore, Auld (1992) contends that because nurse training in the United Kingdom focuses on technical competence, rather than intellectual development, hence nurses are unable to discuss, debate or contend if these new innovations, like reflective practice are effective in improving the care that nurses give to patients. However, the student's sceptical attitude may be due to their negative associations with the nursing process and nursing theories that Walsh and Ford (1989) argue, were implemented without proper preparation.

The result is that nurses in the practice areas do not understand the ideas embodied in these innovations (see Theresa Abigail and Sylvia's narratives in section 6.2) and they appear to view them as of little use in practice (Walsh and Ford, 1989). Ford and Walsh (1994) also, contend that nurses may not view changes in practice, in a favourable light, because these nursing innovations appear to be driven by those in power who have the least knowledge about the reality of current, direct, patient care (discussed in 6.2). In addition, labelling reflection as a buzzword may represent, as argued by Ford and Walsh (1994), an attitude that may be resistant to change.

Zeichner (1990) on the other hand, contends that the student's differing values relating to technical skills and reflective activities may affect the students' learning through the

reflective process. The students may view reflection, as an esoteric and useless diversion, in which they may feel that they can utilise the time allocated to reflective practice, more effectively in learning other skills, in order to survive the course (Zeichner, 1990). The following extracts from members of group A support Zeichner's contention.

Judy; I really felt what on earth are we doing here wasting time when we could be in the library... every hour was really important to us.

Estelle; We went to college to get our diploma and I don't feel that (reflective practice group) has got anything to do with it... there was too much at stake... I must get on with this assignment. I must get to the library. You can't have a meaty discussion when you've got your mind on that one... you don't want it (reflective practice) tangled up with... getting deadlines (assignments) in on time

Kay; I think I would have preferred to be off to the library or doing some literature searching.

Claudia; I felt it was a waste of time that hour we spent once a fortnight... it just seemed a waste of time sitting there looking at each other trying to find something to talk about... I would have used the time in the library to get on with my assignments.

In comparison to the majority of the students, Janet's view of the aim of reflective practice supports Rolfe's (1998) proposal that reflective learning is a continual spiral.

Janet; You can still reflect on what you've done to date and learn... in some ways it's quite useful because you can build on that in the future and go back to it and then build on what's reflected on now at this stage. In a year or 15 month's time you can come back to it and say now with the further knowledge I've got I can obviously see a different way round the situation.

This spiral view of learning is substantiated by Lumby's (1998) argument that in order to become aware of their oppressed status in the health care system, the students need to progress through several, complicated stages that represent the reflective process.

7.1.2 The Self-Directing Property of the Group Process

Each group member was given the freedom to choose whether to attend the group sessions and the autonomy (discussed in section 5.3) to decide which aspects of their clinical

experience they would divulge to the group. In addition, the group members were responsible for initiating, directing and developing the group session. However, some of the students reveal that this was a difficult experience.

Pat; I found it hard to open up in front of a group. I just found it difficult to start off from a silent group. I'm quite willing to add onto what someone else has started.

Sophie; It's just finding the issues to talk about that I found difficult.

Lucy; I didn't initiate anything. Once the discussions got going then I would really join in... I always struggled to find something I particularly wanted to discuss

Jessica; I felt quite nervous about starting up a conversation.

Kara; I don't like talking in a group... I like to be with people I know and to be sympathetic if you like to them and I to them... although they were very pleasant the women who were in the group... but I didn't know them.

One reason why the students are likely to have had difficulty in opening up a discussion on practice issues, within the group, may be due to the students' socialisation into a subordinate role. The students' subservient status means that they do not acquire the ability to discuss, or make decisions relating to their clinical experience, because they learn to implement care according to the doctor's and management's directives (see Becky, Lisa, Pat, Janet, Gemma and Sylvia's narratives in sections 5.1, 5.2, 5.4 and 6.2). The consequence of this social learning is that some students like Pat and Jessica may not possess the confidence to initiate, or direct a discussion within a group situation.

This lack of confidence in their competence to self direct their learning may relate not only to the students' oppressed role within the clinical area in which they learn to obey orders, but may be the result of their previous nurse training. Clarke et al (1994) argue that traditional nurse training ensures that the power holders at the top of the hierarchy direct the students in their learning, because according to Ford and Walsh (1994), the hidden aim is to ensure that when the students qualify as nurses, they conform to the system, in order to meet the needs of those in positions of power. Thus, the development of critical ability is stifled, because knowledge is passed down to the learners in the form of lectures consisting of facts (Ford and Walsh, 1994).

Gemma; *We all learnt by rote parrot fashion and we weren't actually taught to think for ourselves.*

Betty; *I mean the type of training I used to have was the teacher standing up there and telling you what you should know.*

Zara; *When I trained between 1981 and 1984... they dished it out in piles and piles of notes... and then you gave it back in the exams and tests.*

Susan; *In my nurse training... you weren't taught to think or find out for yourself.*

Janet; *When I trained you did as you were told... you couldn't have an opinion or original thought because you were looked at as if you were something that crawled out from underneath the sluice.*

These students' extracts support Davis' (1993) contention that the problems inherent in this system are due to the notion that the nurse teachers tell the students what to learn, hence they do not encourage the students to learn for themselves. Instead, this type of education in which the students are not active participants in their learning, results in the students complying with specific rules, standards and patterns of behaviour that ensures their socialisation into their subordinate position in the health care hierarchy (Perry, 1993).

7.1.3 The Students' Perceptions of the Facilitator Role

The students' lack of competence and confidence in taking responsibility for their own learning also, affects their perception of the facilitator's role, because most of the students would have liked the facilitator to initiate and direct the sessions, as well as provide an agenda with pre-arranged topics to discuss. There are several reasons why the students required the facilitators to take control of the sessions. Firstly, because the students are socialised by doctors and management into following orders, they may not learn the necessary skills to take responsibility for initiating a discussion, or develop the confidence to be able to express their views (Sullivan, 1998). Secondly, as the students may have been socialised during their basic nursing course into the expectation that the tutor tells them what to learn, as well as directing the teaching sessions (Davis, 1993), it is possible that they assumed the facilitator would initiate and direct the reflective practice group sessions. Lastly,

the students may be afraid to initiate a discussion of their practice, because the students are socialised into the expectation that when a senior member of staff (like a tutor/facilitator) questions their practice, this implies a reprimand instead of as a way of helping them to learn (Binnie & Titchen, 1999). Binnie and Titchen contend that because the students may view questioning as negative criticism, this may arouse feelings of anxiousness, inadequacy, and defensiveness that are not conducive to learning.

Freda; I would have liked more structure, more definite guidelines initially as to the real purpose of it (reflective practice) and more leadership.

Carol; We just needed somebody to get us started talking about a topic... without a structure we found it embarrassing and then someone would speak just to fill the silence. We just needed someone to get us started to start talking about a topic.

Pippa; I think initially we wanted A (the facilitator) to say yes that's right that's very good... or no you need to relook at things... it was difficult because you were... thinking come on A give us some feedback... but you knew why she didn't do it because A wanted everyone else to step in as opposed to her giving answers

Sylvia; I think it's better you know what you'll be discussing so that if none of us have had an experience in the week to discuss, you know what you are going to discuss.

Sophie; I think it could have done with more structure... it might have helped if we had taken it in turn to bring something to the group so that each time maybe one or two would have had a subject to air rather than just making it an open forum where you pitch in with anything.

Pippa, reflects on the idea that as traditional nurse training replicates the hierarchical structure of the clinical area, hence the nurse teacher is viewed as being in a more powerful position in relation to the student (Pendleton, 1995). Therefore, because some of the students are likely to view the facilitators as being in a dominant position, they expect the facilitators to direct the group sessions.

The following extracts reveal that the style of the facilitator is important because the students prefer the facilitator to be warm, friendly and motherly and are uncomfortable with the facilitator questioning their clinical practice.

Sophie; B was easier than A... possibly because she was the one that would give you an opening... which would start things off whereas A would just sit there and wait for something to be said.

Theresa; One facilitator (B) was more easy going warm and friendly... was sort of motherly. The other person (facilitator A) was a bit stiffer and you would never know what her opinion was about something.

Becky; I think people found B a comfortable person to be with. She would... join in and contribute slightly more than A... I was sometimes a little reluctant to initiate topics which A would pick up on... there would be a lot of cross questioning of the person, very close questioning. I think sometimes... it made you feel uncomfortable.

Jessica; If A (the facilitator) was there she would ask questions that no-body would know what she was getting at... she was maybe challenging... you were apprehensive about what you said.

This feature that some students (Jessica and Becky) are unable to cope with the challenge of their practice being questioned is a characteristic of the students' oppressed status (Freire, 1985). The consequence of this subservient position is the introduction of rigid, structured learning by the dominated group upon its members (students), in order to ensure that they conform to the orders made by those in positions of power (Freire, 1985). Thus, it is possible that because the students are socialised into directed learning, they are unable to contend with the demands of initiating and directing their own learning. The result is that some students (eg those in group A) impose a structure in which the members decided that

When we went in we would more or less know what we are going to talk about because we decided prior to the meeting who was to bring something up and what it was about... and we found that quite useful but for going in and just making something up you know or routing around for something... we didn't care whether they were talking a load of rubbish so long as they were actually talking to get the time over with and get out. (Judy)

In comparison to group A members Janet views the unstructured nature of the group as valuable.

Janet; I think if you're not careful and you structure it too much then it defeats the object... I think half the value was being able to feel that you could come up with something there and then that had come up that week.

The group's (see section 4.4.1) intended power structure comprises shared power relationship between the students and the facilitators, in order to allow free expression of ideas. Gordon (1972; quoted in Douglas, 1993; p32) argues that sharing power means that group members are liberated from the dependence on the facilitator, as well as sharing the leadership function on a rotating basis, in which each member willingly agrees to take a turn in facilitating the group. Yet, many of the students' statements reveal their dependence on the facilitator that supports Douglas' (1993) contention that the group-centred facilitator's role is important, because in order for the group to become self directing requires a great deal of initial guidance from the facilitator who is the main resource.

The students' ideas concerning the facilitator role substantiate Johns' (1998) and Schon's (1987) argument that reflection needs to be coached. Johns (1998) contends that practitioners require guidance because they need to see beyond themselves, in order for them to start to understand how their own personal distortions and limited fields of vision, relating to the power bases, embedded within clinical practice have restricted their ability to achieve desirable care. Binnie and Titchen (1999) argue that in order for nurses to learn from practice, the facilitator needs to have sensitivity, awareness of knowing when the time is right to initiate a discussion, allow a sharing of ideas without being patronising, have the ability to challenge the student's practice without being threatening and value the student's ideas.

7.1.4 The Effect of Trust, Risk Taking and Sharing Ideas on the Group Process

Other reasons why the group process may not have enabled the students to open up discussions may be due to lack of trust, as well as an unwillingness to share their experiences and take risks. The development of trust within a group equates with each student's evolving perceptions of the consequences of risk taking (Douglas, 1993). Douglas argues that an increase in self-disclosure is viewed as originating from an accompanying increase in trust that is based on the observation of how the other group members handle situations, comprising risk and disclosure. If the response is perceived as non-threatening, then there will be an accompanying reduction in distrust. The following extracts reveal that some students did not feel safe within the group, because they were afraid of confidentiality being

breached, or of being criticised, or of being judged.

Lisa; There were probably times when I didn't feel safe. There was one particular person who could be judgemental without even realising it herself.

Gemma; I mean... I felt... a fear of criticism... that my practice wasn't what it should have been. I think the group was too big to feel completely safe... I trusted them to a certain extent but I didn't get to know them very well.

Zara; I found it very difficult to speak to them (the group members) because as far as I was concerned although I met them every week, they were like strangers I couldn't really trust... that if I say anything will they keep it within the group?

Judy; If it (the issue) was something really professional, a real confidential problem then I wouldn't have discussed it within the group.

Kara's comments show the reluctance of another group member to reveal her drug errors within the group sessions. This student's disclosure supports Douglas' (1993) argument that not divulging this information influences the resources available to the group. For example, if this student had disclosed these drug errors, this may have led to a debate about the doctor's prescribing techniques (discussed in section 5.1), as well as initiating a discussion relating to why drug errors occur and how these could be avoided. However, the student may not have admitted her mistake because of her fear of being judged.

Kara; There was one group member who told me about drug errors she had done... there was no way she would have stood up and said that to the group because it's private... you feel ashamed of something like that... people don't want to admit in front of people that you're... well... negligent in some way which you are. I mean these are 2 drug errors. They were controlled.

The students' extracts substantiate Douglas' (1993) contention that besides a lack of trust, group size and lack of familiarity influence the interaction between group members. For example, Hoffman (1965; quoted in Douglas, 1993; p72) argues that if the size of the group is large (see Gemma's extract), then the more introverted group members may not participate in discussions. Although lack of familiarity may reduce participation, friendship may lead to trust (Douglas, 1993). The following extracts reveal that because some students were friendly

with some of the other members within the group, they felt safe. In addition, non-judgemental attitudes and confidentiality raised trust and increased the group member's sense of security, with the result that group interaction increased.

Janet; I think initially everybody was a bit wary. You were wary of letting part of yourself go really but after a while I think we all felt safe enough with each other to be able to say what we felt without feeling that you were going to be judged unduly.

Becky; That did help me having discussions with other colleagues that weren't actually in my area... it did really help me... knowing that it (discussion about patient's pain in section 5.1) wouldn't go any further and I trusted everyone in the group.

Dawn; I felt it was safe. I was confident that we'd laid the ground rules, so confidentiality was a thing. I don't think that anyone of us talked about issues we raised within the group outside of the group.

Pippa; Initially you felt uncomfortable because you weren't quite sure whether you'd get negative feedback on everything you said. I think because we did get on with each other you felt you were able to disclose things and whether it was something good or something bad they wouldn't jump down your throat.

Judy; I think... as time went on we all felt much more relaxed with each other. You felt you could talk about things without feeling that you were judged. That's the big fear isn't it?

These fears of being judged in a negative way are likely to be based on the notion of the students' previous experience of socialisation techniques (discussed in section 5.3 and 6.2), because destructive criticism (Krieger, 1991; quoted in Ford & Walsh, 1994; p31) of nurses' behaviour and clinical practice is one of the techniques used to socialise nurses into their subordinate position (Perry, 1993). Furthermore, these fears about being judged support the findings of Hatton and Smith's (1995) study, because some of their students like Gemma, feel vulnerable about exposing weaknesses in their practice. Consequently, this may limit or prevent the students from discussing their clinical experiences (Sundeen, 1989; Newall, 1992) within the group sessions.

In addition to trust, Douglas (1993) asserts that a willingness by each group member to *share* experiences is an important aspect of group work. The following extracts support Douglas' (1993) argument that the value of sharing ideas demonstrates the diversity of views that may result in choice during the decision making process. For example, the differing views encourage thinking in different ways (Judy), broaden the nurse's outlook and provide different perspectives (Janet and Dawn), as well as imparting alternative approaches to problems with communication (Pat).

Judy; Well I think their (group members) views probably made me think in a different way. I did take into consideration their opinions on things that we were reflecting on and it gave me room for thought really that they could think in different ways.

Pat; That theme... particular dilemmas with medical staff... seemed to come up over and over again which is obviously a problem... but I think through discussion it did help us to look at... that... issue in a different way and from all angles. It made me think of alternative ways of communicating and tackling problems within the multidisciplinary team, which is quite important.

Janet; It was very interesting what I got back from the other members of the group on a specific midwifery issue (discussed in section 5.4). It was most useful for me to get ideas from somebody who's not a midwife and who sees it from a totally different perspective.

Dawn; If you've got a group discussing the same issues you've got a range of views... there isn't one answer to one particular issue. It's nice to get feedback from others who were experiencing the same sort of issues I was experiencing. I enjoyed talking through professional issues with colleagues to get their support.

Another obstacle that affects the group process, relates to lack of commitment (Douglas, 1993). Douglas proposes that the commonest cause is the perception that what is happening within the group has little or no relevance to the problems encountered in everyday reality. The following extracts support Douglas' assertions.

Claudia; Nobody else had any experience of that (theatre work) so nothing was really relevant to what I do. I am not happy to discuss things that have happened at work with people that I don't really know and have got no idea of what I do... the people I work with can do something about it and offer me valuable advice... they've got better insight into my job and what I do and the environment in which we work.

Kara; Nothing very exciting or relevant came out of it (the group discussions)

In comparison to Kara and Claudia's statements that they did not view reflective practice as relevant, the following extracts from members of group B substantiate Zeichner's and Liston's (1987) contention that in order to learn from reflection, the student requires attitudes such as commitment and a willingness to learn. The students reveal that listening to others, questioning (Susan) and respect for each other (Dawn and Kate) are factors that facilitated group discussion and led to motivation and group cohesiveness (Pippa's extract).

Dawn; I'm so quiet a person I don't often speak out... although there are some more dominant people in the group you still get the opportunity to put your point forward.

Susan; They (the group members) listened to what you had to say. They asked you to elaborate some of the things so that proved to me that they were listening.

Kate; Everyone listened to everyone and if you had something to say you had everyone's attention. You know there was an element of respect for each other in that group... The people in my group had the same thought processes as me and they were there to get something out of it. We did get on as people. I could relate to these people.

Pippa; The people within our reflective practice group were motivated to make it work... I think that helped because... we gelled together more quickly... we were interested in it (reflective practice) and it's a fairly new thing. They (group members) could see the benefit of it... so let's give it a try and because it worked for us quite quickly it sort of motivated you to continue.

Kate's view that the group members' thinking is similar supports Douglas' (1993) argument that nearly all groups tend to generate a pressure towards agreement and this has an inhibiting effect on the production of ideas, thoughts and feelings. This groupthink in which the group members become inward thinking may reduce the awareness for change (Burnard, 1985). Uniformity in thinking is likely to be a consequence of the nurses' socialisation into their subordinate position, because as argued by Giroux (1985), nurses learn that any expression of alternative ideas, or changes is suppressed (discussed in section 7.1.2).

7.2 Students' Perceptions of Learning through the Group Process and Diploma Course

From the previous discussion, it appears that the students' socialisation into their subordinate position, as well as their prior experience of learning has influenced their view of the purpose of reflective practice, besides having an effect on their learning through the reflective, group process. Learning through reflection is a complex and subtle process that involves taking in and making sense of new ideas and fitting them alongside ones that the student already has in his/her mind and learning to use them to change practice (Schon, 1983; Boud et al, 1985), or to become aware of the power relationships that constrain nursing practice (Taylor, 2000). In order to learn through reflection, specific skills are required (discussed in section 3.2.2) like self-awareness and critical thinking. However, before the higher order skills of analysis and synthesis are acquired, the lower order skills of how to do something competently, as well as describing the features of a situation need to be mastered (Stephenson, 1985).

The student's prior learning experience, as well as their socialisation into their oppressed position, has resulted in the student's knowledge being not only derived from the positivist perspective, but is based also, on prejudices, attitudes and beliefs that have no sound academic basis (Ford and Walsh, 1994). One of the consequences of this socialisation is that some of the students have not learnt to question practice, because traditionally education has socialised students into accepting that what is taught is automatically correct (discussed in section 7.1.1). The students have been socialised into not questioning orders from those in positions of power.

The following extract reveals that some students are beginning to question if the decisions made by those in a superior position in the health care hierarchy are correct.

Pat: We have a nurse specialist in our area who at times tends to try and say just do this and do that and I do feel the course has enabled me to question despite the fact that she's at a higher grade than me. That doesn't mean that everything she says is right and I feel more confident not just to question her. I mean anybody's practice and doctors you know. I think when you first qualify you tend to just do what doctors say or anybody above you. Whereas now I feel confident to question if I don't think things are as they should be.

Similarly to Pat, Janet refuses to accept the doctor's criticisms of her actions, because she justifies her decisions, as well as pointing out to the doctor that the policy of the hospital does not take into account, the individual needs of the maternity patients. However, Janet does not reflect on how the policy affects the individualised approach to maternity care. Ford and Walsh (1994) argue that a policy provides one way of executing a task, or making a decision and fails to give nurses the opportunity to consider alternatives, or to adopt differing solutions to a particular problem.

Janet; I had a situation... a couple of weeks ago where I had a lady who was booked to have her baby at home... she was quite a lot over 25 and ... wanting... her first baby at home... obstetrically there was no reason why not at all. This lady had a previous history of depression and I felt by allowing her to make the choice of what she wanted we were perhaps reducing the risk of her having problems afterwards... if subsequently she had to go into hospital ... then we would have had the chance to work through that... and that is exactly what happened... she went very overdue... she ended up having to be induced... halfway through the induction... when everything was completely opposite of what she originally wanted, I came up against a registrar who sort of said well why was this (induction) being done in the first place. I said well this was the policy of the hospital... he was being critical of the policy which I could understand... perhaps it should be more individualistic but on the other hand he was also criticising what we had done and I felt I've got to stand up for what we've done... I actually worked very hard to maintain as far as possible what she wanted (baby at home and normal delivery). I wouldn't have done that in the past. I'd have just sort of sat back and accepted everything they'd said as being the doctor who said this and this and this is what we ought to do. Whereas now no I wouldn't.

Janet's narrative supports Ford and Walsh's (1994) contention that care - like Janet allowing the mother to make the decision to have a home birth, in order to prevent future difficulties from arising - is invisible (discussed in section 6.2). Ford and Walsh (1994) also argue that this care comprises uncertain outcomes (like the mother's pregnancy extending beyond the expected date of the delivery). Thus, Janet's decision to follow the hospital policy, by transferring the mother to hospital when her expected date of delivery is overdue, does not fit into the doctor's idea of a professional decision where the clearly, defined outcome is cure (discussed in section 6.2). As a consequence, nursing care is frequently ignored, (discussed in section 6.2) undervalued and open to criticism from doctors (Ford and Walsh 1994).

Claudia's narrative, similarly to Janet's reveals that she also does not reflect on how a policy affects the administration of drugs. During a group discussion, one group member raised an

issue in which a newly qualified nurse injected a drug used in chemotherapy into an intravenous infusion, without checking the drug and its administration with another registered nurse. The dilemma was whether to report/not report him to the ward manager, because he had not followed the ward drug policy that stated that two nurses were required to check intravenous, chemotherapy drugs.

Claudia; This drug thing... I couldn't believe that somebody wouldn't do something about it and was contemplating whether they should say something about it or not, that quite shocked me the fact that something had happened and the people involved were more concerned about whether they'd drop somebody in it than patient safety really. That was a bit of an eye opener... it made me realise that people place different values on things and that professionally people don't act in the way that I would expect everybody to act which came as a bit of a shock really because I would have thought that there are certain things you do and there are certain things you don't do... there's no in between... and everybody abided by those rules but I know they don't now... and obviously there is an in between but I obviously didn't like to recognise that.

Claudia does not reflect on why nurses should obey the rules and neither does she consider why administering a chemotherapy drug through an intravenous infusion needs to be checked by two registered nurses. Gould (1988) argues, that legally the only drugs that require two nurses to check that the correct patient, receives the correct dose of the correct drug, at the correct time, are controlled drugs. Claudia's view that there are rules you follow substantiates Perry's (1993) contention, that nurses are socialised into obeying the rules made by persons in authority, without knowing the reason why. Furthermore, Benner's (1984) research reveals that when nurses follow the rules, their practice tends to be limited and inflexible. However, Claudia becomes aware that she needs to recognise that there is no right, or wrong way to make professional decisions, but does not appear to like the notion that there is uncertainty when making decisions.

Boud et al (1985) propose that self-directed learning is an important skill that the students require, in order to learn from reflection. This is because this desire to learn overcomes many obstacles and inhibitions, besides enabling the student to direct the type of clinical situation to be reflected on (Boud et al, 1985). Furthermore, Boud et al (1985) contend that the student directs the way in which the experience is reflectively processed and according to Northedge

(1990), it is the student who takes responsibility for what views to hold. However, Freire (1970) argues that students need to be actively involved in the learning process to prevent the socialisation of the students into conformity. Northedge (1990) contends that when students are actively involved in learning, they learn to recognise that the truth (Northedge 1990 p15) is uncertain, as well as forming their own judgement about the strengths and weaknesses of ideas and being able to argue for one idea against another.

The following extracts reveal that some students are becoming aware that not everything they are told or read is true.

Theresa; I'm much more likely to go out and find things for myself. It has increased my self-confidence a great deal... instead of waiting to be told something I'm more likely to go out and find out for myself rather than accept the facts as they are presented to you.

Susan; You're not going to take everything for granted that's written in a research paper. You'll read around the subject and see if it's actually true.

Lucy; The way I read things I don't take everything for granted... I feel much more comfortable going in and researching things on my own with regard to the work place.

Pat; I feel more confident to go out and learn something on my own and I would know where to start, where to go and how to deal with that information... my approach to research has changed dramatically. I think with traditional training you just read it and took it as gospel.

Kara; I'm much more aware of all the research that goes on... I have to say that you always get one piece of research that says so and so and somebody else comes along and says exactly the opposite... I'm aware that there are conflicting reports.

Kara's view supports Northedge's (1990) argument that in order to learn, the student needs to realise that written ideas, when presented, may disclose conflicting perspectives. In addition, reading skills is an important part of the reflective process, because it develops the student's thoughts and integrates new ideas into the understanding that the students already have about their practice and provides new interpretations to the student's thinking (Northedge, 1990).

The students mention their increasing awareness of research that Ford and Walsh (1994) argue is required to develop a nursing knowledge base that differs from that of the doctors.

However, nursing research should encompass more qualitative and action based methods, because they will uncover aspects of care that are important to patients (Ford and Walsh, 1994). This is because, as contended by Schon (1983), the technical, rational approach to research that is utilised in the main by doctors, comprises a narrow focus and excludes knowledge that is derived from the lived experiences and intuitive knowing. On the other hand, Northedge (1990) argues that although research is important, yet it becomes a useless exercise if it does not construct and apply theories to practice besides validating theories.

Attitude change is an important part of reflection, because if nursing practice is to be more flexible and knowledge-based, then attitudes like labelling (discussed in sections 5.1.3 and 6.2) patients need to be changed, in order for nursing practice that is dependent on attitudes to be decreased (Ford and Walsh, 1994). Dawn's extract, concerning students, supports Ford and Walsh's (1994) contention that an attitude change requires keeping an open mind and not accepting things at face value, besides not doing things the way they have always been done

Dawn; I suppose particularly in relation to working with students, discussing how other people within the group have dealt with difficult students. I've used some of what they suggested and adapted my approach to them. Maybe rather than just taking them (the students) at face value, she's a difficult student I'm not going to get on with her as to maybe find out why I perceive her as difficult... trying to sort out with them to find out why they're finding their patients potentially difficult on maternity... rather than just she's got no interest why should I put myself out for her if I'm not going to get any feedback which was very much the attitude I was having when I first started having students

Kate's and Pippa's statements reveal that the sociological knowledge they gained through undertaking the course has changed their attitude towards patients who have heart attacks. They are less judgemental, in that *I try not to blame them* (Kate) and less autocratic, in that Pippa no longer says *if you don't want to have a heart attack you don't smoke*.

Kate; The sociology module changed my attitude to ... smoking totally... I always thought that if patients had heart attacks and smoked they are stupid... they had to give up... I mean I still think they have to stop but I'm not quite so ... you've got to stop... there are more problems than it just being you've got to stop smoking... so there are other issues... and I think I'm aware of how I deal with people like the patient who has come in with a heart attack and he does smoke... I try not to blame them. A lot of them will try and blame themselves anyway and say ... I suppose I should give up smoking... I've changed my attitude to how I deal with that.

Pippa; I work on a cardiology ward and if people smoked I used to look in horror. Now through the sociology module you think about people... and why they smoke... You have to have got more open minded, more appreciative of people and their lives... as opposed to saying... if you don't want to have a heart attack you don't smoke.

However, in order to change attitudes requires self-awareness because this leads to a greater understanding of other people (Burnard, 1985). For example, Pippa (ward manager) reveals that through the group process she develops self-awareness relating to her style of management. Pippa's view of her organisational learning supports Roth's (1989) contention that through observation she learns specific behaviours relating to the management of a ward area. Through the group process, Pippa gains awareness of her strengths and weaknesses in relation to her organisational skills, as well as realising that she needs to change those that are based on the autocratic style of management, she learnt through observation. Orton's (1981), Fretwell's (1982), Ogier's and Smith's (1992) studies contend that the ward sister's/manager's style of management is crucial, because it is his/her ability to create good social relations among nursing staff that helps develop a ward atmosphere that is conducive to learning and nursing care that encompasses holistic patient care.

Ford and Walsh (1994) argue that this interaction between self and others is important, in order for each group member to recognise their strengths and weaknesses This development of self-awareness is essential to the reflective process, because it is through this raising of consciousness between self and others (Boud et al, 1985) that nurses come to realise that they are oppressed (Freire, 1985). Besides becoming aware that she needs to change some of her autocratic behaviour, Pippa also recognises the difficulties involved in changing one's attitudes and behaviour.

One aspect that Pippa does not reflect on is why she may be having problems in changing her style of management. Burnard (1985) provides an explanation why change in behaviour is problematic, because he argues, that self comprises three domains – thoughts, feelings and behaviours that overlap and that in order to change behaviour involves thinking about feelings that in turn changes behaviour. Burnard (1985) contends that this is a slow process

because the nurse needs to reflect on each of these three domains and recognise that the connection between all three will enable the nurse to gradually peel back the layers to understanding self.

Pippa; I've worked with 2 senior members of staff and one of them was quite lapsical, daisical and didn't really have any management style and the other one was quite autocratic... and certainly because of that style I actually manage a ward directly related to the way my role model was (autocratic)... through the discussions in the reflective practice I know that some of my style is not me but what I've picked up from other people and I know some of it is good and some of it is bad and the bits that are bad I've got to try and drop... and the bits that are good I've got to try and develop... and it is just something you can't do in one day... you're one person and go in next and you're somebody else. I think it's just something that you've got to try and change over a period of time.

In contrast to Pippa, Susan's narrative reveals that she does not reflect on her approach to management. For example, Susan (ward manager) makes the decision to remove a staff nurse's assessment responsibilities concerning a student, without prior discussion with the staff nurse involved. The reason for changing the student's assessor is because the student complained about the staff nurse's perceived threatening behaviour. Susan's action supports Perry's (1993) argument that removing an area of responsibility is an example of an autocratic management style that serves the interest of the person in power.

Another issue that Susan does not reflect on is her misconception about the supervision of students on a clinical placement. During the time of this study the students were allocated mentors (English National Board, 1987), not assessors, from the registered nurse pool within their allocated clinical area. The mentorship role involves facilitating the student's learning, as well as assessing their practice in a non-threatening way (Smith, 1992). Therefore, Susan's mistaken belief about the facilitative aspect of the mentorship role - in which the student directs her own clinical learning in partnership with her mentor (Smith, 1992) - equates with the notion that when changes are determined by those at the top of the hierarchy, then innovations like mentorship, the nursing process, primary nursing and nurse led units are misunderstood (discussed in section 6.2).

Susan; I wonder sometimes how much she aggravates the situation because of her attitude. I mean I've never spent a lot of time talking to her... I'd taken a student off her recently that had come to the ward and this was when I had given her the emergency annual leave and she

said to me why exactly had I done that... when she came back I told her that because she had been away I'd given the other student to one of the other staff nurses because I didn't know how long she was going to be away... she accepted that (the explanation why I'd re-allocated a student to another staff nurse) last time but this time she asked exactly why... because this time the student was very unhappy with her as an assessor... she found her (the staff nurse) quite intimidating.

Reflection concerns change, therefore nurses require knowledge of the change process, in order to critically evaluate how to make changes with regard to patient care (Ford & Walsh, 1994). Although Judy discloses that she has developed skills (like reading, setting up a working group and devising an education pack) however, she does not reflect on whether the way she is attempting to implement change will be effective.

Judy; At the moment I'm changing the breast feeding policy at work... I have felt for years that women don't get enough help... so I've gone about changing that. I did my last essay on it as I really wanted to get all the research bits together in my mind and it (the change) made me read up on it (breast feeding)... now we're actually getting... a working party together... I've gone to different people that will be involved in the funding people that are interested in getting a ... working party... together... and doing out a plan... we've got a workshop going and an ongoing educational system... it's got to be something that's ongoing and involves all grades of staff including health support workers at the hospital... I wouldn't have done that before because I wouldn't have had the ability to read the research up on it. I would have just been grabbing bits out of magazines. I wouldn't have been able to condense all the different areas into a teaching package.

The way in which Judy tries to change the breast-feeding policy represents the top down approach. This is because she has included managers (they are the fund holders) in her working party that will organise a plan of action. Peters and Waterman (1986) argue that working groups, seminars and workshops etcetera represent a hierarchical method that suppresses creative ideas. Judy states that she is involving all grades of staff, yet she does not appear to be reflecting on whether she should consult the mothers' view of breast-feeding. However, confirmation that Judy is using the top-down approach to change is due to her view that she is devising a new breast-feeding policy. A policy is a course of action proposed by an individual or a group of individuals (The Oxford English Reference Dictionary, 1995). Judy does not reflect on the notion that her approach to change represents one characteristic of her oppressed status - in that she has been socialised into carrying out care based on rules, protocols and policies. This leads to her in conjunction with others changing a breast-feeding

policy that may become, as argued by Ford and Walsh (1994), a future, rigid inflexible structure that fails to recognise the individual breast feeding needs of the mother.

Judy does not reflect on why the bottom up approach (empowering) to change may be preferable to the top down approach. In this study, changes that have a top down approach have been revealed as not effective (see discussion on primary nursing and the nursing process in section 6.2). Judy has credibility because in comparison to management, she is a practising midwife and that may reduce staff uncertainty that aids in the change process (Bennis et al, 1984). However, Ford and Walsh (1994) argue that nurses need to feel the change agent knows what he/she is doing because that instils confidence. The change agent should discuss the ideas fully, in order to enable each individual nurse to explore where the change might lead and how they as individuals may be affected (Ford & Walsh, 1994). On the other hand, Bennis et al (1984) contend that if change is to be effective, power needs to be shared, so that each nurse is able to participate in the decision making process. Thus, according to Bennis et al, the nurses who are going to implement the change own the change. Besides sharing the decision-making process, Peters and Waterman (1986) contend that in order for change to be effective requires change to occur incrementally. Once the individual sees that small problems are capable of being solved by individuals who comprise differing ranks and statuses hence, this fosters a positive attitude and leads to a belief that larger problems may be solved effectively (Peters & Waterman, 1986).

Besides the students requiring knowledge of the differing change theories Gemma, reveals another important feature required, in order to learn through reflection on practice. Gemma states that she has a

Better feeling of self worth as a nurse... and I've become more confident and a little bit more outspoken

Gemma's revelation that she has gained self worth, as a nurse, supports Taylor's (2000) contention that nurses need to value themselves. Taylor argues that part of the nurses struggle to value themselves as practitioners is due to them not realising the power they have to make a positive differences to peoples lives (see Theresa, Paula and Abigail's stories in section

6.2). However, Taylor contends that when nurses value themselves as practitioners, they begin to realise that they can make important differences to other peoples lives. Thus, developing self worth subsequently, leads to nurses recognising the need to reflect on practice, because then they begin to appreciate its value to humanity (Taylor, 2000).

The students' original experience of education, besides their socialisation into a subordinate position in the health care system appears to have influenced their learning through participation in the reflective practice groups and the diploma course. However, the students do not reflect on how the historical development of nurse education may have affected their learning.

7.3 The Development of Nurse Education

When nurse education was set up by Nightingale in the 19th century, the aim was for social respectability. In attaining this objective nurse education reflected the prevailing attitudes prevalent in Victorian society (discussed in section 5.3). Nurse training emphasised practice-based knowledge and it was doctors, rather than nurses, who decreed the type of subjects to be taught (Jolley, 1995). As a consequence nurses internalised the doctors medical model of care that has been revealed within this study (see sections 5.1 and 6.2)

This apprenticeship system of training was to continue throughout the inception and development of the NHS, because the negotiations which preceded the 1949 Act illustrate how the organisational bodies representing the nursing profession completely bungled the advantageous position that nurse education was placed in by Bevan who recognised the need to establish an improved system of training for nurses (White, 1985). The recommendations suggested by the Wood report in 1947 (White, 1985), set out a scheme similar to the system of training doctors, with independent colleges setting their own curriculum and examinations, subject to the syllabus and standards prescribed by the newly constituted GNC (General Nursing Council). Unfortunately both the GNC and the RCN (Royal College of Nursing) vehemently opposed the proposals and so the policy was rejected.

White (1985) identifies several reasons for the dismissal of these propositions. Firstly, the agendas of both nursing bodies differed from those set out in the policy. For example, the GNC's main concern was for a minimum level of educational qualification to be established and for the nurses to develop bedside skills, not technical skills, whilst the RCN wished to preserve the image of a *dedicated, amenable gentlewoman* (White, 1985; p35). Secondly, there was considerable cross membership between the RCN and the GNC and neither appeared to understand the far-reaching advantages implied by the plans. Thirdly, the GNC wished to remain in control of nurse training budgets and did not want to provoke the hospital authorities through whom they worked. The authorities were mainly interested in the provision of cheap labour, not professional advancement, and opposed the plans. Similarly, because the RCN council members consisted of matrons, so they were afraid of losing their student nurses who were the mainstay of the labour force. The result was that when the Nurses Act was eventually passed in 1949, it perpetuated the apprenticeship system of training that was informed by medical knowledge and the subservience of nurse training to service needs (White, 1985).

This proposed training plan, as well as a policy enforced by the government - which stated that no educational qualifications were needed for entry to nurse training - were to have adverse effects on the profession for several decades. The implementation of these two proposals generated for many years *anti-education* (White, 1985; p117) sentiments and nurse training focused on the belief that nursing is essentially practical. Also, the nursing student was a student in name only - his/her life was hard in comparison to the student at college or university (Salvage, 1985). The student nurse had to study after a hard day working in a physically and mentally tiring job, was poorly paid, lacked status and did not receive close supervision by experts whilst undertaking his/her duties (Salvage, 1985). Thus, it can be determined that

In essence the past still held a powerful and pervasive influence over nurse education; tradition, ritual and unquestioning obedience tied nurse education to a previous era. (O'Brien and Watson, 1993; p5)

The other key problems associated with this type of education were that the curriculum emphasised medical topics such as anatomy and physiology, medical and surgical nursing (discussed in section 7.1.1) (Myles, 1995) and psychomotor skills. Practice issues were taught as procedures (see Judy's story in section 7.2) and there was very little integration of subject matter with clinical practice (Myles, 1995). Another difficulty related to the fact that because nurse training was an apprenticeship system, so most of the learning was expected to be achieved whilst working in the clinical area (O'Brien & Watson, 1993), with only short periods of time allocated for teaching/learning in the school of nursing. A third problem related to the learning in the clinical areas. The students were part of the workforce and because of this, their educational needs were often sacrificed for the exigencies of the service (Myles, 1995). Often, students would repeat clinical experiences, in order to fulfil the workforce planning objectives. Furthermore, there was inadequate supervision of the student nurses in their placement areas and often, this was exacerbated, because the students were counted as part of the workforce (Myles, 1995).

However, O'Brien and Watson (1993) purport that during the 1960's and 1970's it was possible to detect changes that were to be the forerunners of the radical developments in nurse education that occurred during the 1990's. For example, in America, there was a change in the educational preparation of nurses, from diploma to baccalaureate level (Meleis, 1985). This latter innovation provided the impetus for the development of nursing knowledge. The reason was that questions arose concerning the type of knowledge that should be included in the curriculum as to what nurses needed to learn, in order to effectively function as nurses (Meleis, 1985). Walsh and Ford (1989) argue that the catalyst for this quest relating to what constituted nursing knowledge did not occur only, as a result of the movement of nurse education into Higher Education, but was also due to the women's movement challenge to women's subordination in nursing as elsewhere and consumer demand of the nurse/patient relationship. On the other hand, Maslin-Prothero and Masterton (1999) believe that this latter search for a distinct nursing knowledge base was due to a drive for professionalisation in nursing.

As well as these changes taking place in America, it was possible during the 1960's and 1970's to detect changes within nurse education in the United Kingdom. However, it was not until 1974 that Manchester University set up the first Nursing Department in England which paved the way for degree courses in nursing (White, 1985). From these tentative beginnings the move for educational reform gathered momentum. The establishment of the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC) and the four national Boards in 1979 quickened the pace of change (O'Brien & Watson, 1993). In 1984 the UKCC created Project 2000 and in 1989 thirteen demonstration districts implemented P2000 and in that same year the National Foundation for Educational Research was commissioned to carry out an independent evaluation of the initial implementation (Myles, 1995).

Besides the increasing implementation of P2000 throughout the United Kingdom, the 1990's also saw a movement of nurse education establishments into Higher Education Institutes. The reason can be attributed to the fact that nursing qualifications generally had no academic recognition, because the training focused on the belief that nursing is essentially practical and as a result, nursing knowledge has no substantive base (White, 1985; Myles, 1985). The following extracts support this aspect.

Abigail; I think that the reflective practice brings that out really that aspect of looking at people's psychological and emotional aspects... I found it brought back quite a lot of my nursing background... I thought I was doing such a good job and now I think gosh those poor people I was looking after the psychological care... I'm sure I looked after them physically ok but you know I totally neglected their psychological needs... I've improved my research knowledge.

Theresa; Most of my nursing is a problem solving approach and very often it encroaches on the medical model but now I look a bit more into health beliefs and health behaviours and people's health attitudes as well.

Carol; I've gained research based skills... I've gained knowledge really ... ethical... module made me think we should be doing this, we shouldn't be doing this.

In addition, the movement of nurse education into higher education meant that the status of the nursing student would change (O'Brien & Watson, 1993). The student nurse, in comparison to his/her counterpart in the college/university was a student in name only and had to study after a hard day working in a physically and mentally tiring job (Salvage, 1985). Thus, in order to achieve academic recognition, the P2000 courses needed to be validated by higher educational institutions. Besides ensuring a raise in nursing student status and securing a substantive base for nursing actions, there are other reasons for these radical changes within nurse education. Walby et al (1994) believe that the introduction of P2000, as well as primary nursing and the changes in the UKCC code of practice were all attempts at a renewed strategy of professionalisation.

Another justification was that nurse education needed to be conscious of the changing demographic changes in the population, such as the growing percentage of elderly. Nurse education required an awareness of the extent of chronic illness in contemporary society, as well as an understanding that nursing entailed a more health-orientated perspective (O'Brien & Watson, 1993). In order to encompass these latter aspects, it was vital that nurses become knowledgeable doers, so that they know how to learn, are proficient in study skills and can keep pace with new developments in health care (O'Brien & Watson, 1993). Furthermore, the student who successfully completes a P 2000 course attains diplomate status as well as a professional nursing qualification and, according to Myles (1993), should be able to transfer knowledge and skills to a range of healthcare situations, assess client need and deliver individualized care based on appropriate research, if available, manage change effectively, be committed to their own professional development and be a reflective practitioner.

Despite the implementation of these changes, however, it must be remembered that the vast majority of students (including the students in this study) were still largely trained in monotechnic, bureaucratic (Walsh & Ford, 1989) schools of nursing and remained employees of the Health Authorities. Therefore, the tensions between educational and service demands remained as acute as ever (O'Brien & Watson, 1993). One of the difficulties relates to the idea that because the schools of nursing are bureaucratic institutions, so they have strong patterns of authority, with a clear hierarchy from clinical teachers and tutors up through

senior tutors, to director of nurse education level (Johnson, 1986).

The problems inherent in this system are that students are not given the freedom to be responsible for their own learning (Davis, 1993). Furthermore, the people in positions of authority (tutors) do not like being challenged, so if the student does not conform quickly he/she will find him/herself the subject of disciplinary action (Walsh & Ford, 1989). In addition, failing an exam can invoke a disciplinary procedure. Thus, Walsh and Ford propose that if students learn their nursing in this authoritarian atmosphere, it is difficult to see how they will become the thinking and questioning professional nurses of the future.

Summary

Many of the students reveal misconceptions about the meaning of reflective practice, like viewing the purpose of reflective practice as discussing a situation/event that has either gone/not gone well, or a retrospective act in which errors/situations have/have not gone well. In addition, some students equate reflection with sharing ideas, or as a buzzword, or a known concept, whilst Janet (see section 7.1.1) appears to be the only student who perceives reflective learning as a continual spiral. Janet's idea matches Lumby's (1998) notion, that in order for the students to become aware of the power relationships within the health care system, the students need to progress through several complicated stages that represent the reflective process.

The students are unaware that the reason for these misconceptions appears to be due to the idea that not only are the students socialised into a position that lacks power through the domination of doctors as well as the 'new wave' managers (discussed in section 6.3), but the students' prior experience of nurse education also, socialised the students into acquired deference to authority figures (see Jessica, Becky, Lisa, Carol, Betty and Kay's remarks in section 7.1.1), in which students obeyed orders without questioning the reasons why. Thus, the students learn to base their knowledge on the scientific model of care (see Theresa's and Gemma's accounts in section 7.1.1) in which they are taught that there is a correct and a wrong way of carrying out nursing procedures.

The result of this socialisation into their subordinate position means that some of the students find the self directing property of the group process - in which each student was given the autonomy to decide what aspects of their clinical experience they would divulge to the group - difficult to cope with. For example, some of the students, like Pat, Sophie, Lucy, Jessica and Kara (see section 7.1.4) found it difficult at first to initiate direct and open up group sessions whilst, other students like Lisa, Gemma, Zara and Judy (see section 7.1.4) tended not to fully participate because they were afraid of confidentiality being breached, or of being criticised, or of being judged. However, once students became confident that they would not be judged and that confidentiality would not be breached, group interaction increased (see Janet, Becky, Dawn, Pippa and Judy's remarks in section 7.1.4).

A further consequence of the students' oppressed status reveals that the students do not recognise that they learn to base their knowledge in the main on the medical model of care as well as basing their knowledge on prejudices, attitudes and beliefs that have no sound academic basis (discussed in section 7.2). Thus, some of the students had not attained the specific skills that are required for reflection at the critical level, like self-awareness and self directed skills, as well as critical thinking ability (discussed section 3.2.3). However, the students reveal that their learning encompasses features, like gaining questioning skills, as well as beginning to realise the uncertainty involved when making decisions (Claudia see section 7.2). Some of the students disclose that they develop skills in reading and the research process, besides becoming aware that many issues are contentious and that not everything they are told is true. Also, some students reveal that they need to change their attitude towards students (Dawn see section 7.2), whilst others develop self-awareness (Pippa see section 7.2).

By comparison, it appears that some students fail to question rules relating to drug administration (Claudia see section 7.2), or are unaware of their autocratic style of management (Susan see section 7.2). Judy also appears unaware that the way, in which she approaches the change to the breast-feeding policy, tends to match the dominant group methods utilised by NHS managers and doctors. For example, Judy uses the top down technique that is similar to the way in which the nursing innovations discussed in section 6.2

were introduced. Thus, it is possible that Judy's change is not likely to achieve its aim and neither does it consider the individualistic needs of the maternity patients.

Conclusion

The starting point for this investigation into reflective practice in nurse education was the realisation that reflection is both topical within the nursing and educational arenas. However, there remains a great deal to understand about why many students do not reflect at the critical level, because it is at this stage that nurses are able to identify the power relationships within their clinical settings that constrain them and their practice. Reflecting at this level, would enable nurses to analyse and challenge existing dominating forces, in order to create transformative action, that empowers nurses to bring about changes, that free them from their oppressed status (Taylor, 2000).

Although the literature on reflective practice attempts to explore the differing types of knowledge that is gained through the process of reflection, there appears to be some confusion about the levels and meanings ascribed to reflection. For example, Schon's (1983) framework encompasses all levels and stresses practitioner knowledge gained through clinical experience, in which the practitioner makes sense of the unique and uncertain situations, through the framing and reframing process. In comparison, Boud et al's (1985) model comprises three levels that depict the differing skills and cognitive processes involved in reflection. On the other hand, Johns's (1998) paradigm enables the student to develop an understanding of the meaning of reflection, by actually allowing the student to live through the reflective experience. In this way the practitioner may come to understand how the personal, ethical and empirical ways of knowing in practice inform the aesthetic response. The critical theory (Zeichner & Liston, 1987; Taylor, 2000) framework comprises three differing knowledge bases, but it is at the critical level that transformative action occurs, because reflecting at this level raises the nurse's consciousness of the oppressive forces that restrict practice.

Besides an exploration of the differing meanings of reflection, the research pertaining to the group process as a method for fostering reflection on practice was also examined. The main points to emerge are that the authors often assume that the students are reflecting and yet, they inadequately theorise at which stage of the reflective cycle the students were reflecting

at, or if they were aware of the power relationships and how these affected their practice (Goodman, 1984; Richert, 1990; Lyte & Thomson, 1990; Fish et al, 1991; Wade, 1994; Franks et al, 1994; Brommeyers, 1994; Sebren, 1995; Shields, 1995; Durgabee, 1996). There appears to be little evidence of students reflecting beyond the descriptive, recalling situations and feelings level. In addition, there seems to be a dearth of research examining if the group technique fosters reflection and the aspects that may hinder/facilitate group reflection.

Thus, as a result of the literature review, it was decided to use an ethnographic approach to examine at what level the students were reflecting at, besides exploring reasons for the students' reflecting/not reflecting at the critical level and whether the group process facilitated/hindered the reflective process. To analyse the students' narratives I used a reflexive approach, in which I continually questioned the nature and assumptions of the knowledge being produced (Edwards & Ribbens, 1998). In addition, I used the literature to constantly compare and contrast my interpretation of the emerging themes eg *difference in episteme, cure versus care, socialisation, paternalism, labelling, hierarchy, autonomy and power* with other findings to find similarities and differences.

The findings from the study reveal that the students provide many learning opportunities, because they uncover what Schon (1983; 1987; 1991) contends are clinical situations of uncertainty, instability, uniqueness and value conflict (see Becky, Zara, Kara, Lisa, Pat Janet, Lucy, Gemma and Carol's stories in section 5.1, 5.2 and 6.2) that Schon argues the professional is faced with on a daily basis and which are unable to be solved by technical and rational knowledge. Furthermore, the students' accounts show that their disputes with doctors match Walby et al's (1994) findings in that professional boundaries create conflict. For example, Becky's (see section 5.1) details substantiate Walby et al's (1994) proposal that one cause of tension occurs when an important aspect of care that is generally a nursing domain such as pain control can only be implemented through a drug prescription that is a medical responsibility. Lisa and Pat's (see section 5.2) reflections also, reveal arguments over the doctor's judgement, in relation to resuscitation policies, because it is the consultant's responsibility to decide whether to utilise/not utilise intervention techniques. This doctor's domain impinges on the nursing boundary, because not only is it the nurse's responsibility to

inform the doctor if a patient's condition deteriorates, but it is the nurse's duty to initiate resuscitation in the absence of a NFR statement, besides calling out the crash team when a patient arrests (stops breathing). Thus, because the doctors would not prescribe a more potent analgesia, Becky's patient's pain was not adequately controlled, whilst Pat's (see section 5.2) patient underwent CPR, instead of dying with dignity, because the doctors had not decided on a NFR statement. In addition, because the consultant would not listen to Kara's (see section 5.2) assessment of a patient's rectal contents, the patient underwent an unnecessary rectal examination that is quite an undignified process.

Besides disputes with the doctors relating to patients, Sophie's narrative (see section 6.1) reveals a contentious issue that concerns the nurse's role. For example, Sophie discloses the idea, that technical tasks that used to be the domain of junior doctors have been delegated to nurses, without the subsequent increase in nursing staff and this creates problems. Her narrative reveals that some nurses are more than happy to relinquish their caring role, in order to acquire competence in technical procedures (eg. cannulation), whilst others, like Sophie, are not so ready to accept these tasks as part of their caring role, because they encroach on the caring aspect of patient care.

In addition to this conflict, where the nurse's role has changed, to encompass nurses undertaking technical tasks that seem to limit the time that nurses have to devote to patient care, the students reveal further contentious issues that relate to managers. For instance, Sylvia's story (see section 6.2) reveals that because an elderly patient's assessment was based on his physical condition, he was considered well enough to be discharged to a rest home, despite Sylvia, as well as the other nurses, voicing their concerns to management that the patient was grieving. In addition, it appears that no one had re-assessed whether this patient's discharge to a rest home was a suitable decision, because his wife had died unexpectedly whilst he was in hospital. Thus, it seems that the way in which this patient was discharged equates with Perry's (1993) argument that currently patients are processed through the health care system as quickly as possible because of the costs.

However, the students appear not to recognise why these technical tasks have been subcontracted by the doctors to the nurses yet, remain under the control of the doctors because it is the doctor who decides which patient is to be cannulated. Furthermore, the students appear unaware of the reasons why the doctors do not listen to the nurses' assessment of a patient's pain/condition. The reason for the students' failure to recognise the unequal power relationship between the doctor/manager and nurse may be due to the notion that many of the students are reflecting at the technical level, that does not examine the power relationships between doctors/managers and nurses (Taylor, 2000). This is supported by Zara's (in section 5.1.2) and Lucy's (in section 6.2) narratives, that reveal that they required visible signs that a patient was in pain, whilst Gemma (in section 6.2) bases the assessment of her patient's recovery from a gynaecological operation on concrete evidence, like the removal of the catheter, that implied that the patient was passing urine satisfactorily.

The consequence of reflecting at the technical level means that nurses tend to label patients in medical, or behavioural terms (Walsh & Ford, 1989; Carpenter, 1993; Ford & Walsh, 1994). For example, because Gemma (see section 6.2) and the nurses on the gynaecological unit labelled the patient's behaviour as *unstable*, the patient's operation was cancelled. In addition, Zara's (see section 5.1.2) narrative reveals that she, as well as the nurses on the orthopaedic unit, based their assessment of the patient's pain on the label *drug addict* and as a consequence, the patient's level and intensity of pain was misconstrued. Lucy (see section 6.2), however, labelled her patient's pain as *just a mental thing* and due to *anxiety*, with the result that the patient's apprehension about his wife's impending death was not addressed. Therefore, it seems that these students' reflections on practice, support Schon's (1983) contention, that knowledge based on the technical rational approach does not always meet the individual health care needs of the patient.

On the other hand, some of the students' reflective ability appears to support Schon's (1983) contention, that their knowing-in-action is a question of knowing more than they can say. For example, Becky (see section 5.1) reveals that she was unable to explain why she thought the patient's pain was due to cardiac involvement, whilst Lisa (see section 5.2) knew her patient was dying, but could not explain why. In addition, Sylvia (see section 6.2) and Freda (see

section 6.2) were aware that their patients were grieving. However, similarly to Becky and Lisa, Freda and Sylvia were able to say why they thought their patients were grieving (eg Freda's patient's grief was due to the loss of a toe, whilst Sylvia's patient's grief was possibly due to the bereavement of his wife as well as the loss of his home) yet, neither Freda nor Sylvia were able to adequately clarify how they knew their patients were grieving. Schon (1983) refers to this knowledge that practitioners have, which they are unable to adequately articulate, as tacit knowledge. Furthermore, Schon (1983) argues, that because the practitioner like Becky is unable to explain why the patient's pain is cardiac in origin, hence, this tacit knowledge is displayed through action. The action Becky took was to request more potent analgesia for her patient, whilst Lisa asked the doctor to visit her patient and Sylvia requested that her patient's discharge be deferred until after his wife's funeral. Freda, on the other hand informed her patient that it was acceptable to release his grief, because his emotional response to an amputated toe was a normal reaction to illness.

However, not all the students reflect at the tacit and technical levels. For example, Janet's narrative (see section 5.4) reveals that she is possibly reflecting at the critical level, because she is consciously aware of the unequal power relationship between the doctor and nurse. Janet recognises, that because the consultant has explicitly implied that his knowledge is superior to nursing knowledge, this restricts the type of information that Janet may provide the mother with regard to her impending induction procedure. Janet's decision not to fully inform the mother of the risks of an early induction, in a mother who had a caesarian section for the birth of her first baby, is based on moral criteria. In addition, because Janet weighs up the advantages/disadvantages of the harm/help that this information may have on the mother's emotional state, this equates with the critical level of reflection (Hatton & Smith, 1995). However, it appears that although Janet is aware that the doctor's dominant position restricts her practice, yet, Janet like some of the other students within this study (eg Becky, Lisa, Pat, Carol, Kara and Sylvia) appears unaware of why she was unable to influence the consultant's/doctor's/manager's decision. Furthermore, Janet fails to explore, why she views being honest with the patient as a risk that may result in her being disciplined, besides failing to recognise that by keeping silent, she is internalising her own subordination (Freire, 1985; Ford & Walsh, 1994; Harden, 1996).

One explanation for the doctor's power is that because the doctor's knowledge base is grounded in positivism hence, it is perceived as superior to the nurse's caring knowledge base (Perry, 1993; Mackay, 1993; 1995; discussed in section 5.1.3). Medical knowledge and techniques is the product of particular social, economic and political forces that were created during the industrial revolution in the 19th century (discussed in section 5.4). As science took over from religion as the main way of understanding the world, medicine became a powerful and political social force, because its claim to objectivity and factual knowledge contributed to a justification of the sexual division of labour (Hagell, 1989; Pratten, 1990; Kendrick, 1995).

Medicine played an important part in upholding Victorian values, in that women represented motherhood, whilst men were perceived as the economic provider. This gender division resulted in men being seen as the head of the household, whilst women became subservient to men. Therefore, nursing care is viewed conveniently, as an extension of the housewife/mother role, with the result that the value of the nurse's role in health care is inextricably linked to the low value of caring in the market place (Smith, 1990; Perry, 1993; Mackay, 1993; 1995; Kendrick, 1995; Hardey, 1998). Thus, because nursing care is viewed as subordinate to medical cure, nurses tend to accept the authority of the doctor (Walsh & Ford, 1989; Mackay, 1995). Furthermore, because women are viewed as an oppressed group, within a male dominated society (Ehrenreich & English, 1979; Oakley, 1979; Stacey, 1988), hence, the characteristics embodied within the oppressed status may be applied to nurses, because doctors who are predominantly male and have greater prestige, power and status control the way in which nurses practice their care (Freire, 1970; 1985).

The result of this socially and politically gendered division of labour is that doctors, especially consultants, gained power and autonomy, that meant that the decisions about patient treatment were solely in the hands of the consultants (Klein, 1984; Walby et al, 1994; Annandale, 1998; Hardey, 1998). Thus, the consultant has considerable clinical freedom - that is a cherished medical principle - in his/her decision pertaining to how a patient is treated - because the doctor is ultimately responsible for the admission, discharge and

treatment of the patient (Porter, 1991; Walby et al, 1994; Sweet & Norman, 1995). The consequence of the doctor's power is that the nurse – no matter how experienced or how senior her position in the nursing hierarchy is – he/she is powerless with regard to treatment and diagnosis, as the nurse has to summon the doctor for treatment to be initiated (see Becky, Lisa, Pat, and Carol's stories in sections 5.1, 5.2 and 5.3). The reason is because it is the doctor, not the nurse, who has the legal responsibility for the patient (Mackay, 1993; Walby et al, 1994; Kendrick, 1995).

A further result of this medical power is that nurses tend to adopt the culture of the doctors, because they are the dominant group and this reflects the nurses' oppressed status. For example, Sophie's story (see section 6.2) reveals that many nurses absorb the doctors' values, because they perceive carrying out technical tasks as more important than executing basic nursing care tasks, like changing an incontinent patient's bed clothes. Other students in this study show that nurses appear to have adopted the doctor's dominant, positivistic, knowledge paradigm (see Zara, Gemma, Holly, Sylvia and Lucy's narratives in sections 5.1.2 and 6.2), with the consequence that they assess the patients, according to a label and thus, the individual health care needs of the patients are not addressed.

However, there are some students who do not subscribe to this positivist perspective and in comparison, show that they practice an individualistic approach to care, as well as considering the emotional needs of patients (see Theresa, Freda and Abigail's narratives in sections 5.4 and 6.2) For example, Paula and Janet's narratives (see section 6.2 and 7.2), not only reveal that the emotional needs of the mother and her partner were considered, but the mothers were given the choice of where to have their babies delivered. Estelle (see section 6.2) also, discloses her attempts to provide humanistic individualised care, despite the rules and regulations, devised by management, that do not encourage an individualised approach to care.

Besides these students revealing a humanistic and individualised approach to care, other students disclose their preference for being with the patient (discussed in section 6.2), rather than carrying out technical tasks, yet none of the students explore why care is not recognised

as a valued contribution to the well being of the patient. They are unaware that the reason may be attributed to the notion that nursing care is viewed as inferior to medical cure, because care is seen as a natural extension of the female role, with the consequence that caring is viewed as invisible and insignificant (Smith, 1990; Gaze, 1991; Perry, 1993; Reed & Proctor, 1993). In addition, the students fail to recognise that a further consequence of the nurse's oppressed status leads to routine and ritualistic practice, in which answering the phone (Lucy's story in section 6.2) and carrying out a ward round (Becky's story section 6.2), are seen as more important than discussing a patient's pain, or finding out how a patient feels about his wife's impending death from cancer. However, the students fail to recognise that through carrying out these tasks, they are internalising their own subordination (Freire, 1985; Ford & Walsh, 1994; Harden, 1996). For instance, the students do not realise that gaining expertise in reading ECGs (see Becky's story in section 5.1) is only powerful in providing communication with the doctors, because they deem this technical knowledge as meaningful (Henderson, 1994; Snelgrove & Hughes, 2000). The students are unaware that this technical knowledge does not subscribe to patient-centred care, in which the nurse gains autonomy, as well as achieving the development of new practice based knowledge, based on the humanistic and existentialist aspects, that is fundamentally different to the doctor's scientific base (Binnie & Titchen, 1999; Titchen, 2000).

Thus, the question that remains is why these students do not recognise how this unequal power relationship is perpetuated? The doctor's scientific dominant paradigm is continued, because doctors enter medical school, as they are good at science. Furthermore, during their training, they are socialised to perceive themselves as scientists with a clear clinical mandate to use these skills to diagnose, treat and cure disease, as success is measured in terms of curing the patient (Adshead & Dickenson, 1993; Mackay, 1993; Lupton, 1994; Kendrick, 1995; Snelgrove & Hughes, 2000). In addition, medical students are socialised into valuing their knowledge above nursing knowledge, because they undertake a 5-year university education, whilst all the nurses in this study have undergone a 3-year practical training (Mackay, 1993). Also, medical students are socialised into the perception, that nurses are there to help the doctor, as well as being socialised into the belief, that knowledge based on the scientific model is of more value than knowledge based on ethical aspects, or

interpersonal skills (Nuland, 1993; Elston, 1993).

The result of the doctor's belief that they are superior to nurses, is that some doctors attempt to socialise the nurses into complying with their decisions, by shouting at the nurse (see Carol's story in section 5.3), by being disagreeable (see Kara's story in section 5.3), or by being paternalistic - I know best because I am the expert (see Janet's story in section 5.4) because my knowledge is superior to nursing knowledge - (Perry, 1993; Mackay, 1993; 1995; Witz, 1994). In addition, it appears that not listening to the nurse's assessment of a patient's pain/condition (Becky's and Lisa's stories in section 5.1 and 5.2), as well as attempting to ignore the nurse's request to visit a patient (Pat's narrative in section 5.2), are other methods used by doctors, to ensure that nurses do not question their decisions. Management also, attempts to socialise nurses into carrying out work that will achieve management's objectives, by using hidden techniques eg. expecting nurses to carry out orders without knowing the reasons why (Estelle's narrative section 6.2), or providing information on a need to know basis (Gemma's and Judy's stories section 6.2), as well as taking away an area of responsibility (Susan's narrative section 7.2).

Besides doctors and managers socialising nurses into their subservient position, nurse education also, represents a powerful vehicle for the socialisation of nurses into their oppressed status, because they learn to know their place in the nursing hierarchy (Melia, 1990; Smith, 1990; Perry, 1993). Through techniques like injustice, bullying (Binnie & Titchen, 1999; see Betty's remarks section 7.1.1) and humiliating methods such as laughing at a junior nurse's mistakes (see Kay's story section 7.1), students are socialised into their subservient position within the health care system (Perry, 1993). In addition, these methods ensure that students are socialised into performing tasks correctly and efficiently, as well as learning to conform and obey orders, in order to survive (Clarke et al, 1994; Ford & Walsh, 1994). Also, because of the hierarchy (discussed in sections 5.3 and 7.3) within traditional nurse education, students are not encouraged to challenge the tutor's ideas and as a consequence, the student is socialised into his/her subordinate position, besides failing to attain the skills required for self-directed learning (Davis, 1993; Perry, 1993).

Thus, the result of the students' oppressed status reveals that many students learn to base their knowledge, in the main, on the medical model of care, as well as basing their knowledge on prejudices, attitudes and beliefs that have no sound academic basis (Roth, 1989; Ford & Walsh, 1994). Furthermore, many do not possess the specific skills that are required for reflection at the critical level, like self-awareness and self directed skills as well as critical thinking ability (Stephenson, 1985; Boud et al, 1985; Brookfield, 1987; Pollard & Tann, 1993). Despite the provision of an empowering (Mullender Ward, 1991; Burnard, 1985; Boud et al, 1985) setting, many of the students had difficulty in participating in the group discussions. This is because many believed that the group process did not provide a suitable vehicle, where they could divulge clinical dilemmas, without the fear of being judged (Krieger, 1991; quoted in Ford & Walsh, 1994; p31), besides not being able to trust that whatever issues were divulged would remain confidential (Douglas, 1993).

Besides not developing the necessary skills for reflection, another consequence of oppression is that nurses adopt the culture of the elite yet, do not have their power (Freire, 1970; 1985). This feature is supported by the students' narratives, because nurses, unlike doctors, do not have autonomy in relation to pain control (Becky's story in section 5.1), or resuscitation procedures (Pat's story in section 5.2) and appear unable to intervene when a patient's condition deteriorates (Lisa and Carol's narratives in sections 5.2 and 5.3), or to risk telling the patient the truth about the risks of an induction procedure (Janet's story in section 5.4). In addition, nurses do not have the authority to decide staffing levels in the clinical areas (see Becky and Gemma's stories in section 6.2), or whether they want to increase their workload, by taking on technical tasks (see Sophie and Judy's narratives in section 6.1 and 6.2) and neither do they have the freedom to decide when a patient is to be discharged (Sylvia's story in section 6.2).

Therefore, it seems that nurses are no nearer to gaining greater control in the decision making process despite, government proposals (Working for Patients, 1989a) that staff who are directly caring for patients are to attain more autonomy. Furthermore, it appears that the nursing profession's movement to professionalise nursing (Baxter, 1988; Carpenter, 1993; Annandale, 1998; Hardey, 1998), as well as the efficiency drive by the NHS to reduce costs

(Walby et al, 1994; Hardey, 1998; Annandale, 1998, Denny, 1999) has resulted in the formation of an elite core of nurses who undertake advanced technical tasks, whilst the basic hands on care has been delegated to the lower paid health care support workers (Carpenter, 1993). Also, any move by nurses to gain autonomy, like the development of nurse led units (discussed in section 6.2), has resulted in opposition from some members of the medical profession (Pembrey & Punton, 1990; Witz, 1994; Keen, 1995). What the students in this research fail to recognise is that, according to Foucault, they do have the power to change the status quo (Hennemann, 1995), because Binnie & Titchen's (1999) and Titchen's (2000) studies reveal that when nurses exert power, they gain autonomy to practice patient-centred care and this notion is supported by Estelle's narrative (see section 6.2).

In addition to nurses not having autonomy, some patients are not given the freedom to decide their health care needs, or have their problems addressed. For example, Lisa, Pat and Carol's (see sections 5.2 and 5.3) patients appeared to be denied the choice of whether they wished to be resuscitated/not resuscitated, whilst Gemma's (see section 6.2) patient was not given the autonomy to decide whether her operation should be/not be cancelled, until her mental health status had stabilised. Also, Sylvia's (see section 6.2) patient seemed to be given no choice as to when and where he wished to be discharged to, now that his social circumstances had changed and the nurses appeared unaware that his grieving needs needed to be addressed.

Therefore, it appears that because some nurses have absorbed the paternalistic attitudes of doctors (discussed in section 5.2), they are unable to act as the patient's advocate, in ensuring that patients' rights are promoted. Furthermore, it seems that the equitable, consumer led quality service (discussed in section 6.3) is not a reality for certain categories of patients (eg elderly and mental health) and neither are all the patients' rights and expectations that are embodied within the Patient's Charter (1992; 1995) met.

Thus, it can be concluded that the gender division in society, that was the result of socially constructed division of labour is replicated within the health care system (Stacey, 1988; Riska, 1993). The doctors' dominant culture, that is probably attained through socialisation and is pervasive throughout western societies, ensures the perpetuation of nurses as an

oppressed group (Meleis, 1985; Walsh & Ford, 1989; Gaze, 1991; Perry, 1993; Reed & Proctor, 1993; Jolley, 1995).

Historically, doctors gained power by professionalisation prior to the inception of the NHS and by being central to political decisions, when the NHS was created (Klein, 1984, Annandale, 1998; Maslin-Prothero & Masterton, 1999). Despite efforts to curb medical power during the 1990's, the medical profession responded to this threat to their power and dominance by undergoing restratification, in that some members, like male consultants and GP's gained more control and supremacy at the expense of their female colleagues (Elston, 1994; Annandale, 1998; Hardey, 1998). Similarly, nurses who historically have been in a subordinate position to doctors, restratified by forming an elite core of registered nurses who would undertake technical tasks that used to be the remit of junior doctors, whilst assigning basic nursing tasks to the lower paid health care assistants. This restratification has not enabled nurses to gain more power, or autonomy, because despite professionalisation, they remain subservient to doctors (Baxter, 1988; Carpenter, 1993; Annandale, 1998; Hardey, 1998).

The consequence of this medical power is that many of the students reflect at the technical level, because this embodies the doctors' knowledge base and this internalisation of the doctor's dominant paradigm reflects the nurses' oppressive status (Freire, 1985). However, some of the students appear to be unaware that reflection at the technical level means that they label patients that does not always address, or solve the uncertain and unique clinical situations that the nurse is faced with on a daily basis, as well as failing to meet the individualised health care needs of the patient (Carpenter, 1994; Ford & Walsh, 1994).

On the other hand, when students are reflecting at the tacit and critical level, it appears that the students are unaware that because their practice is limited by medical power, their caring actions are restricted, as they do not have the autonomy to tell the truth to the patient, or to control a patient's pain and neither do they have the freedom to intervene when a patient's condition is deteriorating. Furthermore, this oppressed status results in some of the students not realising that they are unable to self direct their own reflective activity, through the

medium of the group process, because they have not been encouraged to develop confidence, or a questioning attitude, or debating skills, or self awareness ((Stephenson, 1985; Boud et al, 1985; Brookfield, 1987; Pollard & Tann, 1993).

A further consequence of this medical dominance relates to the idea that many of the students are unaware of the value of helping patients to cope with the emotional aspects of health care problems. The students do not seem to recognise that they do have the power to influence the decision making process, because when nurses, according to the Foucauldian perspective (Hennemann, 1995), use their power to implement patient-centred care in which the nursing hierarchy is flattened (Ford & Walsh, 1994), the nurses gain autonomy, as well as developing knowledge based on humanistic and existentialistic aspects, that is fundamentally different from the scientific basis (Binnie & Titchen, 1999; Titchen, 2000). Therefore, because the students are possibly socialised into the acceptance of the power differentials within their clinical areas, they are unable to reflect at the critical level, as their narratives reveal that they do not seem to recognise the power structures within their clinical areas (Taylor, 2000).

Although the results from this study support Hatton and Smith's (1995) findings, that many students reflect at the technical level, with a minority reflecting at the intuitive and critical level, despite undertaking a course that emphasised reflection, yet it is important for nurses to initiate and continue with reflective activities. The reason is because many of the students within this study divulge the notion that through undertaking the course, they are beginning to develop self-awareness and self-directed learning skills (discussed in section 7.2), besides sharing experiences where nursing care contributed to the well being of the patient (Abigail, Paula and Freda's narratives in section 6.2). This is significant, because only by reflecting on the rich and valuable experiences that have been identified within this study, can nurses recognise the value of nursing, as Gemma identifies in section 7.2.

In addition, reflection may enable students to develop further skills and knowledge, in order to progress through the many steps involved in the reflective process, that leads to transformative action, where the nurse's approach to care is based on equity and knowledge,

as well as being flexible and sensitive to the individual client's health care needs (Ford & Walsh, 1994). However, the reflective process needs to be facilitated by someone who possesses the necessary skills and knowledge, in order to foster a challenging, as well as supportive environment (Schon, 1987; Johns, 1998; Binnie & Titchen, 1999).

Lastly, nurse education needs to contribute by encouraging the students to develop flexible enquiring minds, in which they are able to self determine their own learning, in order to approach a situation from differing angles. In addition, research that is written in a readily understandable format and is applicable to nursing practice should be high on the educational agenda. Nursing is a stressful occupation, thus students should learn how to recognise and tackle stressful situations. Students need to be encouraged to investigate how the power relationships that are anchored in class and gender result in the oppression of nurses, through placing the major power theories, as well as the political and historical issues relating to the development of the nursing profession, in a prominent position within the curriculum. The fostering of these features may enable nurses to recognise the oppressive forces within their clinical areas and so facilitate transformative action that leads to effective patient care.

APPENDIX 1

REFLECTIVE PRACTICE GROUP MODULE

Year one and two

Terms one to six

Length 72 hours

Credits nil

Rationale

The purpose of this module is to enable students to relate theory to practice having developed confidence as adult learners. This is achieved by enabling students to obtain support from peers, tutorial staff and practice facilitators or mentors throughout their programme of study so that they can identify their own interests and learning needs, and develop their ideas and intellectual skills in an environment where risks can be taken. The Reflective Practice Group is built into a programme in recognition of the particular learning needs of part-time students on professional courses. It provides some structure and time for students to develop their abilities alongside the contact hours of the Modular Scheme and also gives the students an opportunity to reflect on their own practice and how it might be informed by academic enquiry. It is recognised that not all students are able to achieve insights and reflection in the context of being taught in a large class and it is the intention to divide students into smaller groups of approximately 10 students so that they will be able to engage in discussion and seminar work in the hours allocated to this module.

During the first year of the programme the module is designed to enable students to develop confidence as adult learners and will incorporate opportunities for the student to develop effective learning and enquiry skills, negotiate individual learning contracts, engage in formative work in preparation for assessments and integrate the theoretical components of the whole programme with professional practice. The second year of the programme is designed to offer students the opportunity to participate in ongoing small group work where they can explore practice issues. The students meet for an hour every other week with tutorial staff and are encouraged to reflect on their practice in an atmosphere of mutual trust and support, which leads to constructive challenge.

Learning Outcomes

To enable students to:

1. Develop effective leaning skills.
2. Develop skills in information retrieval and information technology.
3. Develop confidence in the negotiation of individual learning contracts with tutorial staff and facilitators.
4. Critically examine issues of professional and personal development within a small group.
5. Debate ideas in a small group and reflect on their practice.

Module Description

During the first year the module will begin during the induction block with an initial focus on students identifying their individual needs as adult learners as many of them will be unfamiliar with study in a higher education setting and will have different learning styles. Students will be helped to maximise time and effort in managing learning and studying through effective use of learning resources. The module will also help acquaint students with the traditions of learning, teaching and assessment in higher education, so as to enable them to realise the central part they will play in the process of 'mutual enquiry' and learning throughout the course. It is hoped that students will use the module to continue to develop effective learning and enquiry skills throughout the programme by reflecting on their progress and learning styles.

The module will also enable students to meet with tutorial staff in order to develop the skills and confidence needed to successfully negotiate individual learning contracts in each module. This will ensure that the programme content and assessment is relevant to students from a diverse range of clinical backgrounds and that each student is able to integrate theory with their own practice.

In the second year of the programme students meet regularly in small groups of fixed membership with tutorial staff acting as facilitators. The aim of these groups is to enable students to reflect critically on their practice and to consider the extent to which their practice is informed by existing theory. The need for such reflection is driven by the tacit nature of nursing knowledge and the gap between espoused theory and theory in use. The challenge and support offered to the students within the group by peers and tutorial staff should enable students to develop personally and learn from experience. Groups rather than one-to-one encounters are thought to be more powerful in terms of learning from others and offering support and challenge in an atmosphere of trust. The reflection facilitated in groups is based on many familiar models of learning from reflection, which are based on the original work of Schon. Such models develop learning from reflection by encouraging students to revisit experiences by describing them and any associated feelings, evaluating the effects of their actions and considering any future possibilities for further action.

Teaching/Learning Approaches

It is envisaged that learning will be consolidated from all parts of the programme by informal teaching and learning methods, and through the benefits of small groups of approximately 10 students. The membership of the small student groups will be stable throughout the programme so that students are able to develop an atmosphere of mutual trust and respect, creating a forum where seminar work and discussion can be pursued in such a way that student-centred learning takes place.

Assessment.

This module is not assessed but is designed to help students achieve their objectives in all other modules

APPENDIX 2

LETTER OF CONSENT

134 White Dirt Lane,
Catherington,
Waterlooville,
Hants.

PO8 OTW

Dear

I am currently working as a research assistant at the Nursing Studies Department, Chichester University. The project I am involved in relates to an evaluation of the reflective practice groups. In addition, I am undertaking a PhD and my study will be examining the factors that facilitate/do not facilitate reflection. Therefore, I am asking your permission to allow the facilitators to tape record the reflective practice group sessions that, are an integral part of your diploma course and which you will be attending on a fortnightly basis during the second year of your diploma course.

Besides asking you to agree to the tape recording of the reflective practice group discussions, I would like to ask you please to participate in a tape-recorded interview that will last approximately an hour and which will take place at the end of your course. The interview will consist of questions to which there are no right or wrong answers. Whatever answers you provide will be valued. This interview will take place at a mutually convenient time and at a venue of your choice and I will be carrying out the interviews.

Also, I would like to point out that the information you provide will be of value to the project being carried out by lecturers within the Health Studies and Education departments as well as to my PhD study and that all information collected will remain confidential. When the project and my PhD study are completed, all tapes will be destroyed.

If you have any queries you wish me to clarify in relation to this project or my PhD study I am very happy for you to contact me at the following phone number: 0203 92595243.

I would like to thank you for taking time to reply to this letter and do hope that you will agree to participate in this study. Below I have included a consent slip for you to sign.

Yours sincerely

Jannice Snelling

Please sign below;

I agree/do not agree to the facilitator/s tape recording the reflective practice group discussions-----

I agree/do not agree to participate in a tape recorded interview-----

APPENDIX 3

JANET'S NARRATIVE

Extract 1

I had a situation where a patient of mine had a caesarean section with her last baby for foetal distress and apart from the fact that she found the Caesarean exceptionally traumatic because it was done after a long labour plus the baby became distressed but not only that it took her weeks to physically recover. She found that really for the first 6 weeks she could barely walk around and the whole thing was a complete nightmare as far as she was concerned and she was extremely anxious and she was very definite that she did not want to be allowed to go over her dates, which is what happened last time and she didn't want a caesarean. She wanted a normal delivery if it was in any way possible

Extract 2

I promised her that I would make her an appointment for her to see the consultant at 36 weeks where he could talk to her and he would assess the size of the baby in relation to the size of her pelvis and told her that he would probably do an X-ray of the pelvis to see whether or not the pelvis was in fact large enough to have a normal delivery and look at the size of the baby but I said if everything was going well it is highly unlikely he will induce you early because you are more likely to run into problems and this I pointed out to her right at the very beginning when she was 3 months pregnant

Extract 3

At 36 weeks the mother went to see the consultant and

The consultant found the pelvic outlet was slightly small it was on the smaller side of normal margin but he felt that the baby was very much baby and everything should be OK. He wasn't going to give her a decision and he wanted her to come back the following week so she phoned me up and said well he hasn't really told me anything so I said wait until next week and see what he says then because you'll be 37 weeks then and they'll make a decision as to what's going to happen to you but don't be surprised if he said right I'm going to wait for you to go to full term and then I'll see you again. So she said I'm not really happy with that so I said tell him how you feel and get him to give you an answer and I said I'll come and see you afterwards

Extract 4

However, when the mother returned at 37 weeks

What she did was she practically pinned the poor guy to the wall and said that there was no way that she was leaving the room until he'd made a decision about what he was going to do and she told him precisely what she wanted him to do, which was basically to induce her early, and he agreed

Extract 5

She said to me you know they've given me an induction date it's next Monday, which meant that she wouldn't even have been 39 weeks at that stage and I was shocked I was so surprised that he'd actually said that and I said well has he discussed the procedure with you, she said oh yes He said that I'd have prostin and all the rest of it but if the cervix was open enough they would break my waters and we'll go from there and I said have they told you that it is likely to take some time because you're not technically due and what we're trying to do is to make this baby come earlier than it should do and its not a question of just giving you prostin so it could take you several days to get you into labour and there is no guarantee that it would work and she said that I'm not worried about it. I just want this baby out before it gets too big so anyway I talked to her about what the actual induction procedure would involve and all the rest of it the more I thought about it the more I thought she doesn't know that she stands a high risk of ending up with an emergency caesarean, from it.

Extract 6

These worries were based on

A situation before where I had a woman who had had a caesarian section first and then was induced the second time and ended up having a ruptured uterus and the baby died... and although it has to be said that a lot of my feelings were based on my previous experience which was only once but it was once too many as far as I'm concerned.

Extract 7

Janet now found herself in a problematic situation.

I thought now what do I do, ... do I tell her that by demanding to have an early induction she's actually putting herself and the baby at more risk, or do I not say anything and just trust that the obstetrician has actual made a clinical judgement in this case and that's what he's likely to do, or do I go and speak to him, so that's what I did, and I went to go and see him. I go and see him on a regular basis and I took the notes with me and said I'm a bit surprised about the decision that you've made in this particular case... he said to me well... the fact of the matter was that she wasn't going to leave until I'd given her a decision, and I

said yes but do you think that that's the right decision to make, in view of her history and in view of the fact that you are inducing her on top of a scar, so he said we'll wait and see what happens on Monday, and I said how much prostin are you prepared to give this girl, and he said well however much it takes and I said you don't think that you're running the risk of actually causing damage you know, he said if we start to run into problems then we'll deal with it at the time and I said did you tell her that and he hedged it and he said I can't remember but I think we discussed about you know induction ... I said I don't think she realises this and I said do you really think it's fair to allow her to come into this situation not being fully aware of all the facts... so he said I'm sure I must have discussed it with her and all the rest of it. So I pointed out the notes and said that nothing is actually written in here. All you've put is that you are going to induce her on this particular date and that she's to be admitted at such and such a time... but he was adamant that that was what he was going to do.

Extract 8

However as a consequence of the consultant's decision, Janet's dilemma continued

I didn't speak to my colleagues I don't know why I didn't really, I don't know whether it's because someone else might have said to me you've got to go and speak to her about it, and part of me thought god I don't want to do this you know this is just awful... if I'd gone to her and said that then she would have immediately lost confidence in the system and then where does that leave her... one way or another this baby has got to come out you know within the next few weeks, and if you shake the confidence that she's got in the system if you like, and in the establishment as far as the hospital is concerned, then are you actually doing more harm than good, as far as that is concerned

Extract 9

Janet believed that the consultant

Let me down really, I felt he'd let me down I went there, I told her to go and speak to him expecting ... a certain course of action, ... and he didn't do as I had expected him to do, which let's face it consultants very rarely do he gave in.....he actually said to me I would really have preferred to have left it for at least another week until the circumstances altered maybe the cervix was you know more favourable for induction or whatever... and I said why didn't you? He said because she was so insistent, I felt like saying to him, for gods sake why are we here if it's not to protect them against themselves My main concern was ... that she actually knew what she had been requested to agree to and she knew what the options were, she knew what the possible outcomes were

Extract 10

Janet

Felt very isolated in as much as I thought that I'm the one that's got to make the decision here, I can't actually go and ask anybody else, because at the end of the day I've got to wrestle with my own conscience it's I've got to live with myself over this, and I just felt that it was sort of me against him in this particular case as far as the obstetrician was concerned, I mean I'm very lucky that I could actually go to him and talk to him like that and he's not going to slam the door in my face, saying who the hell do you think you are you're just a midwife you're just here to do as you're told, but on the other hand you still feel that you've got to not toe the line exactly, but I felt very much that the medical profession in inverted commas was there held up as being the ones that know, and although I'd questioned his judgement and I'd questioned his decisions who was the one that was going to carry the can at the end of it and it's him, but that wouldn't have made me feel any better if there'd been a problem because I would have felt I was partly responsible by the fact that I hadn't told her in words of one syllable even though I had written in the notes the fact that I was unhappy with the decision and I felt that perhaps this wasn't the right thing to do.

Extract 11

Furthermore, Janet implies that

I would never go and do it behind their (the doctors) back as it were because otherwise you can bet your life if the woman then decides then she's not going to do it, she's going to phone up well the midwife says, you know I mean your head's on the block well and truly then.

Extract 12

Janet remained concerned about the doctor's decision.

I wasn't happy with what he'd decided to do and I wrote in the notes that I'd been to see him and that I was unhappy with the decision and that it concerned me, but at the same time I thought what do I do, do I openly go against him and say to her I don't think you should have this, I think you should wait at least another week before you do anything like this or do I have to stand back and bow to his supposed superior knowledge on this, So anyway I wrote it all in the notes

Extract 13

When the mother was admitted despite Janet having a day off

I went straight into the labour ward to make sure she was alright ... and of course nothing much had happened and she'd had 3 lots of prostin by this time, the tracings were alright and she was getting the odd niggles... the head was still high... but I think she was that far from being sectioned. I think it was only for the fact that one particular registrar said no come on we'll do this but if it doesn't work we'll have to section her.

Extract 14

The outcome of the induction was a satisfactory one for the mother.

She got a vaginal delivery but the baby was 8 pound I mean she could have had quite a big baby, the chances are that if she'd gone over her dates the chances are that she would have had a caesarean definitely I saw my life flooding before me at the same time she was over the moon... she thought it was wonderful apart from the fact that she's got a very sore bottom because she's got a large episiotomies. I mean as far as she's concerned she feels 100% better than she did last time and the world is wonderful but that's not how I saw it... I really struggled with myself about which way to go.

APPENDIX 4

SCHEDULE FOR SEMI STRUCTURED INTERVIEWS

1. What are your general impressions of the whole course?
2. How does the teaching on the diploma course compare with your previous experience of education?
3. Can you describe your experience of participating in the reflective practice groups
4. Did you feel the group needed more structure and/or an agenda?
5. Would you have liked to use a reflective diary?
6. How did you feel about being in a group and the kind of issues, which were discussed?
7. Do you find it difficult to discuss issues in a group situation?
8. Do you think your approach to learning has changed since you first started this course?
9. Has the group made any difference to your ability to apply theory to practice?
10. Have there been any occasions in the group when you have been able to make sense of your practice?
11. Have there been any occasions in the group when you have had your practice validated by your peers> That is did you get feedback that you were doing the right/wrong thing?
12. Do you think you have changed in the last two years?
13. If yes can you give specific examples?
14. Can you think of any specific ways in which you have changed your practices as a result of your experience in the group?
15. Did you ever reflect on an incident in the past as a result of your experience in the group?
16. Can you think of any instances where you saw something in a different light as a result of your experience in the group?
17. How willing are you to try out new things?.
18. What do you think about the way the group was facilitated?
19. What effect did this have on you?

20. Do you think the group needed a facilitator?
21. How safe an environment did you feel the reflective practice group provided so that you could discuss aspects of your work?
22. Did you feel the group provided you with support?
23. Did you ever feel judged by members of your group?
24. Has your participation made any difference to your job satisfaction?
25. Do you think the organisation you work for encourages reflective practice?
26. What do you think the effects of this particular membership was on a] you and s] how the group worked?
27. Has the group made you consider any long-term effects that your original training and subsequent socialisation as a nurse may have had on you?
28. Were there any difficulties with your group?
29. Did you feel that your consent was obtained with regard to the setting up of the groups and your participation in them?
30. Can you know what reflective practice is before you have experienced it?
31. Was it a positive or negative experience on the whole?

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