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EDUCATING THE NURSE PRACTITIONER

An assessment of the pre-registration
preparation of nurses as an educational
experience

by

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The University of Durham
School of Education

1989



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TED FRENCH

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ABSTRACT

Educating the Nurse Practitioner: An Assessment of the Pre-Registration Preparation of Nurses as an Educational Experience

PhD Thesis (1989)

by H.P. French

The aim of this study is to assess the pre-registration preparation of nurses as a means for producing women and men capable of doing new things, not simply repeating what other generations had done. The issues which are examined are:-

- (i) The purposes of nurse education
- (ii) The extant forms of knowledge
- (iii) The nature of teacher/student relationships in the process of learning.

The study was carried out in three stages:-

- (i) Analysis of the literature from 1947 to 1983 by abstracting and utilising grounded theory approaches to identify the essential issues.
- (ii) Opinion survey of student nurses utilising content and structural analysis of the audio-taped recordings of interviews to develop a theory of nurse education in the 1980's.
- (iii) Experimental testing of one operational hypothesis describing the effect of teacher behaviours on the student nurse's clinical decision making.

It is concluded that the pre-registration preparation of nurses is not an educational experience on the grounds that the extant forms of knowledge and the prevalent teacher/student relationships are inconsistent with the production of a critical, reflective and self-reliant practitioner. Because of this, the recommendations of UKCC Project 2000 must be carefully planned and closely monitored if the problems of the theory/practice gap are to be minimised rather than exacerbated.

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CHAPTER 1

INTRODUCTION

The Principle goal of education is to create men capable of doing new things, not simply repeating what other generations have done.

Jean Piaget

1.1 The Origins of the Study

The underlying philosophy embodied in Piaget's quotation not only enthused this author during his early teaching days, it also became the source of considerable concern. The concern was brought about by an apparent dissonance between the sentiments expressed by Piaget and the day to day processes of nurse education. The whole idea of educating nurses to 'do new things and not merely reproduce what others have done' seemed to be at odds with the very traditions of nursing practice and learning.

Some recollections of life as a student and a nurse tutor indicated some of these perplexities. One of the most insignificant concerns was with teaching methods. Tutors who had gone before had taught mainly by lecture method. On occasions a 16 mm film or a slide show was utilised to add colour to the activity of teaching. Other teachers, clinical teachers, were employed to carry out practical demonstration in the practical room

and the nurse tutor was expected to deploy them in this way when drawing up the block timetable. When tutorial staff were in short supply, clinical teachers were also 'allowed' to lecture. Occasionally a group discussion was held generally programmed for a Friday afternoon to bring relief to the end of a busy week. These sessions were intended to break the lecture tedium and often resulted in an informal/unstructured dialogue presented by the tutor in 'sitting room' surroundings. The students did not seem to want to make much of a contribution. Their task seemed to be to listen and take notes. Without a set of notes or handouts a session was not real learning. In the mind of the new tutor this was the way it was done. One could argue that this was the way one was trained so it must be good enough for the new students! In the earliest days of the author's experience, teaching methods were not the problem and in retrospect this lack of insight was very unfortunate. The methods were traditional and pre-ordained and the major skills a tutor had to achieve were associated with public speaking, lecture delivery, timetabling and the use of some equipment such as the 16 mm film projector. What to teach seemed a major preoccupation. For each session the corpus of required knowledge was the main concern. The objectives, sequence of teacher behaviours, questions to students, handouts, audio visual aids and evaluation of immediate learning were all important, but the major consideration was content. Without content one is lost as a lecturer. Somebody may ask a question which one could not answer, and even though it was admirable for the tutor to admit that he/she did not know, it was an insult to one's credibility to do this too often.

Whilst tackling the problems of knowledge presentation, the nurse tutor would be satisfied that his/her existence was entirely justified. That was

until some sobering truths eventually cut through the haze of day to day academia. It soon became evident that the content taught in school was not practised on the ward. Indeed the nurses 'settled' into the 'ward routine' by learning to adapt to nursing work. This was usually with the help of advice from the staff or sister along the lines that "You haven't got time to do things the way you're taught in school, we'll show you the way it's done".

Another feature which emerged as my career progressed as a nurse tutor was that one became more and more concerned with the requirements of the examination. The students became more and more 'state final' conscious as the course progressed. The tutor also became 'state final' conscious and this gave rise to utter frustration when one began to realise that students did not value your teaching if it was not directly justifiable in terms of the final examination. One also heard that 'good' nurses failed their 'finals' and some, who caused feelings of horror in their colleagues, actually survived and passed. In such a climate was the neophyte nurse encouraged to do new things, or was she expected to do things the way they have always been done? Should the latter be the case then obviously pre-registration preparation would not be an education, in terms of Piaget's Dictum.

1.2 The Aims of the Study

The origins of this thesis lay in a suspicion that student nurse practitioners were not learning to contribute to the development of nursing practice. They seemed instead to be trained to maintain a status quo and to be preserving and replicating the past, both good and bad. Considered

in the context of Piaget's dictum it seemed that the pre-registration preparation of nurses was not an educational experience. In addition it was also suspected that this lack of educational experience, in itself, was producing nurse practitioners who were uncritical replicators of traditional nursing practice. Many contemporary nursing correspondents had debated the issue of professionalism (e.g. Pepper 1973, Ferguson 1979, Clinton 1981, Melia 1981). It seemed that the production of uncritical replicators of traditional practice was inconsistent with the professional model of nursing.

With this in mind it seemed worthwhile considering how far the pre-registration preparation of nurses was an educational experience and what consequences this may have for nursing in its aspiration to secure professional standing.

A second key issue was that all was not well in the learning setting. The extensive evidence for this can be seen in the volume of discussion on the multiple facets of the theory and practice gap. In those papers cited in Table 1 it was evident that there was a great deal of concern about who should teach, where should student nurses learn, what should they learn and the roles of the students and teachers alike. This thesis examines these issues by:

- (a) isolating factors and analysing which determine an educational experience;
- (b) analysing the previous research in order to generate some preliminary propositions about nursing curricula;

TABLE 1 FACTS OF THE THEORY AND PRACTICE GAP

QUOTED DICHOTOMY	REFERENCE
THEORY & PRACTICE	Abdel-al 1975 Hyatt 1978 Croo 1980 Ravans 1964 Alexander 1980 Ravans 1964 Lancaster 1972 Dodd 1973 Graaves 1982 Lanond 1974 House 1977 Hanson 1981 McFarlane 1977 Roper 1976 Henzios 1961 S.H.C. 1977 Gott 1982 Clinton 1981
EDUCATION & PRACTICE	Abdel-al 1975 Kergin 1980
EDUCATION & SERVICE	Abdel-al 1975 Dextor & Laidig 1980 Clinton 1981 Bendall 1975 Johnson 1980 Fratwell 1975 Alexander 1980 Lancaster 1972 Pepper 1977
THEORISTS & PRACTITIONERS	Jonas 1983
TEACHERS & PRACTITIONERS	Kergin 1980 Alexander 1982
SCHOOL & HOSPITAL	Abdel-al 1975 Johnson 1980
COLLEGE & HOSPITAL	Lanond 1974 Krador 1974
SCHOOL & VARDS	Bendall 1973 Ravans 1964 (wards & school) Bendall 1975 Hutty 1965 Dodd 1974 Gott 1982 Abdel-al 1975 Briggs 1972 (wards & school) Pepper 1977
COLLEGE & VARDS	Dodd 1973 Lanond 1974
COLLEGE & HOSPITALS	Alexander 1980
SCHOOL & WORK	Krador 1974
SCHOOL & PRACTICE	Blanchard 1983 Krador 1974
TEACHING & PRACTICE	Hunt 1974 Alexander 1980 Bendall 1975 Lancaster 1972 Pepper 1977
TEACHERS & SISTERS	Dodd 1974
LEARNING & CARING	Hyatt 1978
FORMAL & PRACTICAL	Pepper 1977
IDEAL & ACTUAL	Brysson-Uhyto 1981 Blanchard 1983 Dextor & Laidig 1980
IDEAL & REAL	Hyatt 1978 Kergin 1980 Bendall 1975 Pepper 1977 Lanond 1974 Hanson 1981 Fratwell 1982 Alexander 1980
STUDENT & APPRENTICE	Smith 1981 Smith 1971 Lanond 1974 Alexander 1980
STUDENT & WORKER	Hyatt 1978 Lancaster 1972 (student & employee)
LEARNING & WORKING	Fratwell 1982

(c) generating theory regarding the extent to which pre-registration preparation can be seen as an educational experience;

(d) isolating particular consequences of the lack of an educational dimension on clinical practice.

1.3 Summary

I wish to argue in this study that the pre-registration preparation of nurses was not an educational experience. This resulted in the uncritical replication of nursing practice. The professional dimension of nursing required that nurses needed to be practitioners who utilised a whole range of intellectual, interpersonal and practical skills. This would necessitate a move away from an uncritical, accepting apprenticeship model to a professional model which involved the development of a reflective and critical practitioner. In this way nurse practitioners would be produced who would do new things and not simply repeat what other generations of nurses had done.

CHAPTER 2

MAJOR ISSUES IN THE PHILOSOPHY OF EDUCATION

In order to understand the meaning of the term 'educational experience', it was thought necessary to look to educational philosophy for an analysis of issues associated with the concept of education. It was decided to look for one or two clear philosophical issues which could be employed in a simple analysis of nursing curricula. It was necessary to isolate just a few issues so as to regulate what would potentially be an inextricable analysis. The process began by a reading of a publication by Moore (1982). It was a concise publication and, as an introduction to the philosophy of education, it presented the reader with the most fundamental issues, in relatively uncomplicated terms. Moore defined educational philosophy as a scrutiny of the assumption and justifications which determined educational practice. It was the analysis and criticism of assumptions and justifications concerning pre-registration preparation which was required at this stage of the study so that the nature of an 'educational experience' could be understood. Once the educational principles were identified then the past and current practice of pre-registration preparation in nursing could be analysed. Moore did not forward his own philosophy of education but presented the body of knowledge as determined by others, thus obviating the need to sidetrack into detailed comparisons of the various philosophies of education. Other authors are referred to as the arguments develop a more specific profile.

One fundamental question was, How can educational philosophy enable an understanding of the activities of teaching and learning in nursing? Moore explained that at the lowest level of educational activity the educational practitioners utilise certain concepts and constructs. They attempt to realise these ideas in their daily activities and these ideas influence the way in which they make decisions relevant to their work. They use these concepts to discuss what they are doing. The influence of these concepts is pervasive, they form the building bricks of educational theory. Moore suggested that educational theories may be of two types.

- i General Theory - making general points about education; its role or function in society.

and

- ii Limited Theory - giving advice or recommendations about what education practitioners ought to be doing, prescriptions for action, and what sort of individuals should be produced.

Both of these have relevance to the nursing situation. Moore suggests that when 'confronted with a general theory of education the educational philosopher will ask what is being recommended? and will it do? Ideas such as Piaget's dictum, encourage one to consider what education can and should achieve. An alternative form of analysis, ie limited theory, is to look at educational theory in terms of the major topics of interest which have emerged. The questions which are typically asked are summarised as follows:-

"What is education? What is the purpose of
it? What should be taught? Why should some

subjects be taught and not others? How should pupils be taught? How should they be disciplined or controlled? Who should be educated and how should educational advantages be distributed? In other words they try to answer questions about the curriculum, about worthwhile knowledge, about teaching methods, about social considerations like the need for equality, freedom, authority and democracy in education".

(Moore 1982, p 15)

It is the aim of this thesis to move from general theory to limited theory and it is the issues concerned with general theory which are addressed here. The major areas for concern deal with the assumptions common in general theories of education. The commonest assumptions are related to:-

- a The aims and purposes of education
- b The nature of man (and woman)
- c The nature and selection of worthwhile knowledge
- d The 'transmission' aspects of education.

These major topics were of particular relevance to the task of identifying educational principles for nursing and as such were considered in greater detail.

2.1 Assumptions about the Aims and Purposes of Education

Moore points to a distinction between aims and purposes. To ask the question, what are you doing? indicates that an aim is being proposed, and to ask what are you doing it for, suggests that a purpose is being questioned. 'Aims' tend to make clear what is being done but 'purposes' point to ends external to the activity itself. Moore gives the following example.

"The distinction between aims and purposes is relevant to talk about education. A teacher may be asked to state his aim in a particular lesson, that is, to make clear what he is doing or trying to do. He may also be asked what is really a separate question, namely, why he is doing it, what is he doing it for, what his purpose is in trying to get his pupils to write poetry or to solve quadratic equations."

(Moore 1982, p 28)

Questions about aims and purposes are relevant to an analysis of nursing curricula because they encourage us to ask questions about what students are actually learning and the relevance of this learning to real life.

A famous satire related by Benjamin (1975) demonstrates the necessary relationship between teaching/learning activities and the requirements of the real world. It also demonstrates the problems which can be brought

about by a mismatch between the two, and has clear implications for nurse education.

Benjamin (1975) describes the sabre-tooth curriculum and the exploits of a man called New-fist-hammer-maker. New-fist was a craftsman who was highly skilled and respected in the community. He knew how to get things done. He was also a thinker who became dissatisfied with the accustomed ways of his tribe. He watched his children at play and noticed that they had no purpose in their play beyond the pleasure gained from the activities themselves. He contemplated how he could get the children to involve themselves in play activities which would prepare them to do things which were relevant to the needs of the tribe. Things which would give more and better, food, shelter and clothing. This would help the tribe to have a better life. In estimating the needs of tribesmen New-fist identified some educational goals. He found that catching fish from the creek, clubbing woolly horses and frightening sabre-tooth tigers with fire were the most relevant things to learn to be a better tribesman and to contribute to the needs of the tribe. He inaugurated activities to teach the children these skills after much criticism from the tribesmen who said that it was against the established traditions and conventions. Eventually a new ice age approached, the creek became muddy and fish could not be caught with bare hands, the woolly horses left for dry lands and the sabre-tooth tigers died and were replaced by glacial bears who were not afraid of fire. The community faced a predicament, they had no food, no clothes and no security from the glacial bear. The descendants of New-fist, who were also doers and thinkers, devised more appropriate skills for catching fish, antelope snaring and building bear pits. The New-fist followers called on the tribe to forget fish-grabbing, horse-clubbing and tiger-scaring in favour of

these new skills, but the wise old men smiled indulgently and proclaimed that this would not be education. How could any sensible person be interested in such useless activities? The followers of New-fist pointed out that fish could not be caught in muddy waters and there were no woolly horses or sabre-tooth tigers, therefore student and teachers could not learn the old skills successfully. But the wise men retaliated by arguing that we do not teach fish-grabbing to grab fish, we teach it to develop a general agility which can not be developed by mere training. We teach tiger scaring to develop courage which could not be developed in such an unsophisticated activity as bear-killing. 'But surely', said one follower of New-fist, 'times have changed'. The wise old men were adamant in their reply, 'If you had had an education like us then you would know that the essence of true education is timeless'.

This anecdote demonstrates a number of issues relevant to nurse education and to general theories of education. It demonstrates how educational aims (ie catching fish) are related to educational purposes (ie providing food). It also shows that aims and purposes may be appropriate to the context in their original conception but time can change the relevance of educational purposes. In the same way that sabre-tooth tigers are replaced by glacial bears, society makes changing demands upon nurses. In Victorian times it may have been appropriate for nurses to be passive and dependent to fit the social structures and attitudes which were prevalent. Rapid changes in technology and science, associated with modern society, requires nurses who are adaptable and can organise their own learning in this changing world. Thus the purposes of nurse education must change to meet these societal demands. As a consequence educational aims must change. The learning outcomes and learning methods must be appropriate to the purposes of

education. The development of adaptable self-reliant nurses requires different approaches to those appropriate to the production of passive, dependent nurses.

The anecdote of the 'sabre-tooth curriculum' also demonstrates a common reluctance to abandon outdated but well established methods. The elders of this primitive tribe became blind to the appropriate matching of educational aims and purposes, advancing esoteric rationales for the preservation of traditional practices. Perhaps their power status or emotional security would be threatened by the emergence of new knowledge and skills which they did not possess. These tribal elders have their parallels in modern society. The leaders of nursing and the curriculum planners may be the contemporary elders who do not recognise appropriate aims and purposes because of the threat imposed by unfamiliar knowledge and skills. It will be argued in this thesis that aims and purposes are central to an analysis of the pre-registration preparation of nurses as an educational experience.

2.2 Assumptions about Human Nature

Assumptions about the aims and purposes of education are closely related to assumptions about human nature.

Some of the old assumptions which influenced the general theory of child education are irrefutable. The Calvinist notion that all children are sinful, Rousseau's belief that all children are basically good and Locke's contention that children are born tabula rasa are all examples of these ideas that are difficult to refute. Moore encourages us to adopt theory

which results from serious empirical enquiry. If a course of learning is to bring about a change in the individual one should ask questions about the perceived functioning of these individuals, both psychological and social. Moore states that two of the major assumptions made about human nature relate to mechanistic and organic views of man. Educational theory based on mechanistic assumptions would see man as a kind of machine. Effective functioning would be revealed by his external behaviour. This could be deliberately regulated by modification and shaping towards some desirable end.

The organic view sees the individual as essentially a 'growing' phenomenon. The aim of education would be to encourage this growth from within. Mechanistic approaches have been adopted by Helvetius, James Mill and B.F. Skinner. Organic approaches are associated more with Rousseau, Dewey and latterly Carl Rogers. The following features of these views of man can be summarised in the following way:

The Mechanistic View

- (i) Effective working is revealed by external behaviour (conformity)
- (ii) Education will attempt to improve external response (behavioural modification)
- (iii) The pupil is seen as a device whose workings can be externally regulated.

The Organic View

- (i) Effective working is revealed by personal growth (uniqueness)
- (ii) Education attempts to encourage individuals to develop from within (personal development)
- (iii) The pupil is seen as a person with capabilities which he must discover and develop (intrinsic potential).

2.3 Assumptions about the Nature of Knowledge

Education is concerned with the acquisition of worthwhile knowledge, understanding and skills and as such questions should be asked about what is being taught. The curriculum provides the manifest evidence of planning for this process.

"The curriculum is one of the means by which the overall aim is translated into achievement: educated men and women are formed by being introduced to and initiated into various kinds of knowledge and skill."

(Moore 1982, p 41)

Hirst (1975) argues that rational understanding is a particular feature of an educational system. As such, the most central objectives of any educational curriculum (as opposed to training) are the acquisitions of knowledge and rational beliefs.

In analysing pre-registration preparation as an education, two kinds of question could be posed: What is knowledge? and what knowledge is of most worth?

The first of these questions, according to Moore, may be subdivided into two further questions, what is knowledge in general, what exactly can be known? and: What does it mean to say of anyone that he knows something?

Differing views of what knowledge represents can bring about very different approaches to education. It is possible to define knowledge from a rational perspective as the grasping of necessary truths, deduced from self evident principles, something analogous to the grasping of mathematical truths. "Mathematical truths are universal: they are truths always, everywhere" (Moore 1982). Others follow a 'science paradigm' where knowledge is the product of observation and experiment in the empirical world. According to Moore the disadvantage of the rationalist view is that it gives no substantial information about the world. This kind of knowledge is relatively empty. Empirical generalisations, on the other hand, are only true in so far as there is evidence to support them. Fresh evidence can show them to be false.

This differentiation between rational knowledge and scientific knowledge demonstrated that knowledge originates from both rational thinking and experience, and, as such, knowledge may be seen to take two major forms - theoretical and practical. The student engaged in the acquisition of the former utilises knowledge derived from other humans and must accept this as a universal truth which is outwith his own experience. The latter represents knowledge which can be acquired from personal experience.

In the same way, Moore distinguishes between two forms of knowledge, 'knowing that' and 'knowing how'. One can know that something is true or the details of its existence, this has also been called propositional or theoretical knowledge. This, however, is not the only form which knowledge can take. As Moore succinctly puts it:

"Knowing how to play a violin doesn't depend
crucially on my holding propositions to be
true."

(pp 51)

Whilst one can make propositional statements about the performance of a skill which one can perform, it is not always the case that a skilled performer "can say much about how he gets his results". (Moore 1982)

There is little argument, however, that 'knowing that' is involved in the performance of many activities. The distinction between propositional knowledge (theory) and practical knowledge (know how) is important in the analysis of the pre-registration learning of nurses simply because it seems that it has important implications for the relevance of the knowledge chosen for the curriculum. The satire of the sabre-tooth curriculum (Benjamin 1975), related earlier, highlighted the necessity of a relevant curriculum in terms of 'know-how', but what of the question of propositional knowledge?

Jurgen Habermas (Mezirow 1981) offered an additional epistemology which expanded the theory described by Moore. He proposed three generic domains of learning each with its own interpretive categories, ways of assessing

knowledge claims, methods of inquiry, distinctive learning modes and needs. The three domains are labelled the technical, practical and emancipatory, and they all represent those areas of human interest which generate knowledge.

- (i) The **technical area** is reflected in the empirical-analytic sciences and requires that objects and events are analysed in terms of dependent and independent variables. Habermas called this aspect of human interest the 'work' area because it is based on instrumental action whereby man aims to control and manipulate his environment.

- (ii) The **practical area** concerns itself with communicative action. It consists of all those consensual norms for interpersonal human behaviour. The validity of this knowledge is not based on dependent and independent variables, but is 'grounded in the intersubjectivity of mutual understanding of intentions'.
(E.g., sociology, history, literature, law.)

- (iii) The **emancipatory area** involves the area of self-knowledge, the way 'one's history and biography has expressed itself in the way one sees oneself, one's roles and social expectations'.
(E.g., psychoanalysis, psychology, ideology.)

In more modern terms these three domains may be interpreted as scientific, social and self-awareness. It is important to reiterate that the areas of human interest isolated by Habermas have a bias towards propositional knowledge. The topic areas given as examples indicate this, although it

can be argued that all of these 'domains' are equally applicable to 'know-how'. It should also be noticed that his use of the term 'practical' differs from the meaning associated with the term practical knowledge (know-how) as used in the previous discussion on forms of knowledge. Habermas uses the term to more literally mean knowledge about interpersonal communication.

This analysis of the forms of knowledge enabled one to consider what forms of knowledge exist in nursing curricula under the headings of propositional knowledge, know-how, technical/scientific knowledge, interpersonal knowledge and self-awareness.

2.4 Questions about the 'Transmission' aspect of Education

In essence the discussion here turns from an examination of 'what' should be taught to a discussion of 'how' things are taught. This involves an examination of the roles and positions of both teacher and pupil and the extent to which authority, discipline and punishment are utilised. The concept of teaching must be considered in some depth. Moore makes two key points in his discussion by saying that:-

"First, teaching necessarily involves the intention that someone should learn as a result of what one does; secondly, that teaching requires a recognition by both teacher and pupil of a special relationship existing between them."

(Moore 1982, p 67)

Even though teaching can be unsuccessful he emphasises that teaching cannot occur unintentionally or by accident. The second point made by Moore underlines the fact that both parties in the 'teaching' relationship must recognise that the relationship exists. It can also be said that the word teach has both a 'task' and a 'learning' connotation. It is worthwhile to note Moore's contention that in the 'task' sense one can carry out the activity of teaching without achieving a change in the student. One could argue that if teaching can be said to have taken place there should be some relevant response from the student. In this sense one can hardly claim to have taught somebody to waltz, for instance, if that person can not demonstrate an ability to waltz as a result of the tuition. Moore makes a profound comment on teaching ability and its efficiency.

"Teaching would still be teaching, given the two criteria mentioned above, intention and recognition, even if the methods used were harsh or immoral. It does not follow from the fact that someone is teaching, and teaching effectively, that education is going on, although it would be generally the case that if education is taking place some teaching is being done by somebody.

(Moore 1982, p 70)

Questions can be asked then about the efficiency of teaching, is it educative? Do the participants recognise the existence of the special relationship?

These questions point to a general concern for the process of education, particularly the relationship between teachers and students. Indeed there is an argument which is currently gaining credence, that most of our approaches to teaching have been derived from the practice of teaching children and that this is not appropriate to adult learning (Knowles 1970). The science and art of teaching children is termed pedagogy and Knowles advocated that an emerging technology of andragogy was more appropriate to adult learning. This expands Moore's contention that teacher/student relationships determine the quality of learning. Knowles argued that pedagogy was based on an 'archaic conception of the purpose of education, namely the transmittal of knowledge'. He pointed out that this was only functional where the timespan of cultural change is longer than the life-span of the individual learner. In such a situation what a person learns during childhood and adolescence remains valid for the rest of his life. This, however, is no longer the case, life expectancy has increased and the timespan of social change (i.e. knowledge) has reduced.

Andragogy, the science and art of teaching adults, as such, requires different approaches to teaching. Knowles maintained that there are four crucial assumptions about the characteristics of adults that are different to the assumptions which pedagogy makes about children. They are:

- (i) The adult's self concept is focussed towards self-direction.
- (ii) The adult accumulates experience and this acts as an increasing resource for learning.

(iii) Readiness to learn is related to the developmental tasks of adult social roles.

(iv) The adult requires immediate application of knowledge and shifts from an orientation towards learning which is subject centred to one which is problem centred.

Whilst Knowles argued that the teaching of children is different to the teaching of adults, it is worth noting that around the time of his publication another author made similar observations on the teaching of young people. This was Rogers (1969) who argued that young people required a certain freedom in order to learn. Rogers considered that education had become a process in which the material to be learned had no personal meaning for the learner. It was not based in the students' experience. He felt that learning should have a quality of personal involvement, be self-initiated, be pervasive and be evaluated by the learner. Rogers maintained that all teachers want to facilitate this sort of learning but they are locked into traditional, conventional and even institutional habits which make this 'significant' learning difficult to achieve. Rogers' original ideas were further developed in 1982 and will be referred to later in this thesis. At the beginning of this study, Rogers' original work (1969) was examined.

Rogers suggested the following principles which should be accepted if meaningful learning is to take place:-

1. Human beings have a natural potentiality for learning.

2. Significant learning takes place when the subject matter is perceived by the student as having relevance for his own purposes.
3. Learning which involves a change in self-organisation - in the perception of oneself - is threatening and tends to be resisted.
4. Those learnings which are threatening to the self are more easily perceived and assimilated when external threats are at a minimum.
5. When threat to the self is low, experience can be perceived in differentiated fashion and learning can proceed.
6. Much significant learning is acquired through doing.
7. Learning is facilitated when the student participates responsibly in the learning process.
8. Self-initiated learning which involves the whole person of the learner - feelings as well as intellect - is the most lasting and pervasive.
9. Independence, creativity and self-reliance are all facilitated when self-criticism and self-evaluation are basic and evaluation by others is of secondary importance.
10. The most socially useful learning in the modern world is the learning of the process of learning, a continuing openness to experience and incorporate into oneself the process of change.

By Carl Rogers, Freedom to Learn (1969)

It is worth highlighting that both Knowles and Rogers emphasised the importance of self-direction, the importance of personal experience as a learning resource, relevance to the students' own purposes/problems and the need for students to cope in a world of change. Perhaps Knowles has made false assumptions about the differences between child and adult learning and Rogers was imparting adult values on childhood experience. Whichever is the case, this argument will not be developed here. For the purposes of this study, it was accepted that the validity of their recommendations would need to be assessed in a nursing context which did not involve children or adults (mature students) per se, but young adults. Knowles encouraged the question, are nurse teachers treating student nurses as children or adults? Rogers seemed to encourage us to ask questions which transcend the age groups, in particular, Do teachers allow students sufficient freedom to involve themselves in learning which is meaningful to them and which is related to their own experience?. This recalls the earlier argument (pg28) that assumptions about human nature are crucial to the analysis of an educational system. Both Knowles and Rogers advocate the organic view of man, Knowles for adult learning and Rogers for the learning of adults and young people.

These ideas encouraged the researcher to ask questions about teacher and student roles as well as the nature of their relationship.

2.5 Education and Training: Separate Paradigms?

The supposition of the opening chapter that the pre-registration preparation of nurses was not an educational experience begged the question, What are the alternatives to 'educational experience'? Two

possible answers were to be found in Moore (1982). They were encapsulated in the concepts of training and indoctrination. Having discussed the main issues which should be considered in an analysis of education, it was apparent that the term 'education' was used in two different ways. In one way the term education was used in a generic sense to label the whole arena of organised learning. In a second sense the term was used to identify a particular approach to learning. It was in this second sense that the concepts of training and indoctrination can be viewed as alternative views of knowledge acquisition to the concept of education. In the applied sense a person may be educated, trained or indoctrinated. In a personal sense he/she may become an educated or trained person. Rarely does one seem to boast that one has become an indoctrinated person. Similarly one may receive an education or a training. This precipitated the question, What was the difference between the three concepts when they were used in this specific way? In this way some alternatives to 'education' could be isolated.

2.5.1 Education and Training

Distinctions between these two terms were best identified by referring to standard definitions. The following two definitions of training emphasised the purposes of the activity:

'The systematic development of the attitude/knowledge/skill behaviour pattern required by an individual in order to perform adequately a given task or job. This is often integrated or associated with further

education. The use of the learning experience to integrate the concept of training and education is increasingly common.'

(Department of Employment 1971)

'Providing learners with a range of strategies and tactics which will enable them to operate successfully within a given field of activity.'

(Moore 1982, p 71)

The same sources also gave definitions of the term education:

'Activities which aim at developing the knowledge, moral values and understanding required in all walks of life rather than knowledge and skill related to only a limited field of activity. The purpose of education is to provide the conditions essential for young persons and adults to develop an understanding of the traditions and ideas influencing the society in which we live, of their own and other cultures and of the laws of nature, and to acquire linguistic and other skills which are basic to learning, personal development, creativity and communication.'

(Department of Employment 1971)

(Adapted from that given by the International Vocational Training Information and Research Centre.)

'The educated man would be one whose intellectual abilities had been developed, who was sensitive to matters of moral or aesthetic concern, who could appreciate the nature and force of mathematical and scientific thinking, who could view the world along historical and geographical perspectives and who, more over, had a regard for the importance of truth, accuracy and elegance of thinking. A further requirement is that the educated man is one whose knowledge and understanding is all of a piece, integrated, and not merely a mass of acquired information, piecemeal and unrelated.'

(Moore 1982, p25)

These definitions pointed to the features which distinguished education from training. The first was the specificity of acquired knowledge to a particular pursuit. The definitions of education seemed to deal with forms of knowledge which are relevant to a broad range of life situations. Training definitions seemed to be concerned with forms of knowledge which are related to a specific activity and to the production of a model operator.

The second major difference appeared to be concerned with the view of man which was adopted. The concept of education seemed to be holding to an organic view of man and training a mechanistic view of man. The approaches which ensue differ in that the 'organic view' is mainly concerned with personal growth and the 'mechanistic view' with behavioural expression. In essence the mechanistic view of man, which is associated with the concept of training, demonstrates a transactional approach to learning. The relationship between the teacher and student in this setting is seen as a transaction between teacher and pupil. All the skill and knowing is on one side and all the shortcomings on the other. The teacher is an authority, a repository of knowledge, an expert. The pupil is none of these. The teacher's role is didactic and regulatory. It is aimed at producing the right sort of behaviour.

The concept of education seemed to promote the concept of growth by discovery. This approach weakens the rigid polarity between teacher and learner which is described above. The aim is to encourage the student to develop his or her own methods of working. The teacher is more a mentor or consultant. Learning will be a process of discovery. The student will be encouraged to explore, experiment, test and check the real world. It was obvious that this emphasis was reminiscent of the Rogerian view of man (Rogers 1969 and 1983). From this perspective it could be suggested that an education allows the student more freedom to grow as a person and learn what is most relevant to him. Training, however, is the antithesis of this, emphasising the requirement that the student should accept externally imposed prescriptions for behaviour which enable the production and evaluation of a model operator. There are strong connotations in the

definitions of these two concepts that power relationships between teachers and students are at issue.

2.5.2 Education and Training Paradigms

There was some indication, from the literature, that it was useful to talk in terms of separate education and training paradigms. Both could be differentiated in terms of aims, purposes, forms of knowledge, teacher roles and student roles. This argument was tentative at this stage of the study. The concept clarification of education and training was useful for a full understanding of the nursing situation simply because the terms were found to be fairly ubiquitous in the nursing literature. The discussion on the relevance of these concepts will be revisited later in the thesis (pp96). The utility of differentiating between education and training is presented at this point to support the proposition that aims, purposes, knowledge and interpersonal relationships were key concepts in an analysis of the pre-registration preparation of nurses.

2.5.3 Education and Indoctrination

Education has been described as a concept which allows considerable freedom for students to grow and learn with a certain amount of freedom to control the knowledge and learning methods utilised to achieve their purposes. Training proves to be more restrictive in that the learning is externally controlled and the knowledge externally prescribed. There is, however, some room for the students to choose whether they participate in this learning setting. If the truth were known it is probable that students in training settings do not learn those things which they do not wish to.

Indoctrination, however, is something more autocratic, and whilst it can be said to be a form of learning it can hardly be described as a type of pedagogy. Moore (1982) considered that indoctrination had the following features:-

- (i) Manipulation by an interested party.
- (ii) Reliance on authoritarian methods.
- (iii) Learners do not enter into the learning of their own free will.
- (iv) Beliefs are accepted without question.

It was apparent that learning in this climate is concerned with the imposition of knowledge and the maintenance of power relationships. This is more antithetic to the concept of education than training.

The concepts of education, training and indoctrination demonstrated that there were alternatives to learning as 'education' and that learning could be an issue of power relationships. Power being the ability of one individual or group of individuals to impose their will on others. The concepts of education, training and indoctrination gave additional potential to structure an analysis of teacher/student relationships in nursing. The degree to which nurse teachers impose their will and knowledge upon student nurses would provide a crude means of estimating whether the pre-registration preparation of nurses was an educational experience. If it could be demonstrated that it was a 'training'

experience or an 'indoctrinational' experience then one could say that it was not educational.

2.5.4 The Synthesis of Major Philosophical Issues

In an effort to discover the distinguishing features of an educational experience a number of issues were considered. Many questions were posed and it was found that the issues could be reduced to three major concerns. These can be briefly stated as, the purposes of learning, the extant forms of knowledge, and teacher/student relationships.

The Purposes of Learning

This study proposed that the pre-registration preparation of nurses was not an educational experience and that this produced practitioners who were uncritical replicators of existing nursing practice. It was argued that an analysis of pre-registration curricula must consider whether pre-registration learning produces practitioners who criticise and change their practice if a professional model was to be adopted by the nursing community. It could also be argued that the professional model required independent practitioners who could utilise numerous intellectual, interpersonal and practical skills to make decisions and solve problems in the interests of their patients. If the professional model was not a feature of nursing curricula then one would expect to find a system operating to provide a model operator who conforms to the traditions and conventions of nursing practice without question. The concepts of education and training were clearly of relevance here. One could conclude that pre-registration learning was not an education if it could be demonstrated that it subsumed to a training paradigm. This would allow one

to conclude that such a learning climate was not appropriate for the production of a critical independent practitioner.

The Extant Forms of Knowledge

Once the purposes of learning could be identified it would be possible to assess the quality of the learning programme by estimating how far the extant forms of knowledge suited the purposes of nursing curricula. This would involve an estimation of the existence of propositional and practical knowledge along with the scientific, social and self knowledge which was proposed by Habermas (Mezirow 1981). It was expected that a professional education would address itself to numerous forms of knowledge in order to develop a practitioner who could utilise a range of intellectual, interpersonal and practical skills in order to make decisions and solve problems in the interests of their patients.

The Nature of Teacher/Student Relationships

The mechanistic and organic views of man as well as the work of Knowles (1970) and Rogers (1969) highlighted the need to assess nursing curricula in terms of the ways which teachers treat their students. Did teachers treat students like children (pedagogy)? Were students self-directed? Did power-relationships exist? And were both parties aware that teaching or learning was an expected aspect of their role? It seemed that a professional education would require that students were treated like adults, that they would be encouraged to be self reliant and that both parties would have a clear conception of their roles within an educational paradigm.

2.5.5 Summary

Major issues in the philosophy of education have been described and they have been reduced to three issues of primary interest. They are:

- (i) The purposes of learning
- (ii) The extant forms of knowledge.
- (iii) The nature of teacher/student relationships.

These three issues were of particular relevance to the analysis of the pre-registration nursing curriculum as a form of professional education. An examination of these issues would provide support for the assertion that the pre-registration curriculum was not an educational experience and that this produced nurses who were uncritical replicators of traditional nursing practice.

CHAPTER 3

REVIEW OF THE LITERATURE

3.1 Introduction

Having identified the relevant 'educational issues' it was thought necessary to look for preliminary answers to some key philosophical questions by referring to the previous research on the pre-registration preparation of nurses. In order to do this, it was decided to abstract the papers describing research work in this area. This obviates the need to describe each piece of work thus detracting from the discussion on the major themes. In addition the studies were tackled in chronological order, yet the themes identified transcend historical boundaries. For this reason this section will discuss the emergent themes, the reader being referred to the abstracts in Appendix I for a fuller account of each study.

A descriptive analysis of the relevant literature can take many different forms, and the selection of parameters for analysis are always relatively arbitrary. Bearing this in mind it was decided to restrict the analysis to a study of the process of teaching and learning. Secondly it was decided to take note of the methodologies employed by researchers in this field in the expectation that it would have important consequences for the progress of this study. The history of master's and doctoral theses in nursing only goes back as far as 1960. It was from this time up to the beginning of this study in 1982 that papers were selected. One study (MacGuire 1969) reviews the literature from 1940 and in actuality the literature analysis reported here covers the time period from 1940.

There are some 44 papers abstracted and they represent almost all of the British work on the context and processes of learning in preparation for registration. Those few which have been omitted were unobtainable from conventional sources. The analysis was limited to a study of literature describing the situation in Britain and to research carried out by nurses.

Before the analysis of the literature can be presented it is expected that the reader will need to be clear about the educational context in which the conclusions were drawn. This will benefit most the reader who has not experienced the nurse education system, and it will also serve to establish in the minds of contemporaries and successors, the system which prevailed at the time of the study.

3.2 The System of Pre-registration Preparation of Nurses in England and Wales

At the time of this study the basic nurse training was controlled, in England and Wales, by a General Nursing Council. This 'statutory body' was set up by Acts of Parliament which also laid down the composition and functions of this organisation. There were 'sister' councils also set up for Scotland and Northern Ireland. The Council for England and Wales was composed of 22 nurses elected by their peers whose names were of different parts of the register and roll, and 20 people (half of whom were nurses) who were appointed by Secretaries of State for Social Services; Wales; Education and Science, as well as The Privy Council, The Central Midwives Board and The Council for Education and Training of Health Visitors. The decisions of this Council were acted upon by a staff of some 200 based in London. The Council was responsible for approving training schools and

maintaining and monitoring standards. Syllabi were drawn up for the different parts of the register. These parts include General Nursing (SRN), Mental Nursing (RMN), Mental Subnormality Nursing (RMMS), and Sick Childrens Nursing (RSCN). Syllabi were also drawn up for entry to the roll of nurses. The training for the roll was shorter and included General Nursing (SEN), Mental Nursing (SEN[M]) and Mental Subnormality Nursing (SEN[MS]).

There were also in existence a number of experimental training schemes which allow for combined training, eg:-

SRN & RSCN

SRN & Health Visiting

SRN & University Degree.

These forms of training were, however, few and far between.

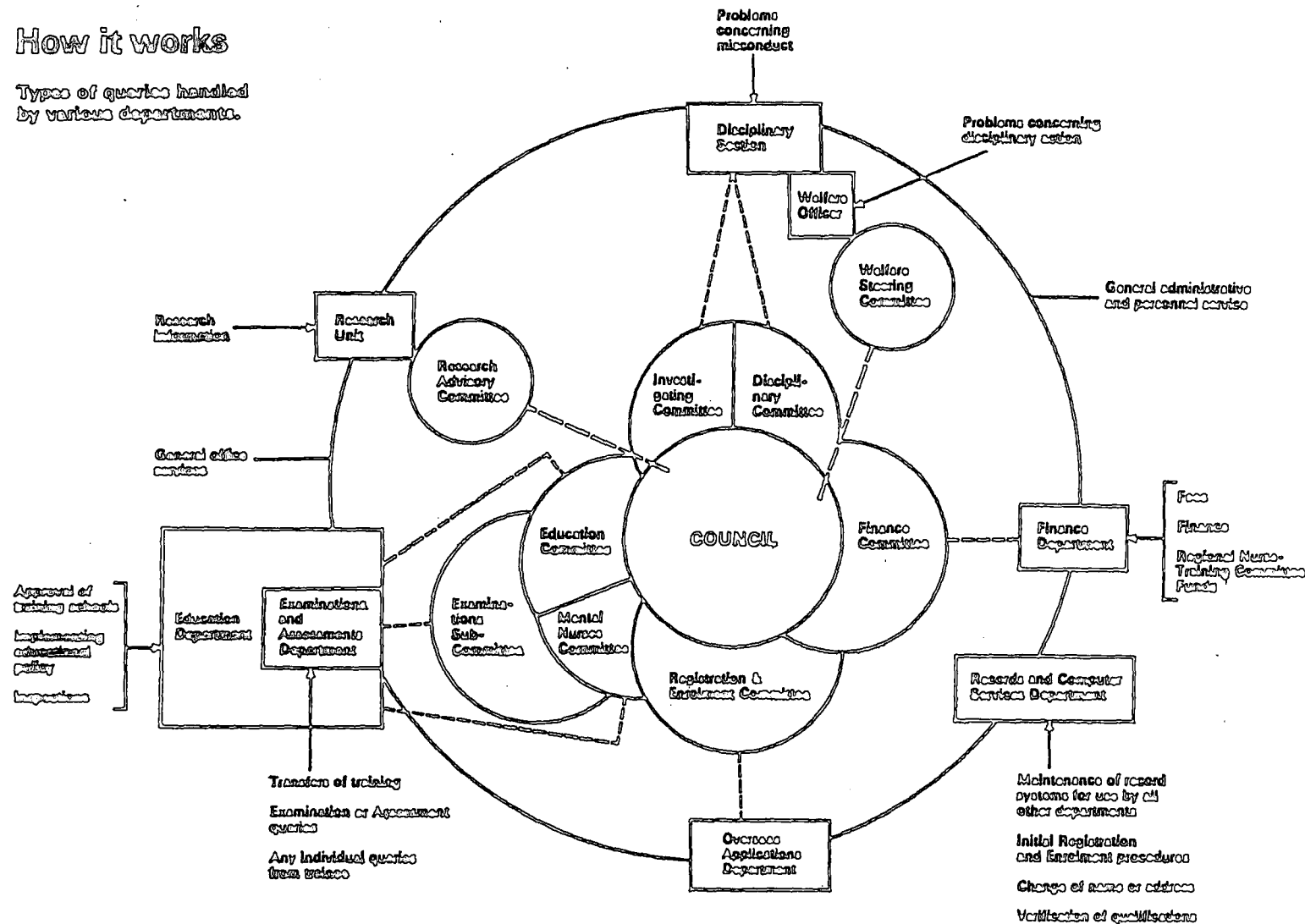
In addition the Council set a national standard method of assessment which was 'examination styled' and consisted of three components.

- a A final examination paper in which five essays had to be completed from a choice of nine in 3 hours.
- b A final multiple choice objective test consisting of sixty items giving four response options in each case (not used for entry to the roll).
- c Four 'ward based' assessments of practice. Mainly carried out in the later half of training.
(Only three assessments for the roll).

FIGURE 1 THE GENERAL NURSING COUNCIL OF ENGLAND AND WALES.

How it works

Types of queries handled by various departments.



Other queries—Registrar or Deputy Registrar, or Information Officers.

Some 30,000 learners took these examinations each year.

A third function of the Council was to maintain the register of nurses and the roll of nurses. Entry to each was firmly controlled on the basis of strict training criteria which also applied to those who were not trained in institutions controlled by the Council (eg overseas applications). The Council also had the function of removing names from the register and roll in cases where misconduct was incompatible with the standards and practice of nursing. The Council had a financial function for nurse teachers salaries and learning resources. Funding was provided by the Department of Health and Social Security. The various sub-committees and their structural relationships can best be understood by referring to Figure 1 (from General Nursing Council 1976).

3.2.1. The Training Syllabi

In order to gain entry to the parts of the register and roll women and men had to undertake a course approved by the Council. They followed the appropriate syllabus which "set out in broad terms the subjects to be studied during training". These syllabi all followed a similar structure and for the sake of brevity the general syllabus for registration and the general syllabus for the roll will be outlined here.

The 'registration' training was described in the syllabus as normally lasting 156 weeks exclusive of excess sick leave and special leave. The total amount of time allocated for study blocks or study days during this time was to be no less than 120 days (24 weeks). The minimum study day requirement, 30 - 40 days (6 - 8 weeks) had to be utilised at the beginning

of the course in the form of an introductory block. In addition to this requirement for 'classroom' learning, the learning/teaching sessions which occurred during practical experience had to be taken into account in the final record of "theoretical instruction". There was, however, no time requirement stated. The syllabus stated that training programmes should 'integrate theoretical and practical learning' (General Nursing Council for England and Wales 1977a). At the time of this study the majority of training schools operated a block system of study days. Students attended the school of nursing for two weeks followed by periods of practical experience of around twelve weeks which usually provided for experience in two different wards or departments (See Appendix II). During each year students took a total of six weeks holiday generally at fixed periods in the training programme. Many training schools gave theoretical instruction, during the study blocks, which was supposed to be relevant to the clinical area which the student was to be allocated after block.

Generally half the students in each 'intake group' attended one type of ward/department in the first half of the allocation (eg medical ward) and the other half attended a different type of ward/department (eg surgical ward). Half way through the 'period of experience' the two halves 'swopped over'.

Many schools of nursing attempted to organise the classroom and practical experience in a 'modular' form. Each period of experience being preceded by a 'preparatory' week and followed by a 'consolidation' week. These 'modules' were generally broken by a holiday period (1 - 2 weeks). (See Appendix III).

The periods of practical experience were specified and the following were given as necessary:-

- a Care of the acute and long term physically ill patients in medical and surgical wards.
- b Accident and emergency nursing.
- c Operating theatre experience.
- d Care of the mentally ill or mentally handicapped people.
- e Community care/home nursing.
- f Maternity care and care of the newborn.
- g Child welfare and care of sick children.
- h Welfare of elderly people and care of the elderly sick.
- i Night duty minimum 8 weeks, maximum 24 weeks (most hospitals gave minimum).

Training for 'enrolment' originated from a post war need to train assistant nurses, that is, those civilians who were making a large contribution to the hospital service. When trained their names were entered on the Roll, which was then called, The Roll of Assistant Nurses. In 1961 the term 'assistant' was deleted from the statutory title and those on the Roll were

entitled State Enrolled Nurses (DHSS 1971). The syllabus described the fundamental features of training for the Roll in the following way:-

"The aim of the Course is to develop competencies in giving total patient care so that the enrolled nurse may take her place as a qualified member of the nursing service. The training does not, however, include preparation for undertaking the full responsibilities for assessment of patient needs and the planning and evaluation of care of which a deeper level of study and practical training is required."

(General Nursing Council 1977[bl])

The period of training was normally 104 weeks, exclusive of sick leave and special leave. The introductory block was 20 days (4 weeks), this was followed by 30 days which could be taken as study days, ½ days or single weeks. At the time of the study training programmes varied in an approximately 50/50 ratio between single study days and study weeks. The theory was laid out in a similar way to that of the 'registration' training. This can be scrutinised in Appendix V.

The following periods of experience were specified:-

- 1 Care of acute and long-term physically ill patients to 'medical' and 'surgical' wards.
- 2 Accident/emergency nursing.

- 3 Operating theatre experience.
- 4 Child welfare and care of sick children.
- 5 Welfare of elderly people and care of the elderly sick.

It is useful to reflect on the General Nursing Councils' declaration on the implementation of these syllabi. The Annual Report for 1980 - 1981 makes some useful observations on the two grades of nurse.

"The movement to develop the 'nursing process' approach emphasises the practitionerhood of the individual nurse as much as it enhances the individual needs of the patient or client. Ideal as this is and fully supportive by the council, it demands a sound education and training for all grades of 'nurses'; the nursing process is hardly divisible and justification for the two present grades of nurse becomes difficult to defend. There is much evidence that present employment practice places Enrolled Nurses in positions for which they have not been adequately prepared and for which it can be argued that they are not paid".

On curriculum development and the practice of nursing the report makes the following comments:-

"There has been much emphasis laterly on building the curriculum from learning units based on periods of experience in the various wards and departments and other care areas required for the course. Many schools have made progress in this educational enterprise which demands close collaboration both between organisational managers between Teachers and Charge Nurses/Ward Sisters. From the smooth running of the master plan of "allocation" there are benefits for education and for service - and from clear definition of the learning unit has strung the setting for serious exploration of learning objectives - and from a scrutiny of practice.

The stage of development is still slow to emerge in some schools and for some courses."

(GNC 1981)

3.2.2 LOCAL ARRANGEMENTS

At the outset of this study there were some 200 schools of nursing offering several of the statutory courses described earlier (GNC 1981). At one time there were as many as 300 schools of nursing when they were each associated with one hospital management committee. Latterly the incorporation of hospitals into District Health Authorities has brought into being schools of nursing which cover health districts. Some were even organised on an Area Health Authority basis as evidenced in the General Nursing Council Annual Report.

"Learners and teachers were employees of the hospital service (HMC or Board of Governors) and since 1974 of Area Health Authorities. In some areas, comprising two or more districts, it has been possible to set up larger educational establishments where clinical experience can be chosen for its comprehensive nature and good standards of care - and where the scarce resources of nurse teachers and self-learning materials can be used."

(GNC 1981)

Schools of nursing largely consisted of a set of classrooms and offices often housed in a separate building in the grounds of the hospital which it both utilised and serviced.

The GNC Annual Report says that:-

"Buildings for educational work have improved, but are by no means wholly satisfactory for every school. A large central provision for each school is essential, together with well serviced peripheral units in hospitals distant to the main centre. Council has advocated the development of effective library services and

learning resource centres run by qualified library staff - and on a health district basis for all staff. There are still only a minority of libraries run in this way."

(GNC 1981)

This extract is given so that the reader can appreciate the standard and variety of educational facility provided at the local level.

In 1980 there were fifteen courses provided in conjunction with universities and offering a degree in addition to state registration. Others, a small number, utilised local further and higher educational facilities.

3.2.3 THE TEACHERS OF NURSES

Those who taught nurses in the majority of nurse training schools came into the following main categories:-

- (i) Registered nurse tutors
- (ii) Registered clinical nurse teachers
- (iii) Sister/charge nurses
- (iv) Doctors, consultants, registrars.
- (v) Subject matter experts.

NURSE TUTORS

Organised nurse training in Great Britain can trace its origins to the Nightingale School of Nursing which was set up in 1860 at St. Thomas' Hospital, London. During the latter half of the 19th Century the matron was the head of nurse training, the head of the nursing service and the housekeeper. The matron lead the nursing sisters in the provision of all these three functions. In 1914 it was felt necessary to appoint a specialist to teach nurses, the nurse tutor thus came into being (Salmon 1966). The matron remained head of the training school and the sister tutor, as she was originally entitled, was freed from clinical commitment to devote her time to the organisation of the teaching programme and teaching activities. In 1949 the sister tutor was felt to be in something of a prestigious position mainly because of the supposed scarcity of women possessing the education or experience to occupy such a post (Royal College of Nursing 1949).

"Since the number of women suitable and prepared to hold such a position is likely to be limited, and in order to retain the services of the sister tutor in her specialised field, she should be accorded her position as senior educational officer, responsible to the matron only."

(RCN 1949)

A full account of the standing orders of the time can be found in Appendix VI. The main responsibilities which are demonstrated by these standing orders are, ensuring that student nurses receive the instruction laid down by the General Nursing Council, timetabling lessons; arranging educational visits; conducting tutorials, revision classes and discussions; giving lectures on the theory and practice of nursing; arranging practical

demonstrations and practice classes in conjunction with nursing lectures, monitoring records of practical work, maintaining records of attendance and examination results, arranging examinations, committee work, library maintenance, nursing school administration and liaison with ward sisters (RCN 1949).

At this time it was advocated by the college that there should be one sister tutor for every 40 student nurses (RCN 1949). This being the case many schools of nursing had more than one nurse tutor. This heralded the emergence of tutorial teams and a leader who would liaise and be accountable to the matron. The senior or principal nurse tutor emerged and by 1966 this function was highly developed as a top management function (see Appendix VII, principal tutor). By 1966 the second tier of the tutorial team management had become well established, that of the senior tutor. This became a middle management role and the function of the grade was to lead a teaching team (See Appendix VIII, senior tutor). The nurse tutor grade had changed little by this time except that more emphasis was placed on the application of theory to practice, participation in in-service training of qualified staff, arranging clinical teaching, counselling a group of students throughout their training and the safety and welfare of students (Appendix IX, tutor). By 1980 the function of the nurse tutor had changed little and the GNC Annual Report was loath to give numbers of registered nurse tutors as distinct from clinical teachers. They were not separated in teacher/student ratios.

By the 1970's principal tutors were increasingly known as directors of nurse education and in the larger schools of nursing they were assisted by as many as two assistant directors. Training in preparation for

registration as a nurse tutor was originally in the form of a two year course for the Sister Tutors Diploma (London University) or a one year diploma in education awarded by certain teacher training institutions.

THE CLINICAL NURSE TEACHER

During the 1950's it was felt desirable to provide more consistent teaching in the clinical area. Ward sisters were finding it increasingly more difficult to teach student nurses because of increasing administrative and clinical commitments. There was a national deficiency of nurse tutors and a ratio of 1:49 existed in 1956 (Dutton 1967). In addition nurse tutors had become theoreticians who did not practice (Pendall 1977).

"Therefore another teaching position was created to guide students in the application of theoretical knowledge to the practical skills and realities of the ward. Competence in nursing care is developed only through practice at the bedside."

(Kirkwood 1979)

Even though this need was the basis for the creation of the clinical teacher it soon became the source of replacement tutorial staff in the school of nursing. In 1966 Treadway reported that some clinical instructors worked in the school of nursing (Treadway 1966). In 1979 Kirkwood said that the clinical teacher spends approximately half her time in clinical supervision and half her time in the school of nursing demonstrating practical skills and procedures (Kirkwood 1979).

An additional development was the employment of registered clinical nurse teachers as 'pupil nurse teachers', that is, as tutors to pupil nurses.

In recent years clinical nurse teachers have become more numerous, 305 clinical teachers were registered in 1980-1981, as compared to 346 nurse tutors. At the same time the ratio of teachers of nurses to student and pupil nurses was 1:23 and there was a shortfall of some 1500 nurse teachers to meet the required ratios of 1:15 for general nurse training (GNC 1981).

In England and Wales only 63.6% of available posts for nurse teachers were filled. The latest figures to be given separately for nurse tutors was in the Annual Report of 1978-1979 (GNC 1979) and this showed that there were 998 in post for a possible establishment of 1,336 posts. Only 73% of the posts were filled. There were many more clinical teachers posts available (2,044) but a similar percentage were occupied (1,557 = 76%). It is interesting to note that clinical teachers were more numerous at this time.

It can be concluded from this discussion that registered clinical teachers assumed two types of role depending on the locality in which they worked. Some were classroom teachers subservient to tutors and equally as many must have been working in the clinical setting (Kirkwood 1979). The job description given in the Salmon Report 1966 (Appendix X), provides a description of the ideal role of the clinical teacher prevalent up to the time of this study. Kirkwood (1979) completes the picture in her survey of clinical teachers opinions of their role. They summarised their own role under three headings.

- 1 Teaching patient-centred nursing care. This involves basic nursing procedures as well as highly specialised nursing care.

ii Helping students apply basic theoretical knowledge to the practice of nursing.

iii Discussing patient care with individual and small groups of students in the clinical area.

THE SISTER/CHARGE NURSE

The nursing sister, as a team leader, has traditionally always had a role as a 'trainer' of nurses. The sister tutor and clinical instructor were originally both 'hybrids' of this grade providing peer support roles in the early days. The most recent commentary on the role of the nursing sister/charge nurse was given in the Briggs Report (1972). In addition to organising the learning environment in the clinical area, sisters were encouraged to participate in teaching sessions in the school of nursing. A few did just that, but most have been prevented because of service commitment.

The Salmon Report (1966) lists the following training responsibilities of the sister.

i Teaching of student and pupil nurses.

ii Training ~~qualified~~ nursing staff in nursing and ward management.

iii Directing the training of other ward staff.

iv Introducing new members of staff to their duties.

v Counselling ward staff and nurses in training.

vi Recording progress of student and pupil nurses and reporting thereon to unit matron (Grade 7).

DOCTORS, CONSULTANTS AND REGISTRARS

Senior doctors have traditionally taken part in the training of nurses with varying degrees of involvement. The most obvious part played by doctors is in the clinical setting. Student nurses may be involved in 'ward rounds' and many consultants use ward rounds to teach junior doctors, nurses and other professions allied to medicine. Some senior medical staff, particularly registrar's carried out teaching ward rounds with groups of nurses. Doctors also demonstrate and talk through various clinical procedure often explaining to the new nurse the part she plays in assisting him. Consultant medical staff have also traditionally given lectures to student nurses in the school of nursing.

SUBJECT MATTER EXPERTS

At various times professionals, ancillary to the medical staff, help the nurse to learn in much the same way as the doctor. They include radiographers, physiotherapists, occupational therapists, social workers and pathologists. They also lecture in the school of nursing on occasions. In recent times subject experts such as psychologists, sociologists, pharmacists, administrators and the clergy, have been included in the classroom teaching programme more frequently.

The description of the prevailing structure of pre-registration preparation is now complete. It has been something of a digression, but necessary in order to set the scene for the reader. It is thought to be particularly useful for the reader who has no experience of the nursing service in England and Wales at the time of this study.

To recap, three issues had been identified which were found to be central to the philosophy of education. These issues would be used as a basis for the analysis of the pre-registration preparation of nurses as an educational experience. Having now set the scene, by describing the organisational context of pre-registration, it is now possible to describe the literature analysis and outline some preliminary theories about nurse education. An unplanned review of the literature was thought to be too casual and a form of content analysis was attempted. This is described in the section which follows.

3.3 CONTENT ANALYSIS OF LITERATURE ABSTRACTS

3.3.1 Method of Analysis

The content analysis of the literature was first achieved by abstracting the literature which referred to the processes of learning during pre-registration preparation. The abstracting limited itself to discussions on the process of learning and in addition account was taken of the methodology used. Having produced the abstracts (see Appendix I), a content analysis was carried out by reading the abstracts and cataloguing, in an index book, the emergent concept headings. The pages of the index book were marked by letters of the alphabet and concept headings were

classified under these alphabet markers (eg authority and rank = A, formal teaching on wards = F). Each concept headed a single page and was enumerated to distinguish it under the alphabetic coding (eg authority and rank = A₁, anxiety in students = A₂). As each concept heading was set up, it was entered in a list of contents at the beginning of the book. (see extract Appendix XI). References to key concepts by other authors were then taken and either added to previously coded concepts, when congruent, or utilised to set up a new concept category. (see examples Appendix XI). This method of coding proved to be thorough even though it was rather arbitrary. It did achieve the purpose of extracting the key concepts as well as providing for a quick system of cross referencing.

The following concept headings were identified:

- Authority and Rank
- Anxiety in Student Nurses
- Better Students
- Best Ward Teachers
- Curriculum Quality
- Communication on Ward
- Change
- Environment - Ward Learning
- Examinations
- Effects of Training in Total
- Formal Teaching on Wards
- Grades of Teacher
- Help and Emotional Support
- Informal Aspects of Training

Individuality - Recognition of
Interpersonal Skills
Interruptions to Ward Sister
Intellectual Skills
Knowledge/Theory Bias
Key to Nursing - Sister
Nurse Tutors
Practice Without Training
Patients - Detrimental Effects
Patients - As Part of Learning
Peer Support
Professionalism
Questioning - Responses to
Responsibilities of Students
Relationships - School and Ward Staff
Relationships - Students and Ward Staff
Relationships - Tutors and Students
Service Reliance on Students
Sisters Teaching
Shortage of Tutorial Staff
School of Nursing
Socialisation Processes
Theory Practice Mismatch
Training for Teaching - Sisters
Time Spent with Student - Sisters
Task or Patient Orientation
Tutors on Wards
University Education

Ward Atmosphere

Work of Student Nurses

Wastage

It is from the listings under these categories that analysis could take place with reference to the major philosophical issues in nurse education.

3.3.2 THE AIMS AND PURPOSES OF THE NURSING CURRICULA

In the earlier discussion it was decided that a philosophical analysis of education should consider what is being done (aims) and why it is being done (purposes). From the content analysis of the literature it was difficult to find a great deal of reference to the aims of nurse training. It was, however, evident that a great deal of emphasis is placed on the transmission and acquisition of propositional knowledge (Scott-Wright 1961, Menzies 1961, Revans 1964, Dodd 1973, Rick 1974, Fretwell 1982, Marson 1981, Clinton 1981). Taking Bloom's taxonomy of educational objectives (Bloom 1956, Karthwohl 1964, Simpson 1966) as a framework for analysis, it was obvious that very little reference was made, in the accounts of nurse learning, to aims relating to the psychomotor or attitude domains of Bloom's taxonomy. This suggested that 'know how' and personal development were valued less than propositional knowledge.

It was also evident from the syllabi and course designs given in Appendices IV and V, that the course was divided into classroom learning to achieve 'theoretical' outcomes and practical/work experience to achieve skill outcomes. The aims for practical/work were more often implicit rather than explicit. There was a great deal of time devoted to work

experience. Of the 156 weeks of training, 18 weeks were usually taken up by holiday and around 24 weeks allocated to study blocks. Over two thirds of the course was allocated to work experience (114 weeks) and this emphasis suggested an emphasis on skills learning. Skill learning objectives are, however, rarely mentioned and students are more likely to describe learning in terms of knowledge acquisition or information giving (Marson 1981).

There was also some indication that knowledge was selected for instrumental action rather than interpersonal or self awareness knowledge. There was sparse reference to the development of interpersonal or communication skills. Dodd (1973) says that there was a general feeling that interpersonal skills could not be taught. This can be taken to mean that they probably were not. With reference to critical thinking, there were a great number of references describing a reduction of many intellectual skills as a consequence of training. Decision making (Marson 1981, Menzies 1961, Dodd 1973), thinking (Abdel-al 1975, Dodd 1973), critical thinking (House 1977, Bolton 1981), problem solving (Crow 1980, Marson 1981, Alexander 1982), and creativity (Crow 1980, Fretwell 1982, Attree 1982) have all been reported to suffer as a result of training and there was no evidence to suggest that there were any positive attempts to develop these capabilities.

It seemed, from the abstracts, that nurse education has mainly attempted to transmit information and provide work experience in an effort to provide model operators rather than critical professional practitioners.

Turning to an analysis of the purposes of nurse education, there was ample evidence that the course of learning was generally justified in terms of providing a safe practitioner and a practitioner who provided a high quality service to the patient (Dodd 1973). Few nurses and indeed laymen could argue with this, yet there was a volume of evidence to suggest that training was neither patient centred nor designed to ensure benefit to the patient. This did not necessarily mean that student nurses did not work for and with patients, or that nurses did not develop helpful behaviours. The point was that it was uncertain that this was in any way due to the planned curriculum. Three concept categories gave some indication of the nature of the problem:-

- 1 Patients-detrimental effects
- 2 Task or patient orientation
- 3 Patient as part of learning

DETRIMENTAL EFFECTS ON PATIENTS

There were numerous instances of consequences detrimental to the patient which were related to the work of student nurses. Many researchers indicated that students had insufficient time to give to patients (Briggs 1972, Ricks 1974, Birch 1975, Melia 1981). Student nurses seemed to be too busy for the patients and they acknowledged that more time should be given to patients as a means of improving standards of care. There was some suggestion that patients were at times 'fobbed off' (Melia 1981).

A second problematic feature of nursing work was the routine. Routines have been reported as a disadvantage to patients (Pepper 1977) and can even

bring about neglectful behaviour (McGhee 1961). One aspect of routine was the widely reported tendency to organise work on a task completion basis rather than an individual patient care basis (Dodd 1973, Alexander 1982, Fretwell 1982, Gott 1982, Bendall 1975, Melia 1981, Clinton 1981).

If work was not patient orientated it is difficult to expect that learning based on such work should engender patient orientated behaviour. Indeed students had found it difficult to form relationships with patients. Students were often too unsettled to form relationships with patients (McGhee 1961) and relationships were described as impersonal (Abdel-al 1975). There was some evidence that this may in actual fact be encouraged by the hospital system in order to alleviate stress in nurses which the organisation would find difficult to deal with. The system was probably maintained to prevent anxiety by splitting the nurses' contact with patients (Menzies 1961).

The effects on the patient of the socialisation of nurses into this system have also been reported. Students have reported that they are unable to care for patients in the correct way (Pepper 1977). There has also been evidence of careless and sometimes dangerous practice when practice on wards differed from the taught methods. Two researchers have reported dangerous situations arising from the student nurses relationship with the sister. Pepper (1977) found that students were reluctant to point out a discrepancy to sister when it was obvious that the sister was making a mistake. The students would let her carry on. In essence students were so cautious that if they could not make the point in a subtle enough way they did not make it at all. Another dangerous consequence was the uncertainty that sister's plan of action would be carried out in the way that she

required. Melia (1981) suggested that nursing, at the patient level, may not always be happening according to sister's directives. The Briggs Report had suggested that practical training dampens the trainees enthusiasm to get to know their patients. Melia (1981) quotes students who say that often they do not know enough about the patient to judge how they should make verbal responses to some of the patients enquiries. There was also evidence that the training discouraged involvement with patients. Dodd (1973) described a 'behavioural and non-involvement philosophy' and Pepper (1977) found that getting involved with patients was frequently deprecated. This could be an even more profound finding when one considers that Hargreaves (1976) found that student responses to patients expressed feelings, in a test situation, were commonly either hurtful, irrelevant or prescriptive. Sometimes even angry responses were elicited. Others have reported that the socialisation of students into nurse/patient relationships seems to focus on the problem of patient control (Dodd 1973). Pepper (1977) pointed out that nurses and patients shared the feeling that they were subject to control and submission. When control is lost, students had to develop coping mechanisms and 'face saving' in dealing with the patients (Melia 1981). One author goes so far as to suggest that the students reproduced the hierarchical structure of the classroom in their care of patients (Clinton 1981). A consequence of this has been described as the non-participation of patients in their own care (Dodd 1973).

THE PATIENT AS A PART OF THE LEARNING PROCESS

A closely related category to that called detrimental effects to patients, was a category which questions whether the patient is the major referent in the educational process. Revans (1964) was one of the first to venture

the idea that patient care is a learning process for both the patient and the nurse. He did however observe that patients were not included in the 'learning of diagnosis or treatment'.

In 1955 the Manchester Regional Health Authority reported that student nurses spent only 55% of their time working with patients and only 12% of this working with patients as individuals.

The Briggs Report (1972) stated that there was often not enough emphasis on 'care' in nurse education. Dodd (1973) reported a total absence, in diary reports from students, of any evidence that could be interpreted as students' participation in the organisation of the patient care process. There was also evidence that patients were rarely included in 'teaching activities' on the ward. Only 3-5% of the teaching activities reported by students referred to patients, the social background of the patient or the patients feelings and reaction to illness (Fretwell 1980). Fretwell also found that the ideal learning environment was one in which the sister is patient orientated. The ominous point about this finding was that many of the sisters were not providing ideal learning environments. Melia (1981) found that students felt that they did not get enough training to speak to patients, and Gott (1982) observed that students, ward staff and nurse teachers did not recognise the value which patients attached to communication skill.

Not only is there some suggestion that students are not encouraged to learn about the patient, there is also evidence to suggest that this becomes more pronounced as training proceeds. Dodd (1973) reports that the relational component to the patient is highest in first year students but

skill/technical learning took the emphasis in the third year. Abdel-al (1975) reports that contact with the patient decreases as the student becomes more senior. Given that students provided most of the direct patient care (Abdel-al 1975) and senior staff engaged in management and administration (Nuffield 1973, Pepper 1977), it seemed that students were drawn away from patient contact as training progressed. Indeed the end result of training was administration and not nursing (Nuffield 1973). Fretwell (1980) supported this when she said that the socialisation process 'diverts from' patient care'. There was more support for this assertion in findings which suggested there was no change in the empathic functioning of students as a result of training (Hargreaves 1976). Training had no effect on death and bereavement as a cause of anxiety (Birch 1973) and trainees moved from a moral to an instrumental approach to care as training progressed (Dodd 1973). The effects of this on the nurses feelings was widely known and reported by Pepper (1977) who said that as nurses progress through training and working life they become 'hardened to some things'.

In conclusion it was plausible to consider that the assertion made by Dodd (1973) was a highly significant feature of nurse education. The patient did not define the situation and they were not a significant factor in the selection of the knowledge which was included in the nursing curriculum.

It seemed that there was a question mark over a most obvious purpose of basic nurse training which was the provision of an effective service to the patient.

There seemed little point in questioning other purposes of nurse education, if it was agreed that providing a service to the patient was not a primary

purpose. One could, however, examine some of the apparent end results of pre-registration preparation and consider whether they could be justified as useful purposes. Six categories enabled one to consider this issue.

- 1 Authority and rank
- 2 Change
- 3 Intellectual skills
- 4 Knowledge/theory bias
- 5 Professionalism
- 6 Service reliance on students.

The category on authority and rank had by far the largest listing for any category. Almost every paper abstracted mentioned the use and abuse of authority. A more involved discussion on this will be pursued later. At this point, however, the discussion will dwell on the proposition that nurses are socialised by a system of control to adopt behaviours which are designed to control patients and junior colleagues. In earlier studies it was frequently reported that trained staff inflicted petty, excessive and arbitrary authoritarianism (McGhee 1961, Huttly 1965, Birch 1975). It was found that learners abhorred this but registered nurses were reluctant to abandon strict discipline (Briggs 1972). Not only did clinical practitioners maintain a discipline which was unpopular with students, the teachers in the school of nursing also seemed to initiate and maintain a process of continuous control (Dodd 1973, Pomeranz 1973, Clinton 1981) the only difference appears to be that a different form of sanction was used by school staff, namely examinations and tests. Learners were frequently reported as adopting coping behaviours which mainly involved submission (Dodd 1973, Pepper 1977, Clinton 1981).

It has already been indicated that patients were subject to the effects of control as were students who were often seen to be in a similar situation to the patients.

It was a worry that student nurses were becoming the very qualified nurses who would eventually impose these same socialisation processes on subsequent student nurses. The maintenance of the control system seemed to have been a significant purpose of nurse education even though the conscious intent may be somewhat questionable.

A second category of analysis which cast some light on the purpose of nurse education related to change. Only one researcher referred to this. Abdel-al (1975) commented that the syllabus was static and slow to change compared to practice which was always changing and less restrained. A guarded inference could be that the curriculum was not designed to achieve change because it lagged behind practice on a day to day basis.

If patient care, self-direction and change were not obvious purposes of nurse education one was encouraged to consider if the purposes of nurse education were directed towards the personal development of students. Only one relevant category could be found in the abstracts which could shed any light on this. It was concerned with the development of intellectual faculties. There were frequent references to the lack of any effective development of some intellectual skills. Initiative, discretion and common sense were said to be destroyed (Briggs 1972, Abdel-al 1975). Critical thinking and thinking for oneself appeared to be either discouraged or not required of the student nurses (House 1977, Abdel-al 1975, Dodd 1973, Bolton [1981 not abstracted]). Crow (1980) found that creative ability

(divergent thinking) helped in problem solving for care planning but found that students on degree courses were more inclined to creative thinking than students on traditional courses. In spite of this Attree (1982) and Fretwell (1978) confirmed that creative thinking had no place in nurse training and that the ability for creative thinking declined as training progressed. Some authors considered that problem-solving was not an obvious feature of nurse training and it was not seen to be developed (Marson 1981, Alexander 1980). The same had been said about decision-making and judgement (Marson 1981, Menzies 1961, Dodd 1973, Abdel-al 1975). Whilst it seemed that these intellectual skills were being discouraged there was no evidence that the skills were being promoted. It was probable, as indicated by the concept category entitled knowledge/theory bias, that the planned curriculum spent quite a lot of time dealing with information transmission and the acquisition of knowledge at the lowest levels of Blooms taxonomy of educational objectives (Bloom 1956). The list of references to knowledge acquisition is notable because of the number of authors who commented on it (eg, Menzies 1961, Dodd 1973, Abdel-al 1975, Birch 1978, Fretwell 1978, Melia 1981, Alexander 1980, Clinton 1981). A more in depth discussion on bias in the selected forms of knowledge will be undertaken later, suffice it to say at this point that the transmission of fact, of propositional knowledge, was an obvious outcome of nurse education, and the conscious intention to do this was an obvious feature of the nursing curriculum.

A fourth category which provided further understanding of the purposes of nurse education was a small section on professionalism. In brief, the promotion of professionalism did not seem to occur even though there was evidence that the leaders of nursing constantly reinforced its value. In

most nurses there has been discovered a distinct lack of even a rudimentary professional awareness of nursing (Pepper 1977). It was evident, however, that there was an academic elite who promoted professional ideology, whereas those in the clinical setting subscribed to an occupational identity (Melia 1980, Clinton 1981, Gott 1982). The professionalisation of nursing seemed to be a purpose of nurse education which was valued by the leaders of nursing and the academic elite, but not by the majority of practitioners. Finally, there was a category entitled 'service reliance on students', and this suggested that one of the purposes of nurse education was to maintain a cheap but safe workforce. Hospitals have been shown in the past to be maintaining as many as 2/3 of the workforce in the form of student nurses (McGhee 1961, Menzies 1961, Lelean 1973). In more recent times it has been demonstrated that there are still instances of students making up 50% of the workforce in hospital wards (Pembrey 1980).

To summarise, it was tentatively argued that the purpose of nurse education had been to provide a controlled workforce which was armed with the propositional knowledge related to their work. The learning process did not seem to be directed towards the provision of a caring service for the patient, or the production of nurses with the intellectual skills (eg decision-making, problem-solving, creativity and empathic understanding) and attitudes required to achieve this.

3.3.3 THE NATURE OF TEACHER/STUDENT RELATIONSHIPS

In order to determine the nature of teacher/student relationships, it was decided to consider two questions when analysing the literature.

(i) Which 'view of man' was most evident in the learning process?

(ii) How educative were the teaching relationships?

WHICH 'VIEW OF MAN' WAS MOST EVIDENT?

Four category listings enabled one to consider this question, they were:-

- i Authority and rank
- ii Curriculum quality and effects
- iii Individuality
- iv Questioning.

Listings related to authoritarian control provided evidence that there was a great deal of emphasis on the regulation of the student nurses' behaviour. McGhee (1961) and Birch (1975) had described the occurrence of public reprimand as a method by which sisters exerted control over student nurses. The punitive effects of this were described by the learners themselves.

Externally imposed discipline seemed to be a long standing tradition in nursing (Bevington 1948, MacGuire 1961). Dodd (1973) reported that in one of the two hospitals under study, the emphasis in training fell on behaviour and knowing your place rather than on skill or knowledge. The process of continuous control was also obvious in the school of nursing and was thus being maintained by the nurse teachers (Pomeranz 1973, Dodd 1973). Student nurses commented that 'tutors preach responsibility but are always breathing down your neck'. The authority utilised in the hospital was seen

as power and inculcated an 'inordinate sense of being controlled'. Dodd also made the point that this control was actually justified in terms of patient care, ie, discipline leads to efficiency. Sisters often made comments which were found to describe the student nurses' progress in terms of her ability to conform. They made no differentiation between 'doing as you're told' and 'progressing as a nurse'. According to Dodd, trainees were given their place and told how to behave in the structure, 'Authority was not negotiable'. Behaviour patterns were delineated by unquestioning obedience and courtesy'. Birch (1975), Pepper (1977) and Melia (1981) confirmed that authoritarianism and the obedience ethic still existed.

Other research suggested that students found this a hindrance and a constraint. The ward sister's 'approachability' had been reported as a desirable feature of better learning environments (Ogier 1979, Fretwell 1978). Marson (1981) argued that good teachers tend more to the participative pole of a communication dichotomy but found that most sisters and staff nurses lean heavily towards the autocratic pole. The autocratic pole is characterised by lots of telling and very little asking.

Other category listings demonstrated that external response was very much a preoccupation of pre-registration preparation. The importance placed on ritualism and routine was obvious. Skills were taught in the form of ritual procedures (Dodd 1973). Attree (1982) has suggested that the socialisation process, behaviourist learning principles, teacher dominated methods, exams and assessments were the main cause of reduction in student nurse creativity as training proceeded. A disregard for the uniqueness or individuality of the nurse is frequently quoted as a dissatisfaction amongst student nurses. They report not being treated like human beings

(Hutty 1965, Briggs 1972, Dodd 1973) or as individuals (MacGuire 1969, Bevington 1948, Orton 1979). Relationships between the teachers and student nurses were often described as impersonal (Dodd 1973, Birch 1975). Marson (1981) has reported a general insensitivity to the student nurses' needs, although 'showing interest in the learner' is a characteristic of a good ward learning climate.

It became obvious that 'growth' had not been encouraged because of the frequently reported response of trained staff to student nurse questioning. Responses to questioning from student nurses had generally been negative (Revans 1964, Briggs 1972). Dodd had described how questioning behaviour lasted only a few weeks on the first ward allocation before it was largely extinguished. Fretwell (1978) described how student nurses were afraid to ask consultant medical practitioners any questions. Dodd (1973) concluded that questioning and the pursuit of knowledge were not evidenced. Earlier research also confirmed that nurse education emphasised knowledge of facts and techniques rather than personal professional growth (Menzies 1961).

The evidence suggested that conformity, behaviour modification and external regulation were the order of the day and uniqueness, personal growth and development of intrinsic potential were not. The mechanistic 'view of man' was most evident and one was drawn to conclude that this was the commonest 'view of man' which the student nurse was exposed to. The discussion here has a very obvious bias in highlighting the mechanistic approach. This is, however, justified because any reference to characteristics of an 'organic view' were patently difficult to find.

HOW EDUCATIVE WERE THE TEACHING RELATIONSHIPS?

It is important for this discussion to make a distinction between the concepts educational and educative. The term educative, in the sense that it is used here can be applied to both training and educational approaches. For something to be educative it must meet two criteria. Firstly, teaching should be intentional, that is, the teacher must be definite about what learning is to be achieved and what she will do to enable the student to achieve it. Secondly, the learner must recognise that the learning opportunity exists and be an active participant in the process.

The literature analysis suggested that a lot of learning, even that which was desirable, was unintentional or brought about by accident. The reasons for this assertion could be supported by category listings entitled:-

- i Formal teaching on wards
- ii Best teachers on wards
- iii Training to teach - Sisters
- iv Grades of teacher
- v Curriculum quality and effects
- vi Practice without training
- vii Work of student nurses.

There seemed to be little doubt that learning in the school of nursing was an intentional activity. This occurred in only 24 weeks out of the 138 weeks of the pre-registration preparation programme. The majority (114 weeks) was spent in the varying forms of clinical experience. It was

probable that the time spent in clinical activity had the most profound influence on the student nurses' learning. Given that it has been established that theory (propositional knowledge) did not appear to be compatible with practical learning, one could work on the assumption that clinical experience was the major influence on the acquisition of practical knowledge. The literature abstracts gave confirmation that practical experience was most influential. Alexander (1980) said that 80% of student time was spent in the relatively unstructured environment of the workplace. It was also implied, in the National Syllabus and the abstracted papers, that practical experience is a valid and important learning experience. Students also reported that the clinical experience was of most significance to them in their learning (Briggs 1972, Lamond 1974, Pepper 1977, Alexander 1980). There was some evidence to suggest, however, that intentionality was lacking in that part of the curriculum related to practical experience. There were many references to the fact that learning in the clinical situation was poorly organised. It was found time and time again that the nurse tutors, who had been trained and who were supposedly most experienced in the principles of teaching, rarely visited the practical setting. Indeed the appearance of tutors on wards elicited consternation in both students and qualified practitioners alike (Dodd 1973). In the clinical setting tutors were invariably rated low on rankings of preferred teachers (Lamond 1974, Ricks 1975, Bendall 1975). There was some suggestion that tutors had visited wards more frequently in latter years, but as many as 80% of students confirmed that they had never received supervision from a nurse tutor (Alexander 1980). One could surmise that on those occasions when it was reported that tutors visited wards fairly often they did not teach on these visits. It had been reported that student nurses frequently said that they had learned most

from their peers and senior students (Bendal 1975, Lamond 1974, Ricks 1974). This was a worrying finding in terms of intentionality and the educativeness of the curriculum. It elicited more concern when one considered the many reports that the qualified nurses, who were most available to teach in the clinical setting, had rarely been given any formal preparation for their role as teachers (Revans 1964, Huty 1965, Briggs 1972, Fretwell 1980, Birch 1978). Even taking account of this inadequacy, student nurses still perceived them to be significant teachers. They had often been found to comment that sister and staff nurse are the most appropriate teachers in the practical setting (Bendall 1975, Marson 1981, Alexander 1981).

There was, however, some evidence of organised learning in the practical setting when clinical teachers were regular visitors to wards (Pembrey 1980). They seemed to combine the legitimacy of the clinical practitioner with the training and skill of a teacher. The deployment of clinical teachers in this way was uncommon and it was apparent that a large majority of the learning was under the control of individuals who had not been prepared for teaching. It was difficult to believe that teaching in this setting had any respectable degree of intentionality. Whilst this did not seem to be true of learning in the school of nursing, there was evidence that the quality of learning here was also questionable.

Dodd (1973) reported that preliminary training was unstimulating and exhausting, and presentation in school was not up to standard. Some tutors had limited ability to make the materials understandable. There was evidence that there was too much material presented in study blocks thus militating against student retention (Abdel-al 1975, Birch 1975). Gott

(1982) observed that students were rarely allowed to give feedback and did not provide an input in classroom teaching. There was also some indication that what tutors believed had been taught was not borne out by students' perceptions of what they had learned (eg, coping with death and bereavement, Birch 1978). Birch had also suggested that the curriculum was guided by subject matter rather than educational aims or objectives.

Two other features of pre-registration learning seemed to indicate that learning was, at times, haphazard. One was that there had been frequent reports of learners carrying out procedures on wards without having been taught how to do them (McGhee 1961, Ricks 1974, Birch 1975, Birch 1978). The second concerned the nature of student nurses' work. Work on the wards had been described as unstimulating, repetitive and boring (Menzies 1961, Ministry of Health 1947, Melia 1981, Marson 1981). Much of it did not contribute to the learning of nursing skills (Oppenheim and Eeman 1955, Ministry of Health 1947, Dodd 1973). It was obvious that the emphasis was on getting the work done and rarely on learning (Pepper 1977, Dodd 1973, Orton 1979). Student nurses are utilised as workers rather than learners (Melia 1981, Fretwell 1978).

The evidence enabled one to conclude that clinical experience was badly organised in terms of learning and that there was also a question mark over the quality of organised learning in the school of nursing. Both reflected the amount of intentionality in the learning process and thus cast aspersions on the 'educativeness' of the nursing curriculum.

The second element of 'educativeness' related to the recognition by both the student nurses and their superiors of the existence of their

teacher/student roles in the recognised learning settings. When learning is said to be going on does the supposed teacher recognise that it is happening and does the learner recognise that she is expected to be learning? Teachers can believe that they are teaching but learners may not recognise this. Similarly learners may want to learn but the supposed teacher may not recognise this or respond to it. There was evidence in the abstracts to suggest that this had been going on. It has already been said that students did not confirm what their tutors say they had been taught. Clinton (1981) had concluded that there was much more emphasis on what was taught than on what students learn. A number of literature analysis categories provided evidence of the quality of teacher/student relationships in nursing.

- i Relationships - students with tutors
- ii Relationships - students with senior staff
- iii Questioning response
- iv Communication on ward
- v Peer support
- vi Time spent with students - sisters
- vii Individuality - recognition of
- viii Formal teaching on wards
- ix Best teachers.

Some of the most interesting findings related to relationships between student nurses and their qualified teachers in the school of nursing. There had been suggestions that there were weaknesses in this relationship. Dodd (1973) found that tutors descriptions of their role hardly ever mentioned the students. The absence of the students in descriptions of

their role was an ominous sign. It seemed that one element of educativeness was that both partners should form some sort of rapport or meaningful relationship in addition to perceiving their own role image. There was some suggestion that tutors had not always formed any meaningful relationship with their students. Abdel-al (1975) commented that relationships between tutors and students were basically functional and impersonal. Birch (1975) put it more strongly when he said that students were scathing in their comments on their nurse tutors and their personal relationships with them. It seemed obvious, particularly from Dodds' research (1973) and from other abstracted papers, that nurse tutor relationships had been fairly superficial. Tutors seemed to be dealing in ideals, firm in the conviction that they were carrying out a valid and relevant job in a close relationship with the student, yet students seemed to be maintaining a pretence, giving the school and the tutors what they wanted in order to survive with a minimum of stress.

These problems were thought to be of minimal significance if it was true that the clinical area was most influential in socialising the nurse into the practitioner role. This being so, it was of greater relevance to consider the teaching relationship in this setting. It has been said that qualified staff in clinical areas received little or no training to teach. It is difficult to see, in these conditions, how they could meet their role obligations in the relationship. It was possible to argue, however, that clinical practitioners could be capable of forming helpful and meaningful relationships with the students in spite of this. Unfortunately the evidence did not support any suggestion that this was the norm in nurse education. There were reports of the unapproachability of qualified staff and fear of the sister (Revans 1964, Fretwell 1978). Many students

expressed dissatisfaction with interpersonal relationships on wards (MacGuire 1961, Briggs 1972, Abdel-al 1975, Birch 1975, Fretwell 1978).

A similar phenomenon to that observed in relationships with nurses tutors was also described in relationships between sisters and students. It related to the dissonance between the teachers' and students' definition of the situation. Sisters had reported that students were 'alright' and quite happy with their training. The comments of student nurses in their charge suggested otherwise (Dodd 1973). Indeed poor staff relationships have been given most frequently as the reason for discontinuing work and training (Birch 1975).

On poor training wards the relationships seemed to take on more significance to the students. On these wards staff invariably stayed 'in the office' or remained aloof (Fretwell 1978). There was evidence in the literature abstracts which suggested that relationship problems were the main reason students gave for disliking a ward. There were also reports that nurse practitioner responses to student nurse questioning had been generally unfavourable (Revans 1964, Briggs 1972, Dodd 1973, Fretwell 1978). This suggested that the potential teachers in the ward setting did not respond well to their teaching role. Some researchers argued that students were deprived of information. Melia (1981), had described this as 'nursing in the dark'. Communication with students had certainly been found wanting (Lelean 1973, Ricks 1974, Roper 1976, Orton 1979). Indeed it was difficult to see how communication could be easily achieved when it had been observed that sisters and staff nurses spent very little time with student nurses, particularly those in the first year of training (Revans 1964, Nuffield 1953, Lelean 1973). Orton (1979) and Ogier (1980) had

shown that, on low student orientated wards where sisters were less highly rated as teachers, the sisters spend only a small proportion of their time with student nurses. Fretwell (1978) indicated that "some sisters hardly came onto the wards and were office sisters". Marson (1980) had commented on the lack of communication between trainees and sisters. In such conditions one might expect that student nurses learn from other people. Staff nurses were an obvious choice and there was evidence that they did help students to learn. There were references which suggested, however, that the person most likely to help, both with learning and emotional problems, was a fellow student. Peers were reported as highly significant people in these situations (Revans 1964, MacGuire 1961, Nuffield 1953, Dodd 1973, Orton 1979, Alexander 1980).

It seemed that sisters, and to some extent all qualified practitioners, spent very little time in forming any useful relationships with students. It also seemed that close rapport was rarely achieved, given the widely reported phenomenon that students felt that they were not treated as individuals or as human beings (MacGuire 1969, Hatty 1965, Bevington 1948, Briggs 1972, Dodd 1973, Abdel-al 1975, Birch 1975, Orton 1979, Marson 1981).

This was more significant when one considered that students did not see sisters or tutors as relevant in helping them with their emotional problems (Dodd 1973, Ricks 1975, Marson 1981). They were more likely to approach peers, parents, friends and occupational health staff.

The evidence in the literature suggested that the pre-registration preparation of nurses was not educative. This assertion was made on the

grounds that teachers were not sensitive to the needs of learners, that students did not actively contribute to their learning, that a majority of learning was accidental or unintentional and that relationships between teachers, in academic and clinical settings, were often formal and superficial. For these reasons it was concluded that the pre-registration preparation of nurses was not educative.

3.3.4 WHAT KNOWLEDGE IS SELECTED FOR THE NURSING CURRICULUM?

It was thought useful to consider how closely the knowledge utilised in nursing was related to day to day nursing activity. Much of the evidence from the listings suggested that it was not. Dodd found that there was a pre-occupation with the acquisition of knowledge as an end in itself. The knowledge in the curriculum was found to serve a purpose which was not related to patient care. In the view of the students, knowledge was for passing examinations, and clinical experience was for patient care. Indeed Dodd found that the knowledge required for practical nursing lay outside of the nationally prescribed syllabus. Dodd also found that knowledge was biased towards physical sciences and this suggests that the nursing body of knowledge may be limited to Habermas's instrumental action. Abdel-al had also found that the syllabus was biased towards biological sciences. She also found that non-nursing subjects held more prestige than nursing theory both in the clinical areas and school setting. Melia demonstrated this by relating one student nurse's comments.

"We get psychology lectures but nothing really on how to just sit down and speak to somebody".

Clinton (1981) made the most pointed observations. He found that the teaching styles utilised in nurse education mirror the 'teaching as fact' approach to learning subjects for examination. He also suggested that the training system polarised theoretical knowledge and experiential knowledge. There was, therefore, some tentative support for the assertion that the knowledge in the nursing curriculum was dealt with in the form of 'necessary truths' rather than in the form of information arising from and relevant to nursing activity. There was an additional factor which related to the typical forms of knowledge found in the curriculum. Moore distinguished between two forms of knowledge, 'knowing that' (propositional or theoretical knowledge) and 'knowing how'.

There was strong support in the literature review that 'knowing how' was more relevant to nursing but that 'knowing that' was the form of knowledge which is emphasised.

It could be shown that technical/rational knowledge was emphasised in the nursing curriculum in deference to practical knowledge (Menzies 1961, Revans 1964, Melia 1981).

It was also apparent that theoretical and practical knowledge served different purposes. Theory was for passing exams, practical experience was for patient care (Dodd 1973).

In addition to this it was apparent that 'knowing that' was the work of the school and its staff and 'know how' was the work of the wards and the ward staff (Dodd 1973, Clinton 1981). These polarisations of theoretical and practical knowledge are further exacerbated by the lack of 'cross

fertilisation' between the school staff and the practitioners. Rarely had they been seen to enter each others domains and both dealt in different knowledge forms. It was well established that school staff rarely visited wards and even more rarely taught on them (Nuffield 1953, Dodd 1973, Lamond 1974, Bendall 1975, Pepper 1977, Alexander 1980, Kershaw 1978, Gott 1982). A number of the abstracts confirmed the lack of shared activity, in that relationships between school staff and practitioners were poor (Revan 1964, Huty 1965, Dodd 1973, Alexander 1980).

One of the most productive concept listings derived from the abstracts was that entitled 'theory and relevance to practice'. There was here strong support for the idea that theory did not promote practical knowledge. One consistent feature was that what was taught, in the school of nursing, was not practiced in the clinical setting (Revans 1964, MacGuire 1969, Crichton and Crawford 1966, Briggs 1972, Pomeranz 1973, Dodd 1973, Ricks 1975, Abdel-al 1975, Birch 1975, Pepper 1977, Birch 1978, Alexander 1980, Clinton 1981, Gott 1982). There was evidence that clinical practice could deviate markedly from the taught methods, sometimes dangerously so (Hunt 1974). Pomeranz (1973) and Abdel-al (1975) argued that one of the causes was that theory and the relevant practice were not related in time. In addition Abdel-al found that the school staff were in control of theory but the nursing service managers controlled the ward allocation.

Alexander (1980), Abdel-al (1975) and Clinton (1981) argued that the problem was due to the lack of the representation of reality in teaching. In other words the 'knowing that' (theory) area of the curriculum was only loosely related to the 'know how' (skill) aspects of the curriculum. Only one third (35%) of nurses sampled by Bendall (1975) reported that theory

helps or sometimes helps ward work. The majority of tutors (81%) in this study admitted that their job was to teach principle rather than detail and 18% said they must teach what is right whatever it costs. There was some contradiction found in the work of Orton (1979). There was 72% disagreement from subjects that theory learnt in school was only really useful for passing exams, yet 90% agreed that tutors tended to teach an idealised version of hospital work. Marson (1981) reported that only 20% of students said that procedures should be practiced as taught in school. There was ample evidence here to suggest that:-

- a The two forms of knowledge (propositional and practical) were not always complementary.
- b The propositional knowledge was not utilised to enhance practice.

It could be argued that propositional knowledge was valued and emphasised more obviously than practical knowledge (Dodd 1973, Menzies 1961, Revans 1964, Abdel-al 1975, Fretwell 1978, Marson 1981). Dodd demonstrated this in many ways but the divisions which she found inside the school of nursing provided the best example of the knowledge split. The school of nursing staff were found to be divided into two sub-groups with different orientations roughly described as academic and clinical. Both were described as polarised and in no way complimentary.

"In the minds of the academics - it was a mark of stupidity to be clinically minded".

There was also some suggestion that the knowledge promulgated by the school of nursing was too simplistic to be of use in clinical practice (Abdel-al 1975, Roper 1976).

In summary, it can be concluded that there was evidence to suggest that there was too much emphasis on forms of knowledge which were irrelevant to the promotion of clinical practice and scant attention paid to the forms of knowledge which produce an adequate nurse practitioner.

3.3.5 IS 'LEARNING TO NURSE' AN EDUCATION OR A TRAINING?

It could be said that learning to nurse follows a training approach because it has been called such since the inception of modern British nursing from the times of Florence Nightingale and Ethel Bedford Fenwick. The General Nursing Councils, since their inauguration in 1919, have used the term 'training' to describe pre-registration preparation and never 'education'. There were many indications that even from the earliest times the training paradigm was the common in nursing pre-registration curricula.

In the Florence Nightingale biography, Cook (1914) described the inauguration of the Nightingale School at St. Thomas' Hospital in the following way:-

"In May 1860, advertisements were inserted in the public press inviting candidates for admission, and on June 24 fifteen probationers were admitted for a year's training. Thus on a modest scale, but with a vast amount of forethought, was launched the scheme which was destined to found the modern art and practice of nursing".

(Cook 1914)

In describing the aims of the training course he related the two essential principles of the course:-

- i. That nurses should have their technical training in hospitals specially organised for the purpose.
- ii That they should live in a home fit to form their moral life and discipline.

(Cook 1914)

It is worthy of note that Miss Nightingale's formative experience was with religious orders and the military. The ethic of obedience was obvious and its origin equally obvious.

"The pupils served as assistant nurses in the wards, receiving instruction from the sisters and the resident medical officer. Other members of the medical staff gave them lectures; and there was a formidable "Monthly Sheet of Personal Character and Acquirements" to be filled up by the matron for each nurse. The moral record was under five heads: punctuality, quietness, trustworthiness, personal neatness and cleanliness, and ward management (or order). The Technical Record was under fourteen main heads, some of them with as many as ten to twelve subheads. "Observation of the Sick" was especially detailed".

(Cook 1914)

Miss Nightingale was an enormous influence on this early training and the climate of early nurse training was suggested in some of her comments on "what it is to be in charge" in her 'notes on nursing'.

'It is often said that there are few good servants now', I say there are few good mistresses now. As the jury seems to have thought the tap was in charge of the ships

safety, so mistresses now seem to think the house is in charge of itself. They neither know how to give orders; nor how to teach their servants to obey orders, ie to obey intelligently, which is the real meaning of discipline.

(Nightingale 1859)

It is evident from these quotations that nursing has always had training aims and those aims which seem to appeal more to an education (eg, moral development) are dealt with by means which are more in the idiom of training. The history of nursing seems to confirm the training emphasis.

If one examines the six major national reports on nurse education through this century one can notice that the earliest tend more to use the word training (Lancet 1932, Athlone 1939) and the more recent show an increase in the use of the term education (Horder 1943, Working Party 1947, Platt 1944, Briggs 1972). The latter is always used in tandem with references to nurse learning as training. Another frequent finding even as early as the Lancet Report in 1932 is the use of the term profession. It almost seems that for some fifty years nursing leaders have striven for professional status and that an education seems an essential prerequisite which has been difficult to achieve. The Briggs Report frequently mentions findings and recommendations which point to the lack of educational principle in the nurse learning environment.

The variable use of the terms education and training may have been a product of ill defined semantic categories. Closer exploration was thought necessary to ascertain whether this confusion in terms was due to a partial transition from a training to an educational paradigm. The pressure for

change was demonstrated by a quotation from one researcher in the very same year that the Briggs Report urged for an educational approach:

"There still exists among some nurses the idea that the main purpose of nurse training is simply to produce a 'good practical nurse' in terms of technical efficiency, that such practical ability is incompatible with administrative ability, and that academic qualifications are irrelevant".

(Lancaster 1972)

What then did the content analysis of the abstracts suggest about educational and training approaches in nurse curricula. The following concept listings allowed an analysis of this issue.

- i Better students
- ii Intellectual skills
- iii Effects of training in total
- iv Professionalism
- v Questioning responses
- vi Service reliance on students
- vii Task orientation not patient
- viii University education
- ix Work of student nursing
- x Curriculum quality and effects

One finding which suggested that nursing was more of a training than an education was that 'better students' have been found to withdraw from training, (Menzies 1961, Briggs 1972, Birch 1973). Birch found that students with high measured IQ tended to withdraw and Hatty (1965) found that more able students find the curriculum boring. Briggs, however,

commented that bright students do less well in some nursing schools than others. There were many references to a lack of stimulation in nursing courses. Briggs (1972) suggested that the early part of the training course was not stimulating but very exhausting. House (1977) described training as an obstacle race. Lack of stimulation was also confirmed as an element in the student nurses' practical experience (Menzies 1961, Ministry of Health 1947, Oppenheim and Eeman 1955, Melia 1981, Marson 1981).

The fact that the course was boring and unstimulating suggested that a training paradigm was operating. The tradition that students must learn whilst they work also suggested a training paradigm. The evidence showed that students had been treated as workhorses rather than learners (Dodd 1973, Abdel-al 1975, Fretwell 1980, Melia 1981). This was borne out by the service reliance on students as the major part of the workforce (McGhee 1961, Menzies 1961, Nuffield 1953, Lalean 1973, Pepper 1977, Pembrey 1980). At its best Abdel-al said learners were treated as employees on the ward and as students in the school of nursing. Fretwell sums up the effect of the workplace by demonstrating the safety of 'social ritual' and technical skill, learning which essentially produces working without thinking. Other authors argued that nursing work was task orientated rather than patient orientated (Alexander 1981, Dodd 1973, Fretwell 1980, Gott 1982, Bendall 1975, Clinton 1981). It followed that the student nurses' learning was based on task completion. Others confirmed this picture by saying that student nurses were not encouraged to use their brains (Orton 1979). Dodd even indicated that the course which she observed did not encourage thinking and students even seemed to be glad to be out of the 'formal education system'. Alexander (1980) went even further in reporting that very little study was done outside of block,

students disliked methods which involved independent organisation and initiation and responsibility for their own study. Teaching methods may contribute towards this

"The socialisation process, behaviourist learning principles, teacher dominated methods, exams and assessments cause a reduction in creativity".

(Attree 1982)

Some researchers reported that the general approach to teaching was to see it as a regeneration process (Fretwell 1980) by which the knowledge and skills possessed by the teachers was passed on to the neophyte almost as a matter of fact and probably without question (Revans 1964, Briggs 1972, Fretwell 1980). These findings painted a picture of learning as task centred, thoughtless and non-academic. It was difficult to believe that an educational paradigm was in operation here. Teacher/student relationships in the learning setting also seemed to demonstrate a training emphasis. There was evidence that conformity, obedience and control had been a constant pre-occupation of those participating in the teaching of student nurses in the hospital setting. Other reports discredit an educational approach because some intellectual faculties seem to have been suppressed. The nursing curriculum has been shown to subdue decision making (Menzies 1961, Dodd 1973, Marson 1981), initiative (Briggs 1972), independent critical thought (Abdel-al 1975, House 1977, Bolton 1981, Fretwell 1980), creative problem solving (Crow 1980, Marson 1981, Attree 1982, Alexander 1980) and empathic functioning (Hargreaves 1976).

The attitudes of nurse practitioners seemed also to confirm that a training paradigm existed. There was evidence that nurse practitioners were very wary of intellectualism. Anti-academia, as it has been called, has been

reported by Lancaster (1972) and Dodd (1973). The gap between a professionalising elite and 'mainstream' clinicians has been hypothesised and it has been mooted that suspicion of academia may rest in its use by the leadership to achieve control of mainstream practitioners (Melia 1981, Pepper 1977). Clinton (1981) suggested that there was a professional ideology which was an important constituent of the classroom and an occupational identity which was the important constituent of ward work. There is here some indication that educational principles were not valued by practitioners, if 'academia' and 'educational principles' could be accepted as synonymous concept.

Another indicator which suggested that a training paradigm existed was the general reluctance for nurses to accept higher and university education as a means of pre-registration preparation and teacher training (Lancaster 1972, Pepper 1977, Dodd 1973, Bendall 1973).

The historical evidence and the literature abstracts suggested that the pre-registration preparation of nurses has largely subsumed to a training paradigm. The training paradigm was seen to be characterised by a concern for behavioural control and the specificity of the learning to a particular task or job. The production of a model operator is the main concern. Education, it could be argued, is additionally concerned with understanding and elegance of thinking. The knowledge, skills and attitudes acquired are likely to be applicable to a variety of life situations.

The evidence suggested that nursing courses were unstimulating. The learning was directed towards the acquisition of nursing behaviours. There

was a general climate of 'anti-academia', bright students did not survive and intellectual faculties were suppressed. It was difficult to accept that an educational paradigm was operating in such a setting.

3.4 CONCLUSIONS ON THE ANALYSIS OF LITERATURE ABSTRACTS

The literature analysis encouraged one to accept the following conclusions:

- i There was an over emphasis on the acquisition of propositional knowledge and less emphasis on 'know how' or personal development in the nursing curriculum.
- ii There was an emphasis on forms of knowledge which were relevant to instrumental action and little evidence of knowledge related to interpersonal relating and self-awareness.
- iii Nursing curricula did not include the patient in the learning process.
- iv The patient was not the central or major referent in the learning process.
- v Nursing curricula seemed to pursue purposes other than patient care
 - eg a control of patients and junior colleagues
 - b work completion without thinking or creativity
 - c provision of a cheap but safe workforce.

- vi Nursing curricula aspired to the promotion of professionalism but this is not always valued by practitioners.
- vii The curriculum was based on mechanistic principles. The 'view of man' was mechanistic and the organisation in which learning occurs was mechanistically structured.
- viii Knowledge was divided by student nurses into two types, one for passing exams and the other for helping patients. Much of the former had no relevance to the latter.
- ix Nursing curricula were not educative. Much of the relevant learning occurred in a situation where teaching was unintentional and student initiated.
- x There was a lack of rapport between students and their teachers (school and ward staff). Relationships being superficial, transient, functional and impersonal.
- xi The student nurse's work takes precedence over her study.
- xii Learning to nurse subsumes to a training rather than an educational paradigm.
- xiii An educational approach is valued more by schools of nursing and the leaders of nursing and the training approach is valued by the clinical practitioners and nurse managers.

3.5 SUMMARY

The literature analysis indicated that the pre-registration preparation of nurses was not an educational experience. The outcomes of learning were not compatible with the purpose of producing a critical thinker who was capable of making decisions in the best interests of the patient. The extant forms of knowledge were propositional knowledge - particularly the sciences which were directed toward instrumental action. Forms of knowledge which developed know-how, interpersonal skill and self-awareness were less evident or absent. The roles of teacher and student operated around a mechanistic view of man, the teacher was the font of all knowledge and the student a passive recipient of that which was given. The nature of relationships between nurse teachers (school and clinical staff) and student nurses did not seem conducive to the development of personal growth or interpersonal sharing. The pre-registration preparation of nurses up to the 1980's subsumed to a training paradigm and many elements of the learning process indicated that the curriculum was not educative.

The overall picture suggested that student nurses were not developed to be men and women capable of doing new things. The purposes of curricula were not suited to the development of critical thinking, the forms of knowledge did not emphasise interpersonal or technical 'know-how' and the nature of teacher/student roles were not conducive to the development of person centred practitioners.

CHAPTER 4

THE DEVELOPMENT OF A THEORY

4.1 INTRODUCTION

The findings of the literature analysis provided some confirmation that pre-registration preparation was not an educational experience and that this was not conducive to the development of a critical independent practitioner. It was uncertain that this was still true in the 1980's, and it was decided to undertake additional empirical study in an attempt to confirm or refute the conclusions derived from the literature analysis. This was found to be a process of theory generation and it was decided to assess the literature analysis as a method for generating theory. A number of nurse researchers had adopted grounded theory strategies for the generation of theory (e.g. Melia 1981) and it was these which provided the basic methodological framework for the second part of this study.

4.2 GROUNDING THEORY STRATEGIES FOR QUALITATIVE RESEARCH

The main objective of a deeper study of the concept of 'grounded theory' was to ascertain how far the conclusions drawn from the content analysis of the literature could be said to be worthwhile theories. Could I have sufficient confidence in these conclusions to formulate hypotheses about the situation and perhaps go on to test these hypotheses?

The work of Glaser and Strauss proved particularly relevant to the preparatory work for this study, in that it was based in methods of

comparative analysis. It was apparent that the structured approach to the analysis of the literature used comparison as a basis for understanding the data. It was of interest to find that Glaser and Strauss suggested that comparative analysis may be utilised for five purposes:

- a. PROVIDING ACCURATE EVIDENCE, to check out whether initial evidence is correct.
- b. IDENTIFYING EMPIRICAL GENERALISATIONS, to establish the generality of a fact.
- c. SPECIFYING A CONCEPT, or specifying a unit of analysis for a case study.
- d. VERIFICATION OF THEORY, evidence is used as a test of hypotheses and thereby the relevance of categories.
- e. GENERATING THEORY, the purposeful systematic generation of new theories from the data of social research.

(Glaser and Strauss 1973)

These definitions allowed the author to assess what had been achieved so far in the study, and what steps to take next. The former was accomplished by evaluating the literature analysis as a method of comparative analysis.

4.2.1 The Literature review as a method of Comparative Analysis

Using the definitions given above it became obvious that the literature

analysis, in this study, had some distinctive features of comparative analysis.

It seemed certain that comparisons had been made, in that different research reports had been compared. The work of different researchers had been analysed and the opinions of different groups had been compared (ie Sisters, Tutors, Student Nurses and Nurse Managers).

There was some suggestion that the literature analysis fulfilled the purpose of providing accurate evidence. Glaser and Strauss concisely describe this purpose in the following way:

"In discovering theory, one generates conceptual categories or their properties from evidence. Then the evidence from which the category emerged is used to illustrate the concept. The evidence may not necessarily be accurate beyond a doubt, but the concept is undoubtedly a relevant theoretical abstraction about what is going on in the area studied In short, the discovered theoretical category lives on until proved theoretically defunct for any class of data, while the life of the accurate evidence that indicated the category may be short".

(Glaser and Strauss 1973).

It was apparent that the analysis of the education literature had provided accurate evidence, and this was confirmed by the conclusions about the pre-registration preparation of nurses given at the end of the previous chapter. This was clearly significant for the development of this study. If it could be accepted that some accurate evidence had been accumulated,

then it was possible to move on to the generation and verification of theory. There was, however, little reason to suspect that the literature analysis had established the wider generality of single facts. At this stage establishing empirical generalisations did not seem to have been achieved or required. Similarly the specification of a concept does not seem to have been achieved either. An example given by Glaser and Strauss demonstrates that this purpose had not been developed with respect to the pre-registration preparation of nurses.

"Trow and Coleman compared the distinctive political nature of the I.T.U. (Union) with the characteristic political structure of other unions to establish their 'Deviant Case Study'".

(Glaser and Strauss 1973)

There was no evidence that the literature analysis attempted to compare one given unit (eg British nurse education) with other similar units (eg American, Australian, Canadian or European nurse education systems) in order to identify, 'Distinctive elements or the nature of the unit that is under study' (ie British nurse education system).

The fourth purpose of comparative analysis, which is that of verification of theory, seems at first sight, to be a more plausible function of the literature analysis. Given that no theory was explicitly stated it can be said that there was no evidence that verification was achieved. Glaser and Strauss, however, gave a different perspective on this when they said that 'Some analysts focus on verifying the new theory that emerges in their data'. From this perspective it seemed that emergent theory was being verified. Accepting that this was an appropriate strategy it seemed

possible to begin a verification study without the existence of a previously stated theory. It was not, however, possible to accept that verification had occurred in the case of the literature analysis because verification was not an explicit intention and a reliable strategy was not utilised specifically with the aim of verifying data as it emerged.

There was every possibility that this could have been occurring but it is more likely that generation of theory has been achieved and that this generation had adopted an element of verification as the analysis developed. The role of theory generation in the verification of theory is described by Glaser and Strauss in the following way:

"A touch of generation may be included, but the researcher's focus is on verifying, he generates theory only in the service of modifying his original theory as a result of the tests, and most of this work is done with existing theories".

(Glaser and Strauss (1973))

It is in this area of generating theory that one could be most confident that the literature search had served some purpose of comparative analysis. The most difficult thing to reconcile was that some of the virtues of theory generation, as described by Glaser and Strauss, seemed to be at odds with the conventional logico deductive model. These were best described by Glaser and Strauss in the following way.

"Generation by comparative analysis requires a multitude of carefully selected cases, but the pressure is not on the sociologist to 'know the field' or to have all the facts from a

careful random sample. His job is not to provide a perfect description of an area, but to develop a theory that accounts for much of the relevant behaviour".

(Glaser and Strauss (1973))

It was with these points in mind that the initial lack of confidence in the conclusions drawn from the literature analysis was alleviated. There still remained, however, the question of where to go next? If it could be accepted that generation of theory had taken place the next step could be seen to be the verification of some or all of these 'theories'. It was decided that data would be generated by a different approach, an approach which enabled one to answer the following major questions.

- i Has the world of vocational nurse training changed? Which aspects of the theory generated by work from the 1950's, 1960's and 1970's are still applicable in the 1980's?
- ii Does the literature analysis give an accurate picture of vocational nurse training processes?
- iii Does the literature reflect the most salient features of the process of vocational training?

In order to do this it was felt that the aim of further comparative analysis should be the production of accurate evidence and the verification of theory. The decision was made to check the conclusions of the literature search with an alternative data gathering procedure in order to check the substantive rather than the formal theories in question.

The method chosen was an opinion survey, utilising interview techniques. This method had been used by other researchers (eg Melia 1981, Fretwell 1980, Marson 1981) and would enable adequate comparisons to be made with previous work. The following section describes how data was elicited from student nurse opinions, so that comparisons could be made between conclusions derived from this survey and conclusions derived from the literature analysis.

CHAPTER 5
DEVELOPMENT OF
THE OPINION SURVEY

5.1 DEVELOPMENT OF THE METHOD

5.1.1 Introduction

Given that much of the data generated from the literature analysis was derived from empirical interpretation and that the product of the pre-registration learning process seemed to be the most accurate source of feedback; it was decided at this stage to attempt to look at the world of nurse education through the eyes of the student nurse. It also seemed an obvious choice because of the possible bias which this study may be taking. The biases related to researcher bias and the occupation of many researchers in this field (ie Nurse teachers). Given that the current field of study was education, it seemed that the source of most of the relevant data would be the student nurse's perception of her own learning. It was learning and not teaching which was the primary concern of this study. It is worth remembering that Moore (1982) had argued that teaching behaviour could exist in the absence of any relevant learning occurring in the student, and that students can learn in the absence of teaching behaviour. Bearing this in mind, it seemed that what they learn will be the source of the most useful data rather than what teaching is intended. By taking this approach, it seemed that curriculum deficiencies could be more easily observed where the dissonance between intent and product became most apparent.

An additional requirement for this stage of the study arose from a need to identify which were the most influential factors in the pre-registration preparation process. To this end it was felt that it would be most useful to explore the most significant features of the training process and those phenomena which had most impact on the student nurses.

The following description of the development of the opinion survey is given so that novice researchers may understand some of the practicalities of developing such a survey. There follows a relatively lengthy description of the preliminary interviews. This is given to provide the would-be researcher with case material which exposes the errors and problems that can be encountered by those who underestimate the complexity of the interview survey method. The description of the pilot study demonstrates how decisions were made for the fieldwork methodology.

5.1.2 The Preliminary Interviews

Having had some experience in selection interviewing and performance interviewing related to student nurse training, the author felt confident about his interviewing skill and decided to carry out some pilot interviews. These turned out to be exploratory interviews and the outcomes of these interviews proved quite fundamental in the development of the interview survey. It was decided that just a handful of students would be interviewed in order to get some 'feel' of the direction in which things would go. Given that the author felt that an 'open' approach was called for and that he had some skill in conducting such interviews he decided to go into these interviews in a relatively unstructured way.

5.1.3 The Sample

It was decided that four students would be selected for interview and the interviews would be audio taped without the students' knowledge. This was done in an attempt to minimise anxiety which could have caused some inhibition. The sample was chosen on the basis of those individuals who were easily available at the time. It had already been decided that those interviewed should hold a considerable stock of memories about the training process and should have had some varied experience of the clinical setting. This required more than one clinical experience and more than one attendance in block study. It was decided that students should have had at least one year experience of the course. Shortly after this decision was made a group of nurses in their 15th month of training were attending the School of Nursing for a two week study block. After discussion with their tutor it was decided that we would ask for volunteers to come and talk to the author during the block evaluation period. Alternatively, they could involve themselves in the already planned course activity of writing an essay on their opinions of the course to date. There were quite a number of volunteers but almost half of the group still preferred to write an essay (Group of 12). The author had known of the particular problems of collecting data from willing subjects and it was decided to choose two volunteers and also persuade two of those who did not volunteer to participate in the interviews.

5.1.4 Aims of the Interview

It was decided in a relatively arbitrary way that the aim of these interviews would be three fold. To:

- i Discover a questioning strategy - mainly to see if the author's interview skills would elicit relevant data.
- ii Practice the art of open-ended questioning and listening before the field work proper.
- iii Test the method - timing - selection - explanation to group and individuals - venue and recording of interviews.

5.1.5 Method

As the interviews drew near the lack of structure brought about some trepidation in the author because of the uncertainty of how things would proceed. To this end a list of 'areas for consideration' was drawn up as a guide to the formulation of open questions (See Appendix XII). This list was produced from an ad hoc recollection of subjects which may be relevant to the students in training. Questions were not formulated on this primitive interview profile and the stated areas were intended to guide the interviewer when attempting to maintain the pace of the interview. The guide would not be followed as listed but used as an aide memoire. Interviews were audio taped for analysis at a later date.

5.1.6 Results

The benefit of this exercise was not due to the sophistication of the research design but to the sheer volume of feedback obtained in this trial and error situation. The method used to analyse the audio tapes was simply to listen to them two or three times. This was sufficient to precipitate the following issues:

- i As the interviews progressed from subject one to subject four it became apparent that the flow improved and the interviewer seemed more at ease. It seemed that more than four pilot interviews should need to be undertaken to ensure that the interviewer settled into the method and achieved some consistency. The resulting confidence would enable the interviewee to relax.
- ii The introductory comments at the beginning of the interview demonstrated some useful points. The first was related to confidentiality and the second to the use to which the information would be put. The overall impression was that the reassurance was probably over done. There was an impression, given from the playback, that the safety of the interview was being overstated. When the dentist goes to the greatest extreme to point out that his treatment is not going to hurt, it very often does.

A second point about this introduction was that it did come across as very hesitant and disjointed. The most salient points did seem to come across but in a very unstructured way. The main functional points were:

- a The purpose of the study is to collect information for a project which the author has to do for a course which he was undertaking.
- b. The need is to understand what student opinion is and what is student's own view of the important aspects of the first year of training.
- c. The interviewee's comments were for the interviewer's use only. They would not be repeated to anybody else. It was not an intention to find out about the effectiveness of their personal tutor but she would be told about some aspects which would help her to run her course better. She would not listen to the tapes but the interviewer would give a verbal summary of general points raised by all of the interviewees as a group rather than what individuals have said.

- d. The introductory comments would probably best have been scripted but delivered in an informal manner after practice in pilot interviews.

A third point was concerned with the time taken to deliver the introductory comments. The time taken for introduction in each interview was 2 minutes 19 seconds, 3 minutes 23 seconds, 3 minutes 26 seconds and 2 minutes 55 seconds. Whilst listening to the recordings the average 3 minutes seemed like a long episode but the worry was that it may be too short to achieve any rapport with unknown students. The students showed no signs of anxiety or inhibited performance, and even though the interviewer did not know them well, he may have delivered one or two lectures to the group. Students may have been more relaxed as a result of this. Fieldwork would attempt to lengthen the time, both for introductory comments to the whole group and for introductory comments during the interview, so that anxiety could be minimised.

- iii The interview schedule proved too complex to facilitate the interviews. The major problem was that the interviewer did not intend to go through the schedule in the order as printed, but to start the student talking and if areas led into each

other spontaneously, then so be it. When the student dried up then a question would be formulated on an area which was listed on the schedule but had not been covered. The interview would stop when all areas had been covered. The problem with this was that coverage became a prime controller of interviewer behaviour and the interviews developed a distinctly directive style. In the later interviews stock questions were becoming evident. They were producing little information and the interviewer was obviously looking for information on areas which he was concerned with rather than developing areas of interest to the interviewee. The interviews were thus frequently interviewer led and the third interview demonstrated this most clearly. The number of questions asked in each interview gave some indication of how directive the interviews were becoming.

Interview 1	-	25 Questions
Interview 2	-	27 Questions
Interview 3	-	50 Questions
Interview 4	-	26 Questions

Given that interviews lasted about 45 minutes, the rate of questioning increased to over one per minute in interview three. There were, however,

some examples of long periods of response uninterrupted by interviewer questions. They were most commonly at the beginning and early part of interviews. This led one to suspect that one purpose of questioning was to keep the interview going at all cost. It seems that the profile was a problem because it increased any tendency to be directive. It probably kept the interview going when it was not absolutely necessary or productive. The third problem caused by the profile was the hesitancy it caused during the interview. Frequent pauses occurred when the interviewer was going through the process of, first, selecting an area which had not been covered and then quickly composing a question. The latter caused a number of problems in questioning strategy.

- iv Questions often sounded disjointed, they seemed to sometimes elicit responses which maintained description of one topic for long periods of time. They also seemed to pursue areas of concern to the interviewer and not to the student. There was some suspicion in two of the interviews that students were checking the question in order to discover which answer would be most acceptable to the interviewer. Sometimes this arose because of a vaguely formulated question. Sometimes a

question which worked with one person confused another. It was very obvious that the first question was the most creative in terms of the interviewee response, but on many occasions the flow was often interrupted by a question from the interviewer. During fieldwork a strategy would be adopted which increased the effect of the opening question, as this seemed the most relevant method of eliciting unadulterated student opinion.

- v The content of the interviews highlighted some interesting features of the responses. The first was that the responses seemed very familiar to the researcher, either because the story lines were similar to the findings and conclusions of the literature analysis, or because the interviewer was subconsciously eliciting data which matched his expectations. Either way it did produce some confidence that the material would enable comparisons with the literature and throw up some consistencies. It would be necessary to explore ways in which one could ensure that the product was more a function of the student's opinion than the interviewer's expectations.

A second point about the content was that a sizeable proportion of time could be identified

where the interviewee seemed to be engaged in what can be conveniently described as 'self-talk'.

This was a type of response which elicited information about the interviewee's personality (eg personal preferences) rather than about the nursing environment or training setting. On these occasions the data was personal rather than contextual. This problem would have to be addressed in order to make field work more economical.

- vi The method of audio-recording using a concealed portable machine seemed to work fairly well. The ease with which students settled to the task in hand made one wonder if the machine needed to be concealed at all, particularly considering the ethical implications of the situation. Tape time was lost, however, because the machine had to be started before the student entered the room. On each occasion the subject was collected by the interviewer. It was decided to alleviate these problems in future by telling students that the interview would be sound recorded and keep the recorder in open view. This would also ensure that the machine could be placed close to the interviewee on all occasions. Audibility of playback was good and only lost on one or two occasions when a subject mumbled or spoke softly.
- vii Timing was of particular interest. The interviews took up the following amount of time:

Interview 1 - Over 45 Minutes

Interview 2 - 44 Minutes

Interview 3 - 38 Minutes

Interview 4 - 44 Minutes

It seemed something of a coincidence that three of the interviews took up a period of time which almost equalled the length of tape time available. One side of a C90 audio cassette lasts 45 minutes and it could be considered that either the interviews were kept going to meet the amount of time available, or the interviews were curtailed knowing that the tape was coming to an end. This did not seem to be a productive way of eliciting genuine data for this study and added to the suspicion that the interviews were too directive.

viii When comparing the volunteers with the reluctant subjects; there were no obvious differences between the interviews. More prompting was evident in interview three (a reluctant subject) but this may again be more to do with the 'Keeping the interview going' phenomenon. None of the subjects seemed nervous nor did some students seem more productive than others. Taking this into account, it was decided that inhibition of response, due to anxiety, was a negligible problem because the subjects were easily encouraged to talk. All subjects felt that the interview had not been an ordeal and would do it again. It was concluded that even though

the interviews were directive they were not seen as interrogative.

5.2 PILOT STUDY DESIGN

In summary the fieldwork design was to take into account the following important issues.

- a Interviewer training.
- b Interview profile - Creating set
 - Minimising anxiety
 - Question formulation
 - (Facilitation vs Direction)
 - (Elucidating students opinion)
 - (Elucidating contextual information)
- c Method of data recording.
- d Selection of respondents.

5.2.1 Interviewer Training

Given that the research designer was the interviewer as well, the approach to interviewer training was to take the form of practice before the data collection proper was to take place. It was felt that the forthcoming design would be very similar to the final survey method and this in itself would provide opportunity to achieve

interviewer competence. The ways in which this would be decided was by subjective interviewer satisfaction, both 'in vivo' and by listening to the interview audio recordings afterwards. It was decided that this should be a major purpose of the pilot study, and that this practice should continue until interviewer satisfaction had been achieved.

5.2.2 The Interview Profile - Creating Set

It was apparent in the preliminary interviews that student nurses understood reasonably well what was required, although there was a problem in that the interviews were said to be conducted for two purposes. The first was to gather information for the researcher's project and the second to help the Course Tutor to improve the respondent's course of study. The latter was really an excuse for achieving the former, but did cause needless complications during the introductory comments. This should not occur in future if the genuine purpose of the interview was given.

Introductory comments were scripted to include, the purpose of the interview, an appeal for help from the respondent and some explanation of the area in which the respondent would be required to talk.

(See Appendix XIII).

5.2.3 Interview Profile - Minimising Anxiety

Whilst anxiety was not apparent in the preliminary interviews it was difficult to assess the amount of inhibition which may have been

brought about by apprehension present in the respondents. It was decided that time should be devoted to the reassurance of the students by:

- a Meeting with the group and talking to them, as well as the chosen individuals.
- b Allowing the group and respondents to ask questions, throughout the procedure, taking time to answer them in a helpful and considerate manner.

5.2.4 Interview Profile - Question Formulation

In order to minimise interviewer directiveness and resulting researcher bias, it was decided to keep questions to a minimum and phrase them in such a way that would enable the respondent to monopolise the conversation. It was obvious that questions could take different forms and reference to the work of Hargie et al (1981) and Oppenheim (1966) revealed that there were at least ten different types of question. They can be briefly described as:

Closed Questions -

Which elucidate the simplest kind of response such as yes or no. It does not encourage additional information.

Open or Free Response Questions -

Allow the respondent to answer in whichever way he wishes and encourage an increase in additional information from the respondent.

Leading Questions -

Indicate the questioner's preferences or attitudes, or suggest what the answer should be.

Prestige bias Questions -

Encourage answers consistent with normative or prestigious values.

Double-barrelled Questions -

Asks about two topics in a seemingly single question.

Recall Questions -

Require relatively simple cognitive skills to be answered often depending on the respondent's memory for factual information.

Process Questions -

Require the respondent to analyse or synthesise information in order to make interpretations or projections.

Probing Questions -

Probing questions encourage expansion but ask for it in a very specific way by asking for clarification, relevance, examples, extension, accuracy or consensus.

Affective Questions -

Ask about the respondent's feelings or preferences.

Rhetorical Questions -

A question asked by the questioner on behalf of his audience but which does not require an answer from them.

It was obvious from the preliminary interviews that open or free response questions were the most productive and gave more indication, than any other, that the respondents were expressing their own unadulterated views. Two other types of question were particularly obvious and problematic. The probing questions were too frequently used and were too prevalent early in the interview sequence. This was the probable cause of much of the interviewer's directive behaviour. Probing would need to be minimised and avoided until later stages of the interview, if used at all. It was decided that probing was not really appropriate to this study and should be kept to a minimum. A second type of question, which may have been responsible for problems, was the affective questions. These questions, asking for the respondent's feelings or preferences, were probably the cause of the

'self-talk' described earlier. It was decided to eliminate this form of questioning so as to preserve discussion on contextual aspects of the respondent's experience, rather than become distracted by data revealing the personality of the respondent. It was also accepted that closed questions, leading questions, prestige bias questions and double-barrel questions had no place in meeting the aims of these interviews. Other types of question seemed irrelevant as they did not naturally occur in the preliminary interviews.

Reference to the work of Hargie et al (1981) allowed the author to be sensitive to a major cause of the disjointed questions. This was a form of closed question known as the selection question. It mainly took the form of asking the question in three or four different ways at once eg:

"Can I ask you again - let's say that when er - I'm more interested in when you're learning, What do you like Tutors to do - What teaching sessions do you like?"

Clearly strategies for minimising the number of set questions, the use of open questions and the use of non-verbal cues to maintain the dialogue, would eliminate selection questions.

The interviewer would be adopting a strategy of listening for the majority of the time. Two types of listening have been described by counsellors, eg Egan (1975). They are active and passive listening. Passive listening is that in which non-verbal behaviour is utilised to maintain the other person's conversation. Active listening is more

concerned with the use of verbal responses which show the respondent that the interviewer has listened and understood. The latter seemed likely to encourage directiveness in the inexperienced interviewer and it was decided that passive listening would be the best approach to adopt.

The questioning strategy which had been adopted at this stage only took account of the type of question to be asked and it became obvious that the purpose of questions was also important. Turney et al (1974, 1976) gave some help in pointing out that the focus of questioning could be questioner-centered, respondent-focused or group-focused. Only the first two are relevant to this study. Questioner-centred items may serve four purposes. To:

- a Obtain information.
- b Focus attention.
- c Arouse interest or curiosity.
- d Initiate social interaction.

Respondent-focused questions may serve five functions. To:

- a Identify difficulties and problems.
- b Ascertain, attitudes, opinions and feelings.

- c Show interest in the respondent.
- d Create insight concerning the future.
- e Assess the extent of the respondent's knowledge.

It seemed that respondent-focused questions were necessary because they attempt to ascertain opinions rather than attitudes and feelings.

It was decided to concentrate on the original purpose of the interviews which was to find out which of the features of the student nurse experience are most important. This would then take the form of a self report of the respondent's perception of the world and rely on her memories of the first year of her training. It was felt necessary to look for theory which would enable one to argue that the student's recollections elucidated by open interview questions would precipitate a valid and accurate recollection of the student's experience. The study of perception and memory gave structure to a rationale for the pilot study.

5.2.5 Theories of Perception and Memory

There are four main approaches to the study of memory:

- 1 The Ebbinghaus tradition and the Bartlett approach.
- 11 Freudian Theory.

iii Gestalt Theory.

iv Behaviourism (S - R Theory).

(Baddeley 1976)

It is the Gestalt Theory which best provides a rationale for the self-report method as a relatively accurate means of identifying the most significant features from memories of past experience.

Gestalt Theory also provides the most favourable link between perception and memory as information processing systems. In essence the theory suggests that memory is not a separate faculty and that both memory and perception subsume to the same laws and principles. In essence the contents of memory can be seen as the encodings of perceptual experience (Baddeley 1976). A second point which Gestalt theorists would make is that perceptions and memory traces are organised into patterns, that is, they are understood as a whole rather than as the separate elements which make them up. This leads one to believe that significant and whole events will be recalled more frequently than trivial data.

A third feature of Gestalt Theory is that the process of organising memories and percepts is passive relying on brain processes rather than intentional attempts to memorise on the part of the individual person. In this model it assumes that the sort of data likely to be elicited has not been intentionally retained by the individual. It is more a product of the impact of the experience rather than the wishes of the individual to memorise that experience. There is further support for this approach in

the work of Tulving (1972). It must be emphasised here that we are not dealing with iconic or short term memory but with long term memory. Tulving distinguishes two types of long term memory, he labels them as semantic and episodic. Semantic memory registers the cognitive referents of inputs. It mainly relies on the organised knowledge which the person possesses and is necessary for the use of language. The Question: What is the capital city of Belgium? initiates this type of memory. It differs from episodic memory mainly because it is not a result of personalised experience. Episodic memory is essentially autobiographical. It relies on episodes which have occurred in the individual's real life experience. The question: What did you have to eat at the restaurant? would elicit information from episodic memory. It seemed apparent that attempts should be made to elicit data from episodic memory because semantic memory is more likely to give the answers that the researcher would like to hear, rather than an accurate record of individual experiences. Indeed Tulving's (1972) suggestion, that episodic memory can be considered a direct record of personal experience, gave some indication that questions could be framed in such a way as to provide data which was contextual and personalised. A comparison of the personal experiences of individual respondents would enable a simple quantification of the qualitative information.

In summary the criteria for question design were:

- a That only a few questions should be formulated. A total of four questions were finally produced.
- b Questions should be open ended.

c Questions should appeal to episodic memory.

The first of the questions was expected to be most useful in identifying what was uppermost in the respondent's memory and this was framed so as to be most open ended.

Two other approaches to question formulation were adopted in order to minimise anxiety, they were the asking of opinions by indirect questioning and the making of comparisons. These methods would determine the student's opinions indirectly. The first was achieved by asking what the respondent's friends say about the situation and the second by asking about two features of the context of their learning experiences. It was also felt that asking the respondent to describe the views of herself and her peers would encourage the respondent to give a more balanced view of what had been experienced. The four questions for the pilot study are given in Appendix XIII. The first question was accepted as the most open ended, the responses being least tarnished by researcher bias. The last three asked in very open terms about expectations, ward experience and study blocks with a view to encouraging the student to speak when her dialogue had come to a halt. They were acknowledged as being mildly directive but nowhere near as directive as the questioning in the preliminary interviews.

5.2.6 Method of Data Recording

In terms of the questioning strategy which had emerged as a result of the analysis of the preliminary interviews, the audio-recording of interviews was confirmed as the best method of recording data for the following reasons.

- a It allowed the interviewer to relax and adopt a more natural/conversational style.
- b The open ended questioning technique would produce a plethora of information in varying forms. This was best recorded in total and sorted at a later date.
- c The interview method and interviewer behaviour could also be analysed at a later date.

The method of analysis intended for the main study was to transcribe the recordings into written form for a more detailed content analysis.

A Phillips portable cassette recorder was used which had a built-in electret microphone. The recorder was battery driven to allow for it to be placed anywhere in the room without being dependent on the mains supply.

5.2.7 Timing of Interviews

It was anticipated that the updated interview schedule would reduce the length of the interview. More than sufficient data could be obtained in half an hour. It was also felt more suitable to be able to interview two respondents in one hour, this being the normal compartmentalisation of the nursing school time-table. It was thought that timings which took up one hour segments would be more attractive to nurse tutors who organise timetables thus facilitating access to students. It was believed that access to student nurses would best be achieved whilst they were in the

School of Nursing for two major reasons. The first was that the author would be able to gain access to potential respondents by having some common interest with nurse teacher colleagues and Directors of Nurse Education. Secondly it was believed that removing nurses from the clinical environment may meet with some resistance because of disruption to the smooth running of the ward. In addition the stresses and pressures of ward work would make it more difficult to settle the student into a frame of mind which was amenable to self-report in the interview setting. In the School of Nursing it was expected that student nurses would be more relaxed and free from the stresses of work.

5.2.8 Selection of Respondents

It was decided that eight student nurses should be selected from a readily available group of 12-15 students. This would enable the group presentation and random selection method to be tested. It was required that students should have completed at least one year of training so that they had sufficient experience of different clinical areas and study blocks to enable their comments to be valid. All students would have completed a 6 week introductory study block and two blocks of study lasting a fortnight. They would have experience of a Medical Ward, Surgical Ward, Elderly Care, Operating Theatre, Paediatric Ward and Night Duty. Approximately eight weeks' experience would be gained in each clinical area. The respondents would predominantly be female and nineteen years of age undertaking training for the general part of the register.

An opportunity sample was taken, there being a group of student nurses meeting the above requirements available in the authors' School of Nursing.

Students would be selected as a random sample by pulling names from a hat, after the introductory comments and discussion with the group as a whole. The group consisted of 20 students and because of limitations of time, eight students were selected for interview. Interviews took place on neutral territory in a small 'living room' sized seminar room furnished with easy chairs which were set around coffee tables.

5.3 RESULTS OF PILOT STUDY

5.3.1 Audio tape Analysis

At this stage a method of recording audio tapes was predecided and prepared. An analysis sheet was devised so that the recording of relevant information was facilitated. It was decided that the following areas of analysis would be required:

Total number of questions from interviewer.

Input from Interviewer.

Timings for introductions.

Timings for whole interview.

Timings for respondent's reply to each question.

Content of respondent's reply.

In order to collect this information a record sheet was devised utilising the following Headings:

Question	Time	Input from Interviewer	Note on response content

Timings were measured using a digital clock which displayed the hour, minute, and seconds at the actual time of day the tape was analysed. The time was recorded when the interview began and finished and at the beginning of each question. At the same, time questions were numbered consecutively and the wording of the question written down. Rough notes were made on the reply given to each question in order to ensure that 'self talk' was in fact kept to a minimum.

5.3.2 Timings

A summary of the various timings can be found in table II. The total time for the interviews averaged just under 28 minutes and it became obvious that the required information could easily be obtained within the half-hour. It was found that the C60 audio tapes in use could last as long as 33 minutes 43 seconds and as little as 30 minutes 30 seconds per side. Even though it still seemed that interviews were taking up the time available it was decided that C60 tapes would be used in future as it was possible to plan for interviews to last 30 minutes at most. The range of interview timings was 24 minutes 14 seconds to 30 minutes 38 seconds.

The second most important timing was the introductory time, that is, the time between the interview opening time and the asking of the opening question. This was important because it represents the time taken to form some relationship and create set for the interviewee. The average time was 2 minutes 40 seconds and the range was 46 seconds to 3 minutes 45 seconds.

TIMINGS	RESPONDENT/TAPE NUMBER								AVERAGE
	1	2	3	4	5	6	7	8	
Total Interview Time In Seconds	1630	1646	1634	1774	1694	1838	1752	1454	1677 Seconds
Introduction Time In Seconds	46	176	156	213	188	2255	174	105	160 Seconds
Number of Questions	23	26	26	19	15	15	19	18	20
Questioning Rate Seconds per Question	70	63	62	93	112	122	92	80	86 Seconds
Tape Time Remaining In Seconds	230	356	389	106	136	0	95	406	-
Uninterrupted Response Time After Question 1 In Seconds	40	70	58	58	134	99	60	90	76 Seconds
Time from schedule Question 1 to Schedule Question 2 In Seconds	259	290	236	108	556	186	209	90	241

TABLE 2 SUMMARY OF AUDIO TAPE
ANALYSIS FINDINGS

It was found, however, that one could not make assumptions about the effectiveness of the introductory comments on the basis of time alone as it was not an accurate reflection of the utility of the actual interview process. The time recorded in interview 1 is the best example. The introductory time took 45 seconds and it would appear that insufficient time was spent, especially when one considers that this was the first interview. In actual fact the content of the tape reveals that the interviewee was eager enough to begin and took a cue from the explanation to begin to discuss her first year and actually interrupted the interviewer's flow. The introductory period timings did, however, tend to increase up to interview six, and one could suggest that this was a function of interviewer experience. It was obvious that introductory periods which lasted longest involved a lot more 'small talk', comments and questions from the interviewee. It was felt that these behaviours should be encouraged even more in the field work interviews.

5.3.3 Introductory Period Content

The introductory comments, as scripted and shown in Appendix XII, did prove to hold the essential elements which enabled the creation of set and the reassurance of the interviewee. The creation of a set, in which the interviewee was encouraged to talk about the experiences and opinions of her peers rather than just personal experience, was found to be a satisfactory approach. It did seem to alleviate anxiety and this seemed to be due to the fact that interviewees did not seem to be under pressure to indulge in self-disclosure. In addition to this settling effect, the emphasis on group attitudes and opinions seemed to enhance the

representativeness of the data. It must be stated, however, that the interviewees always gravitated, sooner or later, to more frequent reports of their own personal experiences. Perhaps this was a product of the indirect approach. This was found to be a highly satisfactory aspect of set creation and seemed to be developed even more as the interviewer gained more experience.

5.3.4 Questioning - Timing

The number of questions asked in the interviews ranged from 15 to 26. The average being 20 questions per interview. The questioning rate was found to be one question every 86 seconds on average, and the range was 62 seconds to 122 seconds between the beginning of each question. There was little apparent difference here with the rate of questioning compared with the four preliminary interviews but two changes were blatantly obvious. The questions were much shorter and the form of questioning differed markedly. The latter was largely responsible for the former.

5.3.5 Questioning - Style

The most interesting change in interviewer style was his greater tolerance for silence. In the preliminary interviews 'drying up' was largely met immediately with an interjection in the form of a question from the interviewer. In the pilot interviews the interviewer maintained a silence much more frequently and this style was adopted as a conscious strategy for the field work interviews.

In addition to the use of silence a further improvement in style was the formulation of questions. This was thought to be largely due to the formulation of the four set questions and a different approach to probing. This was more cautious and took the form of clarification rather than a change in direction.

5.3.6 Types of Question

The idea of focusing on the four set questions and the 'clarification' approach to probing brought about a distinct change in the unplanned questions which were generated. Some questions took the form of just three or four word prompts. There were many instances of questions which were reformulations or clarifications of the set questions. Another form of question found to be most useful can best be described by the following example:

"I found it interesting when you said
Can you tell me more about this?"

A similar type of encouragement was demonstrated by the question:

"Is there anything else you can say about this?"

Closed questions and affective questions were so few that it was obvious that the interview schedule and 'training' time had had profound effect on the interviewer's behaviour. The elimination of affective questions and the creation of set in the introduction kept 'self-talk' to an acceptable minimum. Prestige questions and double-barrel questions were not found and

elimination of such questions had been achieved. It was also obvious that questioning was largely respondent-focused and this was improved as the interviews progressed. The four set questions were found to be useful for maintaining discussion, even though the last three were more directive in the sense that they asked about particular issues. It was decided to keep the questions as they were for a number of reasons. Firstly, the question on expectations readily served the function of extending the effects of the opening set question. It did elicit more comment on the first year of the interviewee's experience. The second question on the schedule asked the interviewee to comment on her own and her peers attitudes to clinical experience, by asking for a comparison between medical and surgical wards. This was maintained so that talk on clinical experience could be elicited if it had not already been mentioned. The last question inquired about attitudes to nursing school attendance. This attempted to even up any bias which may have been brought about by the fact that the interviewer was a Nurse Tutor.

It was certainly the sort of strategy which seemed to obtain a balanced view before the interview was completed. The first question was always used as an opener but the remaining questions were asked in different orders depending on the topics discussed earlier in the interview. This worked well and caused no problems. It was established without doubt, however, that the first question was the only one which gave up data that represented thoughts uppermost in the interviewee's mind. It was also apparent that the later three set questions were shorter than those stated on the interview schedule and this was largely due to omissions involving that part which encourages the interviewee to relate what her fellow students thought and felt. This would need to be improved in the field-

work interviews. Question one also needed some improvement in that the content of the question varied in the actual interviews. When asked to talk about their first year the interviewees were variously asked what was most influential, important, what did they think about the first year or what did they care most about. This brought about a reformulation of the first question so that standardisation could be achieved. The beginning of the interview was now seen to be most important in terms of the production of data which was most amenable to simple quantification. It was decided to concentrate on two key words in this opening question, memorable and significant. Asking the interviewee what was most memorable and most significant seemed to encourage the student nurses to talk about those things uppermost in their memories of the first year.

5.3.7 Student responses and relevance of emergent data

It became obvious that the most important elements of the procedure were the introductory statements to the student group, the introductory comments to the interviewee and the open-ended first question. The interviewee responses and the general direction which questioning took revealed that the three set questions, which followed the opening question, were in some senses irrelevant and that the elimination of these questions should be seriously considered. Given that the question on expectations built upon the opening question it was decided to keep this in the schedule. The quantitative analysis of data would be restricted to this section of the tapes. This segment of student response varied in length and there is every probability that the generation of relevant data, at this point, was least affected by interviewer direction and time constraints. The two set questions referring to medical and surgical wards and to the School of

Nursing were kept for one main reason. This was so that data was available which would allow one to check on biases which may have emerged in the first segment of the interview. The most obvious was any reluctance to talk about the School of Nursing or teaching personnel because of the occupation of the interviewer/researcher. The preparatory and pilot interviews indicated that students were not too reluctant to do this. This was something of a surprise considering that the interviews were carried out in the interviewer/researcher's own school of nursing. Retaining the two final set questions would allow one to estimate how much the early part of the interview was eliciting the most salient points, and also, that these salient points were selected from relevant recollections of both clinical and school experiences. This data would then allow one to assess the relative salience of conclusions which had been derived from the literature analysis described earlier.

5.3.8 The Analysis of the Audio Tapes

An attempt to transcribe the pilot tape recordings in full showed that the time spent on this was considerable. It took at least one hour to listen to and write down comments from each recording. This effort did not seem to be justified in that the notes on student responses had given as much indication of the content of student responses as the full written transcript did. A question then arose as to the objectivity of such an analysis. Many of the studies found in the literature review used these methods and seemed to paint a variable picture of the major features of the learning process. It was felt that this was partly due to the 'generation of theory' approaches used by the authors such as Ogier (1980) and Mellia (1981), and to the different fields of study and perspectives which

generated this research. The interviewer/researcher's personal influence, on the direction in which data was generated, seemingly brought about variations in the conclusions which authors derived from the data. It was felt that the present study should not add to this state of affairs. It was felt necessary to look at some method of analysing the open responses and indeed to decide if the audio recordings needed to be transcribed in part or in total.

Content and Structural Analysis

There were two traditions which most obviously met the requirements of the study at this stage. The traditions of content and structural analysis arose from the study of communication, particularly the analysis of media communication. As one author describes it:

"Content analysis refers to any procedure for assessing the relative extent to which specified references, attitudes or themes permeate a given message or document".

(Stone 1966 in Curran 1976)

Content analysis originated from early attempts to quantify the significant elements of a given communication and whilst some authors emphasise the objective qualities of the quantitative approach, the majority of content analysts argued that quantification does not necessarily guarantee objectivity (Curran 1976).

Curran describes evidence which suggests that the subjective elements in this quantitative approach arise from the values and predispositions of the

researchers. He demonstrates how contradictory findings can be elicited by different analysts examining the same material. This was in fact an acknowledged problem related to the analysis of literature abstracts, described earlier, and something to be avoided at this stage of the study. What then were the benefits of the content analysis tradition? Curran sums this up in the following way.

"The answer given by content analysts is that quantitative procedures minimise participant bias and the distortions generated by casual, impressionistic analysis. These procedures require that all of the relevant content is analysed in terms of all the relevant categories so as to prevent investigators from selecting out elements of content that merely support their hypotheses".

(Curran 1976)

The approach attempts to support qualitative comments such as 'trend', 'tendency', 'frequent', 'often' and 'recurrent' with some numerical value which supports the arguments which are being put forward. It is believed in this paradigm that content analysis is a method of observation which relies on the assumption that communication reflects social and cultural phenomena.

Curran contends that content analysis has moved on from the denotative meaning of communication to the more risky area of analysing connotative meaning. This seems to move basic tenets of content analysis nearer to those of structural analysis. The structuralist model in essence is anti-quantitative. It assumes that quantification distorts the meaning of any

communication by assuming that frequency is synonymous with significance. Structuralists argue that because an item is mentioned most frequently it does not mean that it takes on any intrinsic importance simply because of this alone (Burgelin 1968 in Curran 1976). Clearly, if a nurse was to mention the word 'dressings' twenty times in an interview, it would not necessarily mean that this concept was of more significance than a single mention of her distress over the death of a patient. It is with this sort of phenomenon in mind that structuralists defend the validity of their approach.

Content or Structural Analysis?

It was difficult to argue that either approach would serve the purposes of this study any better than the other, so the utilisation of both seemed a logical consideration. The qualitative approach was more controlled and the quantitative approach more creative, Curran sums up these differences in a succinct way:

"This merely amounts to saying that content analysis is usually enumerative, whereas structuralist analysis is rarely so. The advantages of enumeration in terms of statistical precision are sometimes offset by its disadvantages in terms of lack of sensitivity".

(Curran 1976)

It seemed that one could carry out a content analysis in the opening part of the interview and a structural approach to the analysis of the whole interview. The content analysis would have particular problems of

categorisation, and with this in mind an attempt was made to analyse the pilot interviews. The preliminary analysis of the pilot tapes confirmed that the categorisation of the interviewee responses generated numerous problems in attempting to separate the meaningful and meaningless comments. It also caused problems when classifying the ideas produced by the infinite variety of sentence structuring which interviewees could produce. The analysis of human language was found to be of such complexity that further study in this area was required.

5.3.9 The Analysis of Human Language

There are four main levels at which language is traditionally studied. These levels are the phonetic, syntactic, semantic and pragmatic (Greene 1976). Phonetical analysis is concerned with a study of the sound forms and patterns which carry information. The pitch, volume and combination of sounds is the basis of this analysis. Alternatively language can be studied at the level of word meaning. This semantic analysis is concerned with the meaning or common understanding which is carried by the phonetic or symbolic form of language.

At a different level one can study the way in which words combine to produce sentence structure. Here the ways in which words are sequenced is most important.

Finally language may be studied in terms of the function it achieves. This study of the pragmatic nature of language looks more at effects which language may have on the sender and receiver alike, and the use to which language is put. It was apparent that a semantic analysis was of most

relevance to this study and it was in this area that deeper study took place. Semantic analysis can take place at two levels, word meaning and phrase meaning. It is word meaning which seems to have received most attention. Stevens (1975) described three kinds of meaning which may be attached to any given word. The meaning may be denotative, connotative and indexical. Denotative meaning encapsulates the critical attributes of the phenomenon which is being referred to. It is a name or label which indicates a clearly definable entity. On the other hand connotative meaning refers to associated ideas and emotions which are attached to and carried with the denotative meaning. Words may have various connotations which can depend on the emotional experiences which the user has linked to the word in question. One mans freedom fighter is another mans terrorist. In this way the word 'Guerilla' may have bad or good connotations depending on the disposition and experience of the word user. Indexical meaning is that which conveys the characteristics or attributes of the speaker, for instance sex, age, class, education or occupation. Sometimes words carry indexical meaning by indicating the person's attitudes and prejudices, his relationship to the listener and to the emotional state of the speaker.

It seemed that the analysis of connotative meaning did not fit the bill for this study because it would require too much interpretive input from the analyst. Similarly indexical meaning would only be giving personal information about the attributes and relationship of interviewer and interviewee. This led to the conclusion that denotative meaning was the only relevant area for analysis. This still left the question of: should the analysis be carried out at the level of word or phrase meaning? A look at the elements of phrase or sentence analysis showed that this can be a very complex business. A theory which demonstrates this is that described

by Chomsky (1957, 1965, 1968). A major issue in the analysis of transcripts is the level of confidence which one can have about the relationship between the syntactical and semantic elements of a phrase. The transcript in essence provides a syntactical representation of the language from which meaning must be derived. Can one then derive sufficient relevant meaning from the written record of what was said, given that it is out of context at the time of analysis? The reading of a novel or non-fictional work gives a great deal of confidence that this can be achieved, but how can it be carried out at a more objective level? Chomsky provided a model which enabled one to understand how simple grammatical analysis of sentences can provide a key to phrase meaning. In his analysis of syntactic structures Chomsky postulated a theory of generative transformational grammar, whereby, he suggests that the language user learns certain rules which enable him to relate an infinite number of sequences of words and meanings in the particular language which he understands. Two types of rules need to be acquired and are essential to syntactic analysis. The first concerns phrase structure rules, these are synonymous with the grammatical rules associated with those combinations of the different parts of speech which bring about a meaningful English sentence. This allows one to construct combinations of nouns, verbs, adjectives, articles and pronouns to produce an English sentence such as:

"Normally she is a Competent Nurse".

One must also, however, learn transformational rules, that is, rules which allow for the given example to be rephrased sometimes without a loss of meaning. For instance a different form of the previous statement could be:

"She is normally a competent Nurse".

An additional example shows that this can be altered slightly without losing meaning.

"As a Nurse she is normally competent".

This demonstrates that it is the phrase structure which carries meaning and that it is possible that the almost infinite variety of sentences generated by interviewees can provide data which is amenable to comparison in syntactic form. In Chomsky's view, sentences have a surface structure which transmits the sounds of the sentence, and a deep structure which carries the actual meaning which is being conveyed. Within Chomsky's model it is the surface structure which is largely eroded by transcription and the deep structure which is preserved by transcription.

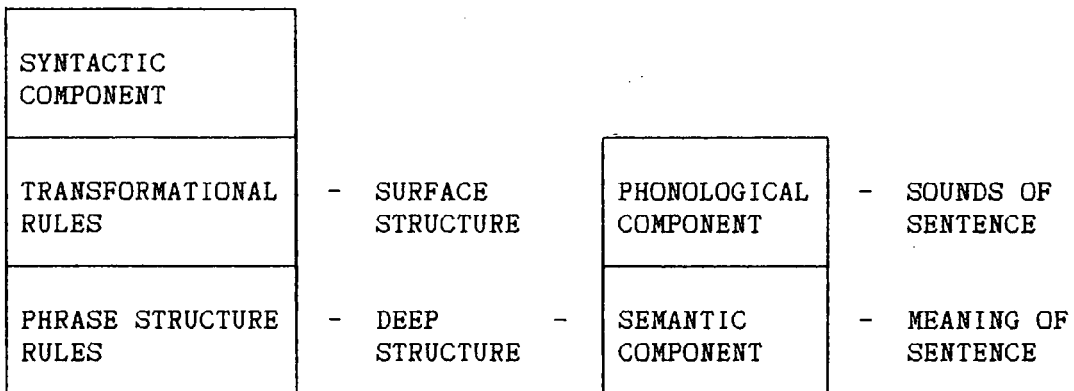


FIG 2 CHOMSKY'S MODEL - RELATIONSHIP BETWEEN
DEEP AND SURFACE STRUCTURE

(From Greene 1976)

Whilst one could be confident that transcription would preserve the essential data it was still necessary to decide whether the whole phrase should be analysed for meaning or individual words?

Given that denotative meaning was found, by process of elimination, to be most relevant, it was decided that the most relevant element of phrase structure could be the noun. It seemed that this had most relevance for identifying what was uppermost in the interviewee's mind. Whilst verbs were not irrelevant, it was felt that this would over complicate the analysis. It also demonstrated a method of quantifying the data in the tradition of content analysis. In this way the 'most important' elements of students reports could take on a less subjective aura.

It was felt then that the categorisation of nouns would provide a two stage analysis. The first part of the analysis would entail the simple categorisation and counting of nouns to discover the concepts which were of most relevance to student nurses. The assumption was, in the content analysis tradition, that the more the noun is elicited the more salient the noun referent becomes. This analysis would be carried out on the responses generated from the opening question, as well as question two (expectations) if it followed on from the opening question. This first part of the interview would need to be transcribed. The second stage would involve an analysis of the whole of the interview and this could be analysed more in the tradition of structural analysis. In this way one could simply listen to the audio tapes forming impressions of major trends in interviewee responses. During this second stage phrase meaning would be most relevant and this did not depend on transcription. Analysis of two of

the pilot tapes demonstrated that this was a very informative, productive and 'handleable' method. The only unexpected occurrence in the quantitative analysis was the interpretation of certain nouns which are commonly known as pronouns. A certain level of interpretation was required for words such as 'they', and 'we'. Another problem had to do with what can best be described as dialectical turns of phrase. The best example was the use of the word 'you', instead of 'I', to refer to self. Another problem is the generic 'they' as used in the phrase 'they say that nursing is a vocation'. This final example, though not a frequent occurrence, also needed to be dealt with. Because of this a set of analysis rules were drawn up in order to maintain some consistency (Appendix XV).

5.3.10 Audio Recording of Interviews

The audio recording of interviews proved an efficient method of collecting data. It enabled the interviewer to concentrate on the standard elements of the interview schedule and to maintain a relaxed conversational atmosphere. The only inhibition here was the presence of the recording machine. This caused many of the interviewees to comment on its presence either unsolicited, or when asked after the interview had been completed. In essence the interviewees were aware that they were being audio recorded and the level of concern was sufficient for them to mention it. It did not seem to be inhibitory, in terms of the type of information which was being elicited, but it was an effect which one could not easily discount in this way. It was felt that the recording machine should be concealed from view. This suggested two major problems concerning the audibility of recordings and the ethics of secret recording. The first problem really took the form of a risky compromise. The recorder would be concealed in a bookcase, or

at floor level, close to the interviewee. Obviously the machine may not be within the optimum range for microphone pick up. Because automatic sensitivity level was a built-in feature of the machines' fixed microphone, background noise would be increased thus reducing audibility. Some preliminary tests proved these assumptions to be true but audibility of the final recordings was still satisfactory for accurate transcription.

The second problem was that of the ethics of secret recording of confidential interviews. It was decided not to mention audio recording in the introductory comments to either group or individuals. Instead it was decided that the interviewee should be told of the recording as soon as the interview had finished and an explanation would be given as to the reason for this approach. The reason being to reduce any anxiety or worry which the interviewee may have experienced. In addition the interviewee would be asked to consent to the interviewer keeping the tape, explaining its use and guaranteeing confidentiality. The offer would be made for the interviewee to be given the cassette if she was unhappy about this. It was felt that the risk of losing data was well worthwhile in order to maintain a fair and confidential approach.

5.3.11 Sampling Method

It became obvious that the opportunity sampling method used for the pilot study was effective enough for exploratory work but inadequate for fieldwork. There were two reasons for this, the potential effect of the interviewer's job and the representativeness of the sample.

The inhibitory effects of being interviewed by an individual who is a senior member of the organisation and a participant in the setting which the interviewee was to describe, would obviously have to be eliminated. Secondly, if results were to be generalised to a wider population then one could not be confident that a single hospital school of nursing would be a standard example of the wider situation. The educational processes found in one hospital school of nursing may not be found in any other school of nursing and features present in other schools may not show up in the single study. In order to achieve the best representation, random sampling of the whole student nurse population would be ideal. This would involve the sampling of a population of at least 25,000 individuals. Accessibility was also a problem in that the researcher was unable to travel to all parts of England and Wales because of constraints on time and available resources. Another alternative was cluster sampling whereby one would select all the individuals in one cluster, the cluster in turn being selected from all the available clusters. The cluster in this case would be a school of nursing. As discussed earlier, the disadvantage of poor representation looms large again with cluster sampling. A satisfactory compromise for this study was stage sampling. This avoids the rigour of true random sampling and the loss of representation of cluster and opportunity sampling. Three stages of sampling were identified one at the Regional Health Authority level, the second at the District Health Authority level (almost synonymous with the school of nursing level at the time of the study) and thirdly at the individual student nurse level. Because of resource constraints it was decided to identify one region out of the 14 available for study. An accessible Regional Health Authority was chosen. At the second level it was found that there were 15 schools of nursing providing a population of about 290 student nurses who had completed one year's training, (given that

full recruitment had been achieved for all the available places). The discontinuation rate in the first year, according to national figures (G.N.C. Report 1980), was 4.27% meaning that there would be around 277 students available. Recruitment was not at one hundred percent and it was felt that 250 students would be a more accurate figure for the available regional population, although no accurate figures could be obtained at the time. The size of each student group in each school of nursing could vary from 8 to 60 and it was felt that a percentage of the total population would be best obtained if two student nurses were interviewed in each school of nursing, this would provide 28 interviews for analysis and would represent at least 10% of the total population of students who had commenced training in the region. The selection of two students from each school of nursing would facilitate access to the schools of nursing and it was felt that this would cause a minimum of disruption to the school timetabling. At that time timetabling was quite rigid and the work pressure in many schools of nursing seemed intense. Given that two interviews would take a maximum of 1 hour to carry out, it was felt that a request for just one hour would be looked upon with a more positive attitude. There were three additional considerations for the sampling design at the student nurse level. The first two had to do with experimental variables. In the pilot studies it became obvious that recollections about the first year could be heavily coloured by where the student lived during their off duty time. Quite a number lived in hospital owned accommodation, often on the hospital site, others lived at home. It was obvious from one pilot interview that students who live in at the hospital can have severe adjustment problems commonly associated with what is usually known as home sickness. It was decided to choose one student who lived away from the hospital and one who lived in at the nurses

home/flats. Then, if there were some distortion because of this, it would become apparent by comparing the two groups. If there was no effect then there would still be no problem for the analysis. A second consideration had to do with the variation in training programmes provided by the schools of nursing. The types of clinical experience in the first year varied, but a simple check showed that all students from which ever school of nursing, would have completed experience on a medical ward, a surgical ward and at least one other clinical experience (eg elderly care, theatre, night duty and paediatric). All would have attended the same two types of clinical experience, at least three clinical experiences. and the same number of study block weeks. The selection of students who had completed the first year was thought to be a satisfactory criterion. A final consideration had to do with potential sex differences in the sample. There were only a small percentage of male nurses in training, a ratio of something like 1:20. By random sampling, the male nurses could have been selected. It was decided to carry out a normal random selection procedure, but not accept male nurses on the rare occasion that they were drawn from the hat. Explanations could be given if this did occur. Whilst it would at first appear that quite valuable information on sex differences would be lost, the small numbers sampled (1 or 2) would not provide sufficient comparable data. In addition this was a distraction which did not facilitate the purposes of the study.

The selection of students, as has already been inferred, would be carried out by simply asking students to write their names on a small piece of paper and these names would be drawn from a hat. First, those who lived in at the hospital, and secondly, those who lived out. Names would be drawn

after a full explanation of what was required. Those who were reluctant to participate could avoid selection by not placing their names in the hat.

5.4 OPINION SURVEY FIELDWORK

5.4.1 Gaining Access

It was quite fortuitous that the author had carried out some fieldwork for a different project some 18 months earlier. At that time many districts were managed by an Area Health Authority, and because of the previous fieldwork, formal letters had been sent to Area Nursing Officers and District Nursing Officers, asking for permission to approach Directors of Nurse Education in order to gain access to students in schools of nursing. At this stage it was possible to thank Directors of Nursing for their previous help and to ask for help with a second study, a continuation of the former study. This former fieldwork was a part of the researchers early work on this thesis, but it became irrelevant when the subject matter of the current work changed direction. The experience of the previous fieldwork meant that a satisfactory relationship had been achieved with the schools of nursing. It was mainly because of this earlier contact with schools of nursing that the current fieldwork was carried out whilst students were in block. The alternative would have been to interview the student nurses whilst they were working in the clinical setting. The clinical experience, however, seemed to sustain a greater pressure of work and it would have been necessary to give explanations and to persuade as many as 56 different unit Nursing Officers and Sisters to release each student nurse for half an hour. Suitably private interview areas would need to be identified in each case and these may not be in the ward area.

The good relationship with Directors of Nurse Education, achieved because of the satisfactory accessing in the previous fieldwork, was seen as an advantage which would facilitate access. A second consideration was that work on hectic wards can be very preoccupying and there was every probability that the students would be made available after becoming preoccupied with ward activities, stress and patients' problems. It would then be necessary to allow the student to 'wind down' and this would take up even more time. In addition one could never be sure that preoccupation with ward work would influence their recollections of the first year.

The letter to Directors of Nurse Education explained the need and purpose of the fieldwork, and asked for permission to speak to student nurses (one resident and one non-resident). The sampling method was described and anonymity was guaranteed for both the school of nursing and the individual student. The fact that the study required student nurses nearing the end of the first year was emphasised. A copy of the interview schedule was included in the letter. All the Directors of Nurse Education in the 14 schools of nursing who had an intake of students relevant to the sampling profile, agreed to participate in the study.

CHAPTER 6

RESULTS OF OPINION SURVEY

6.1 CONTENT ANALYSIS OF OPEN QUESTION RESPONSES

The interviews were transcribed as far as questions referring to either medical/surgical wards or the school of nursing (see example appendix XVI). The transcripts were then analysed initially by underlining all the nouns using the set of predecided transcribing rules (appendix XI). A recording sheet was devised which allowed for the entry of a particular noun category and a check mark for each occasion the noun was used by each interviewee. Nouns were divided on the recording sheet into two main groups which can be simply described as people and things (see appendix XVII). Once the recording sheet was completed the data was transferred to a similar sheet which showed the analysis in figures (see appendix XVIII).

The largest number of references were to the interviewees themselves, some 1037 nouns referring to I/Me/My/Self and You/Your (Oneself). The next most frequent referent was the fellow student nurse. There were some 253 references to peers. Following this the third most frequently mentioned nouns were identified by the generic term 'trained staff/the staff' (156). After these, the ward (154) and patients (112) were the only other groups mentioned more than 100 times. It is worth noting that the other high scoring topic was 'other/non-specific/unrelated'. This referred to things rather than people and it represented a collection of mainly proper nouns which were not reproduced by that interviewee or other interviewees.

The most interesting feature of the analysis so far was the greater number of times that peers were mentioned when compared to staff, and the greater number of times that staff were mentioned when compared to patients. The ward as an entity was also mentioned more often than patients. It is with these aspects of the findings that the following discussion will dwell.

6.1.1 The Significance of Peers

The finding that peers were mentioned most frequently, next to self, was difficult to interpret. The reason is that the interview method actually encouraged interviewees to include their colleagues' opinions as well as their own, in an attempt to obtain representative data and to minimise anxiety. There was evidence in the literature that fellow students were an important source of emotional and practical support. It was difficult, however, to be sure that there was anything of value in this finding. The second stage analysis proved to shed light on this subject and this will be discussed later.

6.1.2 The Significance of the Qualified Nursing Team

The reference to 'staff' was often qualified as 'trained staff' or just the staff. This noun was always used in a sentence context which referred to the qualified nursing group working at ward or departmental level. It was interesting to note that members of this group were sometimes referred to as 'they'. This reference to the nursing team, as a collective, infers that they have characteristics in common. What was even more notable was that when one added together the number of times nurses were mentioned, it could be seen that the nursing team was mentioned an additional 124 times

(Sisters 62, Staff Nurse 50 and Assistant Nurse 12). This meant that in actual fact the ward/departmental nursing team was mentioned in one form or another some 280 times. In this light the nursing team was now mentioned more frequently than peers and more frequently than any other category besides self. The use of the word 'we' always referred to peer group and never to the nursing team. There was a strong feeling here of a 'them and us' situation or a 'them and me' situation. It was also surprising to find that assistant (non-qualified) nurses were mentioned on 12 occasions in total by three separate interviewees, yet no interviewee made any reference to enrolled nurses.

6.1.3 The Significance of the Ward

The ward was the most frequently mentioned non-animate item and the third most frequently mentioned item after self. The significance of this lies mainly in the finding that it was mentioned almost five times more frequently than the School of Nursing. There are other items which can be seen as indirect reference to the School of Nursing. Mention of exams and the introductory course could be seen as indirect reference to the School of Nursing, and in total all these categories gave a total of 52 tallies. The greater number of references to the ward (152) and the 42 references to the hospital suggested that the clinical setting was uppermost in the students recollections of their first year. A different type of analysis can confirm these raw comparisons. If one compares the number of individuals who mentioned the ward more often than the school, it can be found that 24 out of 28 interviewees did so, and 3 mentioned it an equal number of times. One could also discover that 18 made no mention of the school at all and only one individual made no mention of the ward. It

seems from this evidence that the clinical experience was uppermost in the student nurse's recollections of the first year.

6.1.4 The Significance of the Patient

It is of interest to find that the patient was mentioned less frequently than self, peers, trained staff and the ward. An examination of each individual interviewee's tally shows that only 6 mentioned patients more frequently than 'the staff' and 4 mentioned patients more frequently than Staff/Sister/Staff Nurse combined. Similarly patients are only mentioned more often than peers on six occasions, and 4 mention them an equal number of times or not at all. It is also worthy of note to find that 10 interviewees made no mention of patients during the period analysed and 7 mentioned patients only once.

6.1.5 Summary of Content Analysis Findings

1. Fellow students were mentioned more frequently than the
trained nursing staff. 253:156
2. Fellow students were mentioned more frequently than the
ward. 253:154
3. Fellow students were mentioned more frequently than the
patients. 253:112
4. Trained nursing staff were mentioned almost as frequently as
the ward. 156:154

5. Trained nursing staff were mentioned more frequently than patients. 156:112
6. The ward is mentioned more frequently than the School of Nursing. 154:52
7. Sisters were the most significant members of the nursing team compared with Staff Nurses. 62:50
8. Other members of staff were infrequently mentioned. 12
9. Sisters were mentioned more frequently than Nurse Teachers. 62:28
10. Staff Nurses were mentioned more frequently than Nurse Teachers. 50:28

In nominal order the top ten items uppermost in the students minds can be listed as:

	Value
1. Fellow Students.	253
2. Trained Nursing Staff.	156
3. The Ward.	154
4. Patients.	112
5. Sisters.	62
6. Staff Nurses.	50
7. The Hospital.	42
8. The School of Nursing.	32

9. Nurse Teachers.	28
10. Exams/tests/assessments.	20

It is also of interest to note that of all the items mentioned 841 tallies referred to people, other than self, and 473 tallies referred to inanimate objects.

6.1.6 Preliminary Conclusions

These content analysis findings were most relevant to the issue of teacher/student relationships. The findings indicated that the most significant people, to the first year student nurses, were the ward staff. This was also confirmed by the prominence of the clinical setting. They both seemed more important to the student nurses than the School of Nursing and Nurse Tutors. This suggested that teacher/student relationships in the clinical setting were of paramount importance in the pre-registration preparation of nurses. With this in mind it would be foolish to make recommendations about the improvement of nursing curricula by simply concentrating on the relationships between 'classroom' teachers and student nurses. The development of nursing curricula must take most account of the actual and potential teachers in the clinical setting.

6.2 THE STRUCTURAL ANALYSIS FINDINGS

This description of the quantitative analysis is quite long and is carried out in two ways. Firstly there will be a description of the findings from the first part of the interview (open responses) and

this will be followed by the findings of the qualitative analysis of the remainder of the interviews. There will then be a comparison of both qualitative analyses and finally there will be a comparison between qualitative and quantitative results. This was done to isolate those features which were common to all analyses and to identify those which were not. This was thought to be particularly necessary because the interview was more directive in its later stages. The separate qualitative analysis of the open and 'directive' parts of the interview means that there is some repetition in the results reported here. They are given without hesitation for the sake of accuracy and because repetition is an indication that findings are confirmed as more salient than those which are not. A full account is given so that the reader may appreciate as fully as possible the richness of the qualitative findings. This lengthy, but necessary, description will be followed by a discussion on the relevance of these findings to the proposition that the pre-registration preparation of nurses is not an educational experience and that this produces uncritical replicators of traditional practice.

6.2.1 Method of Analysis

This analysis, though arguably not in the strictest tradition of structural analysis, still followed the theme of recording frequency of comment. The key criteria for this stage of the analysis were:

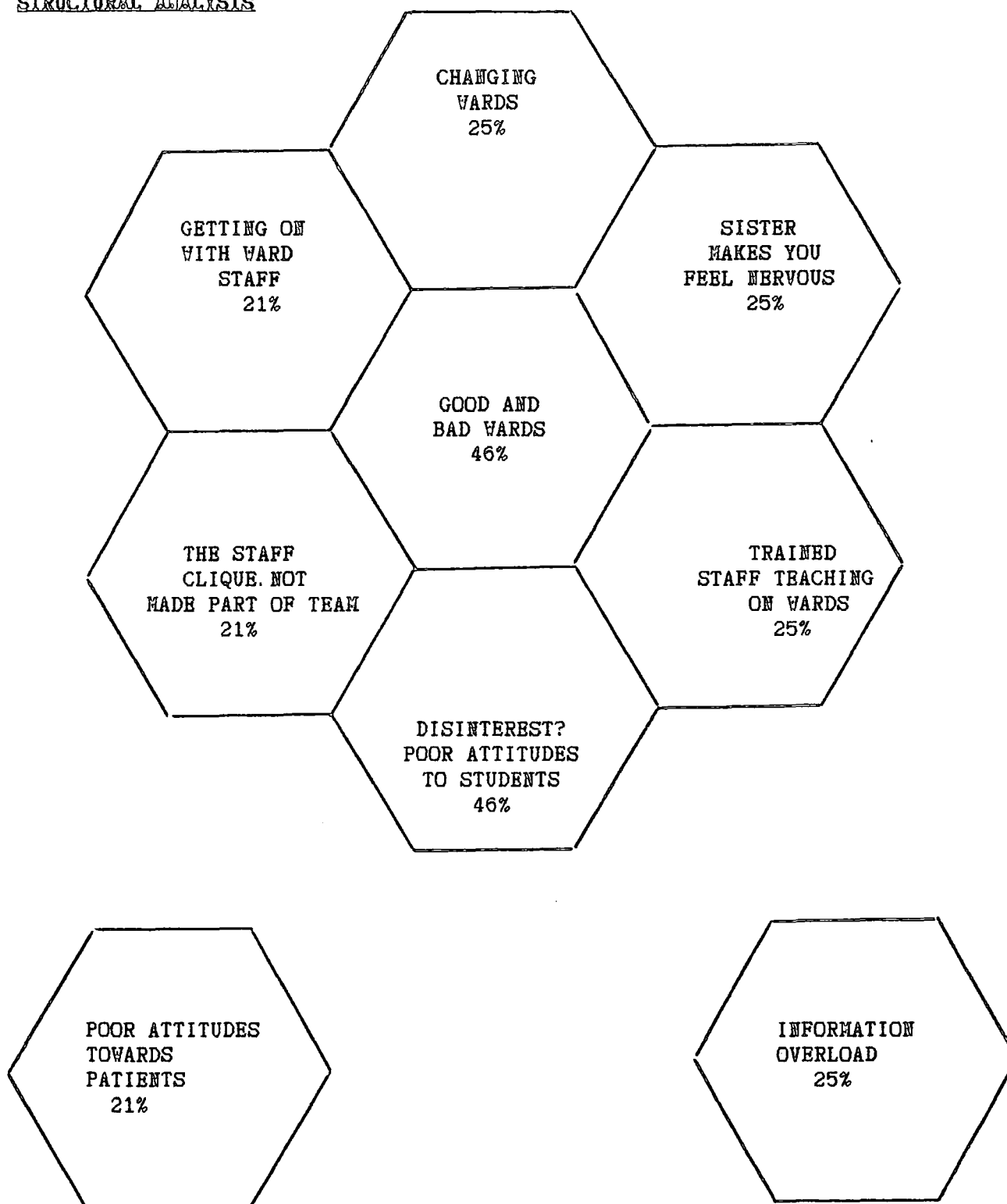
- a. The frequency of comment.
- and
- b. The relationship of emergent concepts to other concepts.

The frequency of comment was identified out at two levels, those elicited from the opening question and those elicited from more direct questioning. Indeed the structural analysis of the open responses, which were transcribed, would add meaning to the findings of the content analysis and in turn the structural analysis of the responses to the more directive questioning could add meaning to both of these analyses.

6.2.2 The Open Response Structural Analysis

A method was devised to record the findings of these data, which involved the identification of every topic of the interviewee's dialogue. Each topic was identified from a sentence or a paragraph. The topic was written in brief summary form, and every time the topic was repeated by the interviewee, or subsequent interviewees, the interview number was recorded next to the topic title. Each segment which referred to a topic was labelled with a letter of the alphabet to facilitate quick referencing at a later time (see appendix XIX). The topics which were mentioned by 20% or more of the interviewees were then transferred to a recording sheet which consisted of honeycomb shaped boxes. In this way concepts could be rearranged to display obvious links and relationships. The summary sheet showing this method of recording can be found in figure 3.

FIG 3 A SUMMARY OF THE EMERGENT ISSUES IN THE OPEN RESPONSE
STRUCTURAL ANALYSIS



6.2.3 The Findings of the Structural Analysis of Open Responses

Good and Bad Wards

One of the main findings was the ease with which 42% of student nurses were eager to point out that some wards are bad for them and other wards are good. It seemed that these individuals had had unsatisfactory and indeed unhappy experiences on some wards finding that this was reversed on others. The differences almost exclusively involved differences in attitude to students and their learning role. Less major differences involved the amount of learning available in terms of skills, appropriate patients and opportunity to practice and rehearse those elements of work which enhance what the student saw as valuable learning.

Changing Wards

Many of the students mentioned problems of changing experience which tended to emphasise a phenomenon which could best be called starting again.

"Everytime you go on a different ward you feel right at the bottom again and you work your way up to the top and then they move us".

"When I came off my medical and surgical I felt as if I was ready for anything, but then when I went on to nights and theatre I

really felt as if I'd just gone down again and I don't know anything".

"I mean sometimes you finish on one ward on the Sunday night and go on the next ward on the Monday morning. I think you want a little bit of a break to think about what you've done on that ward, and perhaps consolidate the knowledge a little more".

"You're absolutely lost for the first week and that's everytime you go on a new experience. I suppose it's pretty stressful, you know, it's like starting a new job every time".

These student comments revealed that starting new wards and departments tended to bring about fairly negative feelings. Some of the findings which follow tend to indicate why the students feel some trepidation about the adjustments which may be required when changing clinical experience. Not only can the student be worried about going to a 'good' or 'bad' allocation, they also seem to be in a situation of becoming unsettled, just as they are beginning to settle in their current clinical experience. Some clinical experiences can be as short as four weeks, but the most frequent is eight weeks. This 'change stress' seems to be related to changes in work and work relationships rather than changes in student role.

Attitudes of Disinterest to Student Nurses

This topic represented a catalogue of negative attitudes directed towards student nurses. They were found in the trained nursing staff in the wards and departments of the hospital. Thirteen individuals mentioned aspects of

negativeness and this represented 46% of the sample. The overall impression was that students were recalling their worst experiences. The following description is best taken in the context that 54% of the sample did not seem to suffer these experiences during their clinical practice.

The picture which emerged indicated those attitudes which were not uncommon on those wards and departments which have been selected for training. The picture is one of a lack of sensitivity and patience for students. Some students reported a distinct impression that the trained nurses did not want them, some Sisters and trained staff obviously having no time for them. Reported behaviours include poor treatment, being treated like a 'dogs body', strictness, personality clashes, being talked to like children and not being trusted. The most obvious negative piece of behaviour was to not acknowledge the individual student nurse's presence. Being ignored indicates the use of social disapproval as a means of punitive control. In addition to this topic area, four students reported aspects of authoritarian discipline mainly in the form of bossiness, doing as your told and treading carefully.

Getting on with Ward Staff

A key feature associated with changing wards/departments, and settling in, had to do with 'getting on with the staff'. When it happened things went well for the student. Many comments suggested that it was helpful.

"My next ward I loved. I got on with the staff there and since then it's got a lot better".

"I've never had a problem starting new wards, and that, I've always got on with the staff and, you know, I get on with things and I've progressed quite well on the wards".

Others suggested that not getting on with staff was a key feature of being unhappy on a ward.

"When you have a bad experience, when you go to the wards where you don't get on and they just sit there, and oh, I'm in charge".

"The things that make the difference are the ward staff, whether they are nice ward staff".

There was no indication that getting along with the qualified nursing staff was more prevalent than not getting along with them.

The Staff Clique

A concept which was closely linked to 'getting on with the staff', was that of the resident nursing team acting as an exclusive group. This made it obvious to the students that they were outsiders. This exclusion from the team occurred on the 'bad' wards and seemed to be particularly directed towards first year nurses. Some wards were found to treat students as equals, others used the clique to maintain the subordinate role of the student.

"Well its the Sister on the ward, the staff were very clanish you know they stick together".

On many occasions the students were treated less favourably than nursing auxiliaries who have little or no training. This emphasised the status advantage of being a team member.

"The auxiliaries on the wards seem to be really well in. When the students come on we seem like an outsider at first. Nobody helps you and talks to you until they know you and like half the allocation is over before you really get to know what you are doing. They seem to leave you out a lot".

It was also obvious that some nursing teams did this because they found the constant change of student nurses something of a strain.

"Well you're an outsider really, you're only there two months so you don't get to know the staff and they just get sick of the new people coming along".

The next emergent issue reinforced the general idea that clinical experience was particularly stressful where interpersonal relationships were poor.

Sister makes you feel Nervous

This was a consternation expressed by a quarter of the respondents. There were no consistent recollections of 'good' ward sister behaviours. It seemed that when Sister became something of a threat it took the form of constant checking and mistrust. The student nurses felt that they were

being watched. This made them nervous and instilled a certain lack of confidence,

"The Sisters on the ward, they have no time for you. I always feel that I'm being watched. I'm very conscious of that".

"The Sisters they were a bit, (pause) they seemed to (pause), everything you do, you seem to be doing it wrong and there's no teaching facilities".

"Other times they don't really understand that you're having difficulty with what you're trying to do, and they think that you're really stupid and pathetic. Then you just get to the stage where you're frightened to ask anybody and you'd go and ask a Student Nurse rather than go and ask a Staff Nurse and the Sister".

"Some wards you go on they are behind you all the time, the Sister, and you know, I don't like that, I'd rather just be left to get on with it, but they don't".

Some of the nervousness is related to the Sisters' unapproachability.

"On a lot of the wards you can't really approach the ones in the blue dresses very well, I mean some of them are approachable but others, you know, they sort of snap answers back at you".

This seemed to be inconsistent with a supportive learning environment and could be further supported by findings related to the next issue.

Qualified Staff Teaching on Wards

Around a quarter of the interviewees mentioned teaching on the ward as an important feature of the first year. The overriding opinion is one of contrast. Some staff helped the students to learn but just as many seemed to be reluctant to teach students.

"Basically I've enjoyed it. I've learned a tremendous amount and if only the trained staff would only take the attitude that you are students, you are meant to learn, that if there is a learning opportunity you should be offered it. It seems that really it's the only way it's going to stick in my mind".

"There's no teaching facilities on the ward and they just won't teach you, and when you sort of, like, go and ask them a question their attitude is well there are plenty of dictionaries on the ward.".

"The staff and the Sisters they like tell you what to do but they don't like show you a lot. They just like tell you what to do and you have to go and get on with it They'll leave you on your own but not all wards are like that".

"And I think they just leave you on the ward and you learn about it the hard way, by other peoples' and your own mistakes".

"I think, because on the first ward they were more interested in teaching. On the second ward they were more interested in getting the work done and you were there to allow the qualified staff to do more interesting things, like dressings, and you didn't get to watch them".

Occasionally students made positive comments about the teaching oriented qualified nurses.

"The qualified staff were very good really they tried to teach you a lot straight away. I was surprised by the amount of things I was taught in the first four months."

One student even described a conflict of attitudes on the same ward.

"The trained staff didn't like this at all because we were getting a thing called preferential treatment from the Sister. She used to do things like say 'you come on' and the Doctor would be admitting a person and examining and everything, say maybe a kneejoint, or something, and let them get on with the work and send one of us because we were learning".

The overriding impression was that some wards were so poor at providing an adequate learning environment that they caused the students considerable problems. This left a long lasting impression as did the examples of helpful teaching behaviours. The disappointment, however, seems to be linked mostly with an expectation that teaching should occur on the ward and that often it did not.

Most of the previous findings were linked in that they all revolved mainly around the permanent nursing team and in an indirect way to the ward. One of the other main findings related to attitudes towards patients.

Poor Attitudes Towards Patient

It was interesting to find that there were almost no recollections of incidents of good nursing care and perhaps this was taken for granted. What did seem to stick with some students were examples of poor patient care and poor attitudes to patients. Six of the interviewees recalled such incidents and they were important because they demonstrated the distress which some students can experience.

"The way the ward was run was like a sheep dip. Every morning, everybody was bathed but I felt that was wrong".

"So when I went to get this phone, the portable phone, I couldn't find the plug, so in the end I went to the office and Staff said, Is it for Mrs X? Yes I said, well its not available. I said yes it is I've got it, Oh she says, when will you ever learn".

"But I went there under the thoughts of helping people, and when I got there I was very upset because I really thought that they were being looked after like animals".

"And the way they cut corners, and sometimes it's not to any advantage to the patient".

"Well it's not fair being a first year I wouldn't like my mother and father to be looked after by somebody who doesn't really know what they are doing".

One commented on a colleague who had discontinued her training.

"She didn't like the attitude of like some of the nurses to the patients".

It must be pointed out that these comments are not representative of the quality of care in the hospitals under study. They are, however, examples of bad practice which indicated that students were allocated to wards which have poor standards, no matter how uncommon they may be. These few examples of bad practice remain uppermost in the students' minds and examples of good practice were not recalled, maybe because they are taken for granted or maybe because they do not have as much permanent impact.

Information Overload

One finding concerned the pressures of learning and was mainly associated with the School of Nursing and less frequently associated with the wards. One gained the distinct impression that learning which was valued most by the teachers and learners alike was the acquisition of propositional knowledge. In school students reported the incessant barrage of information.

"Well the first was the first six weeks, I found that too much. Everything was crammed in six weeks".

"I'd prefer it instead of having a block like having one day a week or something in school. You'd feel more in touch, it's easier to remember it instead of having everything crammed into two weeks".

"I'm absolutely amazed since then at the amount a nurse is expected to know".

"We seem to be going into things or trying to go into things in a great deal of depth, and there's no end to it, there's no bottom to the well, you can still be going on and on and on and on and you get a real sense of panic".

On the wards many students mentioned the need to work all day and then study after work.

"I think when you first come into it you aren't really prepared for all the work you have to undertake like working on the wards as well as having to work at home like on a night, you know".

"The work we've had to do. I didn't realise there was so much work to do. Well studying you know, going into depth with things. Somebody said the other day, it was just about up to 'A' level standard, well I didn't know how much you've got to do and that kind of thing".

Other passages emphasised the unreasonable demands which can be made on student nurses whereby they become physically and mentally drained by work on some wards. At the end of such a day the idea that they must then begin to study remained a constant source of pressure.

"You don't realise how much hard work there is both, in school and on the ward, and when you've done a full days work and you've got to come back here and start thinking about the study for the next week, and you end up shattered by about 9 o'clock. You know if you've been on an early".

Some students even indicated the sanctions which were used to maintain this state of affairs.

"In the introductory block we were scared stiff when we came on they were telling you, every other lecture seemed to be what you could be sacked for".

There was every indication that pressures were evident in the need to acquire information and that the amount of effort directed towards this seemed self defeating. This finding matches similar findings already cited in the literature analysis.

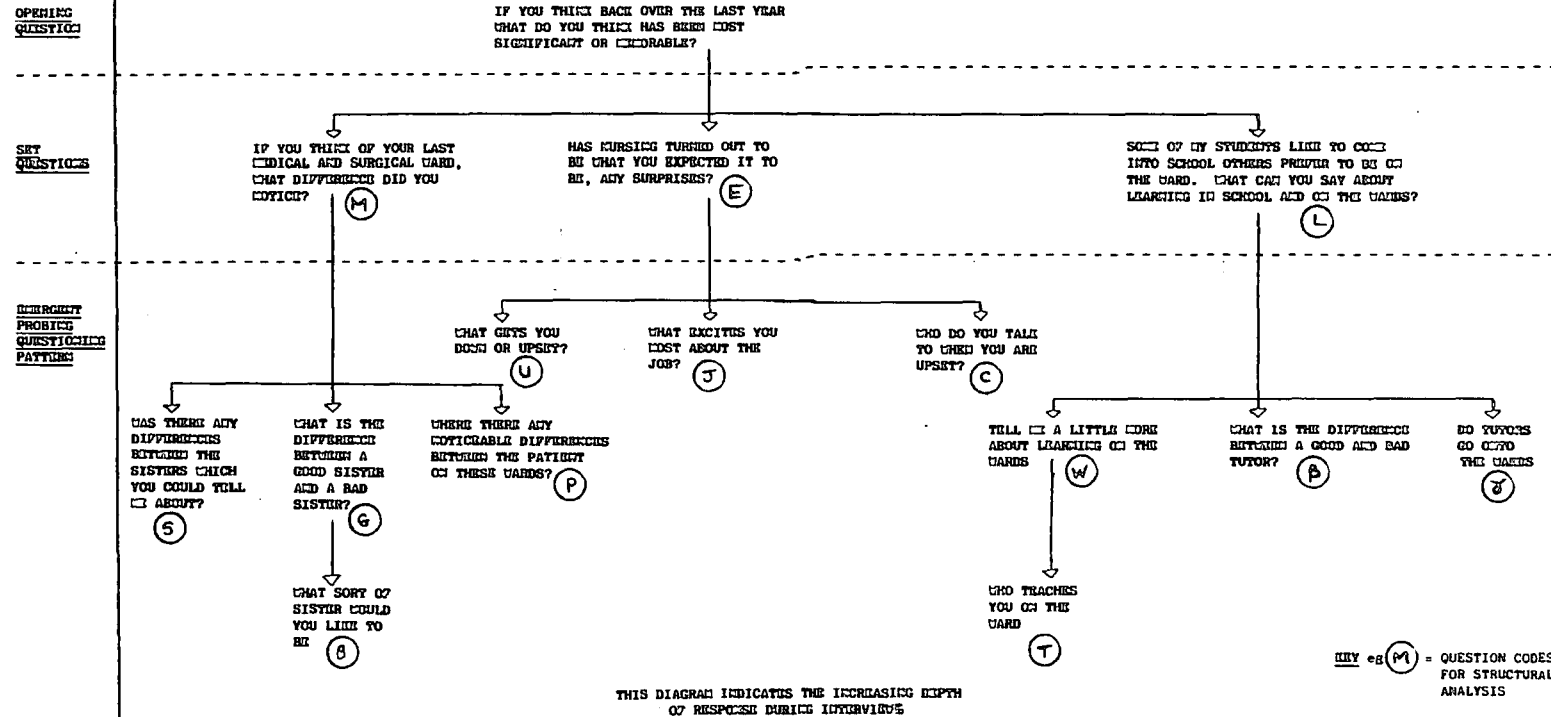
This concludes the description of the emergent issues extracted from the analysis of responses to the open response section of the interviews. The following analysis looks to data which represent a more detailed explanation of attitudes.

6.2.4 The Findings of the Structural Analysis of the Guided Responses

The findings up to this stage represent a summary of the major points which presented themselves in the analysis of the responses to the opening question. The second part of the structural analysis provided information acquired from the more specific set questions and the emergent probing questions. This analysis was carried out by listening to the untranscribed remainder of the audio tape recordings and making notes on the main issues. At the same time the questions were recording. It was found that a consistent questioning structure, beyond the three set questions, could be identified. This structure can be represented by an algorithm and was of importance for two reasons. Firstly, it enabled the analyst to code each response in relationship to the question which had been posed. Secondly, it enabled the analyst, and enables the reader, to understand how far each response had been freely volunteered or encouraged by a line of questioning (see Fig 4). This figure demonstrates an increasing depth of response within the interviews. The method of recording involved the use of hexagonal boxes in a similar way to the design used for the earlier structural analysis. One difference was that notes were entered into hexagonal boxes as soon as they were identified from the audio tape recordings (see Appendix XX). As each new concept was identified a new hexagon was created and drawn in close relationship to a hexagon on a closely related topic, wherever possible.

Those hexagonal boxes which contained the greatest number of references were extracted and the key concepts listed. The remaining data were then examined to discover any relationships between items which may have been misplaced, or had some relationship which was not immediately recognised

FIGURE 4 EMERGENT QUESTIONING PATTERN
DURING THE INTERVIEW FIELDWORK



during the recording of concepts. This method seemed to reveal the concepts which were important to students, but which required some encouragement from the interviewer to ensure elaboration of ideas most relevant to the student nurses. The analysis of this part of the interviews was also expected to provide more detail on some of the more sketchy points which were uppermost in the interviewee's consciousness. The method of analysis can be understood in greater detail by references to Appendix XX.

The emergent questioning structure (figure 4) provided an obvious framework within which to discuss this analysis. This is because the emergent questioning structure is almost synonymous with the emergent themes, both influencing each other as the interviews progressed.

Differences between Medical and Surgical Wards

This question precipitated more information about the characteristics of the preferred learning environment than specifically about the nature of medical and surgical wards. It was interesting to find that some characteristics could be found, or not found, on medical and surgical wards alike. Others were consistently related to one type of ward rather than the other. The main concepts precipitated by this question can be called:

- i Getting to know the patients.
- ii Age of patients.
- iii Getting results.
- iv The pace of work.

i Getting to know the patients

It became obvious that this was valued by students and can be considered a key feature of their experience. In a nutshell this was a preferred feature of medical wards and, generally, surgical wards were too busy for the students to get to know the patients well. On the medical ward there was more time to pay attention to the patient. The patients also tended to be on the medical ward longer than on surgical wards, where the students reported a quick turnover.

It is also interesting to note that students reported that staff generally had more time to spend with them on medical wards. This indicated that on wards that are less busy, staff have more time for each other as people, and more time for the patients as people. This finding relates closely to the next concept which concerns the age of the patients.

ii Age of Patients

A third of the interviewees commented on the relevance of the age of the patients and to their relationships with them. The significance this had on the relationship was demonstrated by the general finding that patients on medical wards were older, mostly elderly, and the patients on surgical wards were younger. The effects of age on Nurse/Patient relationships was that the student nurse could associate with, or relate better to, younger people. They found it difficult to

gain this rapport with elderly people. This really took the form of being unable to understand the patient's values and background. When the student nurses reported good relationships, the significant feature was an emotional rapport which took the form of maternal, paternal or kinship attitudes. Rarely could one find the relationship based on an understanding of values, lifestyle and the background of the patient. This seemed to highlight the importance of interpersonal skills learning during nurse/patient relationships applied to different age groups and the potential this can have for the learning process.

iii Getting Results

It was worth noting that student nurses seemed to obtain quite a lot of satisfaction from seeing patients get better and go home. This occurred more frequently on surgical wards and was related to the quicker turnover of patients. The medical wards tended to bring about more frustrations if the patients stayed longer and were more likely to die. There was also a higher incidence of chronic disorder which brought about long term dependence e.g. stroke patient. There was one example of a surgical ward which had an unusual proportion of cancer patients with distressing conditions, long term treatment and rehabilitation. On this ward the student described features more commonly associated with medical wards. This suggested that it was the nature of the work which was most important, rather than the function of medical and surgical wards. It was easy to conclude that wards should be selected for training on the basis of critical features of the client group, rather than just on the basis of titles

such as medical and surgical. A better distinction may be between acute and chronic illness wards.

iv The Pace of Work

The pace of work was generally found to be faster on surgical wards than on medical wards. The medical wards were often described as more easy going with less rush and less bustle. There were uncommon examples of the surgical ward being described as less rushed and similarly there were occasional instances of medical wards which were described as very busy. This tended to suggest that it was the pace of work rather than the type of work/patient which was the critical factor. On wards which were busy, the overall impression was that this was more stimulating for the student, because there was more to learn. Conversely the qualified nurses had less time to show the students what to do or how to do it. The main stimulus for learning on the busy wards was being involved in constant activity. On those wards which were less hectic the opposite was reported. There was less to 'see and do' but the staff had more time to show the students how to nurse.

The pace of work was also important to the learning process because of two other reported features. Busy wards could be an advantage to students because they were given more responsibility. This increased the level of their participation in nursing activities. The counterproductive feature of the busy ward was that the work could be hard, which usually meant physically exhausting and monotonous. This seemed hardly conducive to learning.

This analysis suggests that there are critical features of the clinical experience which enhance the learning process and that they are closely related to, but potentially independent of, the stated medical function for the ward. One can summarise these findings by listing the emergent features as indicated by the student nurses' opinions.

Students tended to prefer clinical experience:

- a In which they were able to get to know the patients better, and in which they could relate to the patient's values and personal background.
- b Where they saw the results of their work in the form of patient's recovery and return home.
- c Where the pace of work was sufficiently involving for it to be stimulating and where it provided frequent learning opportunities. This without working the student to the point that she was unable to take advantage of the learning opportunities.
- d Which allowed the qualified nurses time to teach, show and relate to the students and patients alike.

It is likely that these preferences reflect an ideal clinical learning environment and that they provide indicators which may be used for the

careful selection of learning settings. They can also form the basis for more preparation and support when these preferences are not met.

Ward Teaching

The responses which related to the learning process on the wards and departments highlighted some key yet familiar features. They will be discussed under the following headings which represent the emergent themes.

i Clinical practice as significant learning.

ii Ward practices and school teaching.

iii Time devoted to teaching.

iv Fellow students as teachers.

v Tiring work and studentship.

i Clinical Practice as Significant Learning

The most consistent response to the question comparing 'the school' and 'the wards' was that the students said that they learned more on the wards than in the school. Two thirds of the students made relatively spontaneous comments which indicated, in one form or another, that learning in the clinical area was most satisfying, more relevant and most helpful.

Students were generally more scathing about the relevance of the material taught in the school of nursing to nursing practice.

"You can learn more on the wards than school, too unrealistic in school and too ideal, it's not like that on the wards".

There was also evidence to support the age old addage that doing is better than seeing and seeing is better than hearing. The school of nursing seems to be a place where a lot of listening goes on but very little 'doing'.

"I think the wards are best, when you're doing something it sticks in your mind, you can relate back to it whereas in the school it's just words on a page".

"In the ward you can see the illnesses that they are talking about. In the school they must be out of touch".

"When we had our 'gynae' lectures I hadn't a clue what they were going on about in these lectures, but once I got on the wards it all fitted into place. I seem to learn loads more on the ward, instead of listening to somebody, it seemed to sink in better, because you were actually nursing patients".

"In school it's strictly theoretical you sit there all day and you absorb all this knowledge and you think Phew! Have we done all that today? You just sit there and absorb it

all. It's interesting if you've seen it on the wards. You can relate to it then it's great".

"I've learnt more in the ward than I have in block I think In block we do backgrounds, various illnesses and things, you sort of study up in the library about them but as far as practical things go I've learned more on the wards".

This last comment emphasises the distinction between theory and practical learning. The school seems to be an acceptable place to learn theory but unacceptable for the learning of skills.

It was obvious that the majority of students found the clinical experience the most relevant place to learn nursing. Some acknowledged the importance of 'School Learning', but what was more obvious was the inefficient use of teaching time. The following section demonstrates one of the most distinctive features of nurse training, the theory and practice gap.

11 Ward Practices and School Teaching

Almost half of the students described the inefficiency of the classroom teaching programme as a preparation for ward work. It was said that the school taught one way and the wards did things different. Some students reported how some of the 'good' wards did things the 'School Way'.

"It is difficult sometimes because, we are told one way, and when we go over into the hospital, you're taught that it's an entirely different way on some of the wards. On some of the wards some of them are very good, they'll say we will do it as they do in the school, then other wards will say do it this way".

It was also obvious that what they teach in the school is often impractical and too idealistic to be achieved within the constraints of the 'real setting'.

"Practical stuff in school is a waste of time, I think you should be taught your practical stuff on the ward. It's just a different world, they show you one thing but it's not the way it's done on the wards, all the bits and pieces, you just can't do it all half the time, you just haven't got the time".

"They don't do things on the wards to procedure, the school teaches the procedure book, but on the wards they say it takes too long".

A comment by one of the students sums up the probable waste of time due to an inappropriate curriculum plan.

"I think you learn more on wards, sometimes they tell you something in school and when you get out onto the wards it's completely different. It's the opposite and you think what

was the point of the school teaching us it when you've got to do it completely different".

The artificiality of some of the learning situations in the School of Nursing can be observed in the following extract.

"Well I mean in our job it's very difficult to learn anyway because when you're being taught you're not being taught with the real thing, that's in school, and when you go onto the ward you're suddenly being confronted with people who speak, instead of a rubber dummy in a bed, which is quite a frightening experience. In the first place, but there's nothing can be done about that, it's just a barrier you've got to overcome. On the wards, again you get taught in school the way things are done and tutors come round on the wards and make sure you're doing it the way you were taught, which is fair enough, but, when you get into the ward situation it is virtually impossible. I say virtually, because, I mean, you can do it but it's virtually impossible to do things the way you were taught, you've got to sort of come to terms with it and do it as best you can in the surroundings, the time and the circumstances, so again you're, you need to know the proper way to do it first before you can start taking shorter methods obviously. I don't think anything can be done about that, but you definitely do it different, a bit quicker and still with the same amount of care but just certain circumstances are different. You've got lots of other things to do, not just

that one thing, and you've got other things on your mind as well".

There is some suggestion in this segment that pressure of work made it more difficult for students to learn and rehearse skills in the practical setting.

One particular extract demonstrated the folly of attempting to remedy this situation by teaching input alone.

"I don't know they teach you so perfectly, although I suppose it's better to learn perfectly and then adapt it to the ward. Plus as well, on the wards you haven't got time to be learning by someone who's not a member of the ward. If they came up separately they would have to take you separately and they are really short staffed at the minute. With one person off sick you're in a state where you haven't really got time to be taken away by a tutor to be taught something, cause the work would just sort of pile up".

The conflict between the ideal way and the most expedient way of nursing is encapsulated in this brief comment.

"You haven't got time. Like in the school it took us 15 minutes to make a bed. You're expected to do a whole ward in 15 minutes".

It was obvious that the conflict between 'school learning and 'ward learning' was most relevant to skill learning rather than to knowledge acquisition. There was a feeling that the propositional knowledge that was acquired was independent of, and irrelevant to, the activity of nursing. It appeared that there is not so much a gap between theory and practice but that the theory selected was not always relevant to practice. The classroom learning was both incompatible with the requirements of practice and an inaccurate reflection of real life practice. On analysing the audio tapes one came to the conclusion that all nurse learning should take place in the clinical setting and that students would prefer this situation. Much of what followed in the subsequent analysis suggested that the preference for ward learning was an indictment on the quality and relevance of classroom teaching. The students frequently described the inadequacy of formal teaching and support on the wards, even though the ward was the preferred setting to learn nursing. The school appeared not to facilitate learning related to practice and the clinical setting seemed to be poorly organised and resourced for it to enable learning related to practice. The students were learning to nurse, more because of the impact of experience rather than because of the quality of the planned programme of teaching. The following two points which emerged as significant features of ward learning demonstrate the potential waste of the learning potential in the practical setting.

iii Time devoted to teaching

Over a third of the students mentioned the lack of teaching on the ward. Generally this manifested itself as lack of time for qualified

nurses to spend teaching.

"The surgical ward that I was on you couldn't go and do dressings on your own and they were too busy to take you, the senior ones, and I've had to take my aseptic technique assessment, and that and they were just too busy to take you and everything".

"I don't think we learn enough on the wards because of the staffing situation, one trained staff and three students. There just isn't time for teaching, you're part of the staff, part of the work force, and you get on with it as best you can. If anything special turns up there isn't enough staff for you to go and stand and watch it, and that's what you're there for. You haven't got time to watch it because you're too busy bathing somebody".

A few of the students described a sort of trial and error learning which occurred in the absence of any teaching.

"I suppose you sort of fumble through things and sort of say, AH! that's the way it goes, sort of pick it up".

"I enjoy it, obviously we have to learn, I don't know, just pick it up as you go along, I think we do that".

Some students were surprised at not being taught on the ward. Others adopted the idea that it was not the job of the Sister and Staff Nurses to teach them.

"I think I was under the impression more that Sisters helped the students a bit more than they do you know, practice wise, you know, giving us part of our practical training, which they don't seem to do".

Sister puts you off, like catheterisation, because the Sister is not responsible for teaching you these things anyway".

"Only when the opportunity is there, well I assume, I don't know what a Sister does really. I would assume that if she is there she has her own particular responsibilities to do without actually teaching as well".

"Their job's not teaching on the wards, really. You're more or less left to your own devices. You can come over and get work from school, but they don't say to you what to learn this week on the wards".

One interesting example of attitudes to ward teaching was the general response to questioning by students.

"Sisters and Staff Nurses, they always seem busy in the hospital and that, so you tend to think, OH! if I go and ask

them something they'll be thinking oh! is she bothering us again, so we tend not to go and ask them".

"Well there is a lot of staff on the surgical wards as well, not so many students, and theres a bigger ratio of qualified staff to students, so I think sometimes they sort of get sick of answering questions by the end".

The overall expression of dissatisfaction was with the lack of teaching carried out by qualified staff, either because of lack of ability, lack of interest, or most frequently, lack of time. There were some examples of helpful teaching attitudes and the impression was that there may be as many good teaching wards as poor ones but the students seem to take the good ones for granted.

"I think it depends on the staff on the ward because on the last ward I was on the Sister was very helpful and she liked you to ask questions. In fact you got wrong if you didn't".

iv Fellow Students as Teachers

Whether asked or volunteered, the students frequently mentioned their recourse to their friends and senior colleagues for explanations and help with learning practical things on the ward.

"I don't have any feelings on that because I can learn just as well from the second year student nurse, because there's

no tension like between you and the Sister. Sometimes it can be better".

"Staff Nurses you don't learn a lot from because they are always in the office answering telephones and things. The third year students are left to do the more important things, they are more on your level".

"The third years tend to be helpful and the qualified staff and Sisters, but then again you can't always approach qualified staff because they're busy with office work and Doctors' rounds. Third years tend to be helpful even the auxiliaries are helpful with, erm! Just the practical side the jobs that they've picked up over the years you seem to learn off everybody, even the Domestics".

It became obvious that senior student nurses were preferred because they were easy to approach and gave an explanation which the junior nurse could understand. The second point was that fellow students were preferred as practical work teachers because qualified staff were too busy. Even in busy situations fellow students still seemed to have some time to help.

"The other students, the second and third years. I think it is because they tend to talk a bit more at your level because they've done it so they can explain it a bit more clearly. Occasionally we have teach-ins as well, where we

go round and the staff nurse will ask you a question on each patient and if we didn't understand she would explain it, but we very rarely have the opportunity of doing that because they are too busy all the time".

Three of the students mentioned Enrolled Nurses in the same vein as fellow students. It seemed that the least qualified and least experienced members of the nursing team were most approachable. They were helping students to learn the practical nursing as carried out in actual practice.

v Tiring work and studentship

Half of the students commented on the tiring nature of clinical work and the difficulty experienced in trying to study after a day of physical and mental exertion.

"When you come off the ward, like the surgical ward was really heavy, and like, we had the head injuries and car accidents as well as surgical and we just couldn't learn we were so tired. We feel mentally exhausted all of the drains, and I.V.'s and thirty M.L.'s hourly and you come and you just, sometimes you just sit and you don't say a word and you sit for about an hour and you don't say a word. You don't cook or anything you don't even drink, you just sit there on the floor with your bean bags and you just ache. And you're expected to write essays and get all your books out".

This last quote demonstrates just how inconsistent the demands of ward work were with the requirements of continuous studentship. The idea of working hard, however, was not always, described in negative terms.

"It's a lot harder work on the medical ward, it's a lot more satisfying, we were shattered".

Some comments indicated that the work was obviously physically tiring and in addition it was also hard because it was stressful.

"Nursing is a lot of hassle, it's a job that easily gets on top of you. It's something you've really got to want to do".

It was easy to conclude that the student was trying to satisfy both clinical requirements and learning requirements. During clinical practice the most pressing requirements not only made learning difficult at work, it also made learning difficult after work. The effect of clinical practice on learning often lasted beyond the work time and into free time. It could be argued that we were expecting student nurses to work hours well beyond the average worker of their age group and that this 'overtime' work took the form of academic study. In reality, student nurses rarely met these extra study requirements set by the School of Nursing during clinical practice.

To summarise, it was possible to conclude that teaching on the ward was valued by student nurses as the most significant

learning. At the same time it seemed that the learning which occurred was more a product of being involved and participating in working practice. A busy ward meant more to learn, but it was ironic that this often meant that learning was made more difficult. It seemed that a busy ward also meant that the 'formal' learning was interfered with. Clinical staff were too busy to teach and the possibility of study after work was limited.

The expectation, engendered by the school, that students should study during and after work, only served to compound the stresses of clinical work. Sometimes this study was formalised by the imposition of work books and essay deadlines.

In addition to these stresses one could find further stress caused by the disjunction between what was taught in the School of Nursing and what was practiced on the ward. Finally it was obvious that teaching on the ward was most likely to be carried out by the most inexperienced nurses. Fellow students, and occasionally nursing auxiliaries and enrolled nurses, were called upon to give help when learning practical work. Having examined the general status of learning in the clinical setting it is worthwhile turning to another emergent issue related to the clinical setting. This concerned the Ward Sister. She was clearly the major influence in the clinical environment. This was not altogether surprising given that she was the nursing team leader.

'Good and 'Bad' Sisters

When asked to compare the Sisters on medical and surgical wards and 'good and 'bad' Sisters, the following main themes emerged:

- i Works with us on the ward.
- ii Sitting in the office.
- iii Talks to us/with us.
- iv Makes you feel nervous.
- v Likes to teach.

1 Works with us on the Ward

One attribute of the preferred Ward Sister was her active participation in the delivery of care. This was seen as advantageous for a number of reasons. The first seemed to be a straight forward admiration for the fact that she was not too status conscious and helped students with their work.

"A good Sister comes and helps you to make beds on the morning".

"The Sister on the surgical ward might have helped more".

"Both Sisters got 'stuck-in', like some sisters don't seem to do".

"She should work the same as everybody else. She should teach the students as much as she can".

This last comment suggested that when the Sister worked by the bedside the opportunities to learn from her were greatly increased.

Other comments indicated that modelling was a powerful source of learning in the clinical setting. Working on the ward was sometimes synonymous with caring for the patients.

"The Sisters on the surgical ward had a lot more to do with the patients than they did on the medical ward. On the medical ward they just seemed to sit in the office and do the paperwork. But on the surgical ward they came out onto the wards and talked to patients".

The Sister who works on the ward was admired even more if she worked with the Student Nurse and not with the other qualified nurses.

"She went into great depths to explain things and when she came on the wards she never used to work with the qualified staff she always used to work with you. We never used to work student with student, she said you learned more when

you worked with the qualified staff. You've got a good guide if the Staff Nurses or Sisters work with you".

Likewise, an attribute of the 'bad' Sister was leaving the work to the staff.

"Sister never did anything, it was left to the Staff Nurses, always rushing about, doesn't have time for anyone".

"A good Ward Sister will realise everybody's needs, staff and patients alike. A bad one will be happy as long as everything has gone along smoothly or will give the orders and walk away and expect everything to be carried out without 'mucking' in. A good Sister to me works with you, not just do all the office work and making Doctors teas you know, and working on the ward and make sure that everything is done on the ward".

A concept demonstrated in this extract and perhaps the antithesis of 'working with us' is that of 'sitting in the office'.

11 Sitting in the Office

Twelve of the interviewees mentioned this issue, seven of them specifically in relationship to the 'bad' Sister and two related to the 'good' Sister. A good Sister doesn't sit in the office as can be evidenced by the following comments:-

"A good Sister gets on well with the patients and staff, respects other people, they respect her. One used to work hard she never used to sit in the office".

"The Sister on the medical ward came out of the office and she worked with us, she was good with all the staff".

More frequently though the 'bad Sister' was described as one who sat in the office.

"The Bad Sister is high and mighty, they sit in the office and don't do their share of the work. One didn't know the patients' names".

"Comes and helps you make beds on the morning, one Ward Sister just never left her office. Some just talk down to you".

"The Sisters on the surgical ward had a lot more to do with the patients than they did on the medical ward. On the medical ward they just seemed to sit in the office and do the paperwork, but on the surgical ward they came out onto the ward and talked to patients".

This last quotation demonstrated again the close relationship between the two concepts 'working with us' and 'sitting in the office'. In addition one can detect, in a number of the recent quotes, that the students really notice the Sisters' lack of

knowledge about her patients. Sometimes this is perceived as not caring for the patients.

"One who doesn't really care what is happening on the ward. She sits in the office all day and drinks coffee. She hasn't got a clue what's going on. She doesn't know if you've given anybody an enema or anything. The Staff Nurse runs the ward".

There is also some evidence that other senior members also engage in this dissociation from the ward activities.

"A lot of the time a lot of the Staff Nurses are involved in the paperwork and bits and pieces that are in the office. Fair enough! If they are busy and there is all of that to do. But, I don't want to be like that I'd rather have someone else to do the paperwork and I can get back out with the patients, because that's the most important thing".

The concept of 'sitting in the office' indicated a form of isolation and 'working with us' suggested that this isolation was significant to the student nurse. The next concept adds another dimension to the need which students seem to have to relate to the team leader.

iii Talks to us/with us

The idea that the student appreciated communication was demonstrated by those comments which say that this was a characteristic of a good Sister. Six of the students commented that a good Sister talks to them.

"A good Sister you feel relaxed with, you can talk with her, she doesn't shout if you've got nothing to do".

"She wasn't able to communicate with us like this other one, the good one, she was teaching us and talking to us as an individual and just making you feel really relaxed".

The relationship between 'talking to us' and teaching began to be demonstrated by other comments.

"The Charge Nurse on the surgical ward wanted to help you learn. He would talk about things with you".

Another comment suggested that this concept was part of being acknowledged as a person.

"On the surgical ward well the Sisters talk to you, whereas the other two they never talk to you as a person, not as like an underfoot sort of thing. You feel more like a human being".

There is some suggestion here that not talking to first year Student Nurses is a strategy used by some Sisters to maintain the subordinate role of the student, and thus control over them.

The less preferred Sister seems to discourage communication because of the fear she engenders.

"I like a Sister to be easy going and you dare go up and talk to her. But this other Sister you didn't dare have a conversation with her".

It was obvious that it was not only the first year students who were the recipients of this behaviour.

"Sister doesn't speak to first year nurses. She just ignores you. If you ask a question she goes humph! and just walks out it's terrible, she even did that to a Tutor!".

Other Sisters seemed only to talk to students when a reprimand was necessary.

"She just basically ignored us she didn't take much notice of us at all. Everything had to be done proper, but we were only starting and I know we were slow. She was quick enough to pick us up on that. She didn't talk to you. She never

seemed to speak unless you had done something wrong, or you were in trouble".

The probability that this has to do with distancing the student from the Sister was demonstrated by the following excerpt.

"She always seemed to have time for you even if your problems were like small. You could go and talk to her and one of the other surgical Sisters was like that. But the other two, one on medical and one on surgical were both a bit 'stand offish' you know keep your distance, which I suppose you've got to you can't be too friendly".

After hearing the last lines of this excerpt one was encouraged to imagine the ways in which this sort of behaviour might be transmitted to neophyte nurses.

Some of the students mentioned a variation on 'talking to us' which can be entitled 'approachability'. Five mentioned the subject of the approachability of Sisters in the following way:-

"But the other wards, those wards that you had problems at, it was the Sisters and Staff Nurses - you couldn't go to them".

"If you're a good Sister they've got to respect you for who you are but not be frightened to approach you".

"You weren't frightened of her you could go and ask her anything you weren't frightened of getting your head bitten off, if you went anywhere near the office door. She always seemed to have time for you even if your problems were small. You could go and talk to her and one of the other surgical Sisters was like that. But the other two, one on medical were a bit 'stand-offish' you know, keep your distance, which I suppose you've got to, you can't be too friendly".

"The other surgical ward was the male surgical ward, it was very well run by the Sister but nobody can approach that Sister".

One can also note in these comments that the approachability of the Sister was reduced when the student nurses were frightened of her. This may seem a rather obvious link but it is worthy of attention as the discussion moves to the next significant feature of the students' discussions on 'good' and 'bad' Sisters.

iv Makes you feel Nervous

Over a quarter of the students described a sense of unease with some Sisters and that a good Sister made them feel at ease.

"I found the Senior Sister was not so much a dragon but she was a typical Sister. She would sit there and really make you feel really small, an old fashioned type of Sister

really. On the surgical ward the two Sisters were very nice and made you feel at ease straight away and I didn't feel scared of them. If ever I was on duty with the Sister on the medical ward I'd be terribly worried what I was doing all the time, terrified in case she came out and, just a typical Sister she was".

The fear which students expressed for some Sisters could be further demonstrated by the following quotes:

"A good Sister you feel relaxed with, you can talk with, she doesn't shout if you've got nothing to do".

"You would stand around in the linen cupboard so she didn't find you doing nothing, you know, you feel really uneasy. It knocks your confidence because you daren't do anything in case it's wrong, cause you probably get told off for doing something if it's wrong".

"The surgical Sister was on another level, you felt frightened of her, which I don't think anyone should feel of someone that's above you and you're supposed to turn to. I don't think you should be wary of her, I don't think that makes adequate working surroundings. I think you should get on with the people you work with. I was a bit frightened of her, she just basically ignored us. She didn't take much notice of us at all".

It was also obvious that some Sisters exacerbated the uneasiness experienced by the students with a form of overzealous supervision.

"One Sister always seemed to be on my back".

"The Sister has got to earn her respect from colleagues and not be on your back all the time. One, she doesn't think you can do anything, they have no confidence in you".

"She didn't trust you with anything, she would come and check to make sure you had done everything whereas the Sister on the medical ward trusted you that you do things correctly and get on with your work".

The last of these extracts demonstrated once again something which must be emphasised. This was that the student nurses often contrasted their unfavourable experiences with experiences which demonstrated a more preferable state of affairs.

v Likes to Teach

Over a third of the students commented that the hallmark of a good Sister was that she likes to teach. This tended to support the general impression that it was difficult for students to learn on some wards because Sister did not enter into a meaningful relationship with them, and that the students wanted the Sisters to teach them. They saw the Sister as a significant resource person. She was also a powerful model to imitate. Seven students described 'liking to teach'

as a preferred characteristic of the ward Sister and two mentioned "Don't teach" as an attribute of a poor ward Sister.

"Preferable Sisters like to teach and are more friendly".

"She wasn't able to communicate with us like this other one was, she, the good one, was teaching us and talking to us as an individual and just making you feel really relaxed".

This comment demonstrated a strong and understandable link between communication, teaching and feeling relaxed. Good teaching behaviour was often described in terms of a willingness and ability to explain things.

"Sister was very good for teaching purposes, she left a lot up to you. If you didn't know what you were doing she would explain".

"There's absolutely no communication, whereas, the other Sister, the nice Sister, when she did the ward report she went into great detail about the medical terms and things and she'd explain a bit more.

"On the medical ward she understood more about the nurses in training and she went into great depths to explain things and she came on the ward".

The whole picture became one in which it was obvious that some Sisters helped students to learn and others didn't. This is not only restricted to the learning of practical things:-

"The medical Sister was into teaching she made sure you knew the theory side. The surgical Sister left you to find out. I preferred the medical sister, she helped you a lot more".

"The Charge Nurse on the surgical ward wanted to help you to learn and would talk about things with you".

It is possible to summarise the significant findings associated with Ward Sisters in the following way. The Sister appeared to be important not only because she determined the attitudes to teaching and learning of the ward team, but because she was such an influential and impressive individual. She could help the nurses learn by her overt 'teaching' and 'helping' behaviours and also by demonstrating a good role model which the students could copy. This was not achieved by Sisters who sat in the office and ignored students when they went onto the ward. There was also a worrying tendency for least preferred Sisters to cause fear and unease in students and this was coupled with an inability or unwillingness to communicate with them. It pointed to a poor teacher/learner relationship within the Sister/Student nurse roles. There also seemed plenty of scope for hope in that there were many examples of good teaching behaviours in practice.

The specific nature of this Sister/Student relationship bears specific relevance to one of the findings of the literature analysis. This was that there was a lack of rapport between students and their teachers. The evidence in this structural analysis suggests, in many instances, that this was true in the clinical setting.

After such lengthy discussion on the findings related to the learning process in the clinical setting it is now appropriate to discuss the significant features related to the School of Nursing. These findings in the structural analysis were just as illuminating.

The School of Nursing

The School of Nursing was certainly described as a centre for the acquisition of propositional knowledge. This 'theory' related more to the retention and recall of fact. It has already been established that learning practical things in school was largely inefficient and confusing. What was taught in the school was different from what was done on the ward. Four major issues emerged which demonstrated what was most significant about the School of Nursing in the students eyes.

i Seeing friends again.

ii Information overload.

iii Exam pressure.

iv Learning is unrealistic, irrelevant and boring.

i Seeing friends again

This was the only consistent advantage to be found in relation to coming into school. Seven student nurses mentioned this as something which they appreciated.

"We like coming into school because it's a change for us all to get back together again".

The emotional support which the group gave can be demonstrated.

"It helps coming back into school, us all talking getting things that have happened off your chest".

"When we come back into school we see everybody and there's loads to talk about".

There is little more that can be added to this except to say that, by inference, it was probable that contact with friends was an important source of support for individual nurses. This could be lost each time they returned to clinical experience. Besides some occasional comments on the benefit of the School for catching up with study, the students made very few other consistent and significant positive comments. The other three comments indicated negative features about school work.

ii Information Overload

Over a quarter of the students mentioned something associated with the school which has been labelled 'information overload', although no student actually used this phrase.

The concept arose from a general impression that the blocks of study were either too long, too intense or both. The introductory course was particularly troublesome:-

"The six week introductory course was too much, far too much. By the fifth week we were pig sick and then there was the two weeks' medical block to follow. You didn't want to know anymore".

"We had six weeks in school initially which I think should have been three months because an awful lot of ground is covered".

"When we first started we were in school eight weeks solid, all of us, we were just about pulling our hair out - it was terrible".

"Being in block I think the eight weeks introductory block was a bit long. They seemed to be padding it out".

"Well the P.T.S. block was very long and everybody was dying to get out by the end because it was all basic stuff you'd done at 'O' level Biology".

These last two quotes indicated that the unhappiness associated with being in school for a long time was not only due to information overload but to an unimaginative curriculum as well.

The students seemed to be able to tolerate block time if they were able to work with patients, and if the information was acquired in a stimulating and interesting way. There was some indication that too much information was presented in a short time, and that this was made worse because of its uninteresting form. It was obvious that information overload had a lot to do with the promotion of the physical sciences, particularly Anatomy and Physiology.

"I didn't have any 'O' levels and I'd never done any Biology or anything like that so it has been quite difficult to get into it. I mean the human body doesn't change so once you learn it you learn more and more".

"They did an awful lot of Anatomy and Physiology which I think they are dropping now and putting a lot more patient care into it".

The suggestion that the School of Nursing was less likely to involve itself with 'know how' is indicated by the following quote.

"In school it's strictly theoretical. You sit there all day and you absorb all this knowledge and you think, Phew! have we done all that today. You just sit there and absorb it all".

Another comment suggests that some individuals who entered nurse training underestimated the amount of knowledge a nurse needed to acquire.

"You need to know an awful lot more than you would ever imagine".

It was interesting to note that the learning in school was particularly tedious, and at the same time students were expected to study after work on the wards. Wherever the students went they were liable to find learning difficult. This suggested that serious curriculum deficiencies could be found in the pre-registration learning programmes which nurses follow. The emphasis on acquisition of propositional knowledge can be further demonstrated by the next emergent issue.

iii Exam Pressure

Ten of the students mentioned examinations and tests at some stage in their discussions on the School of Nursing.

"Working hard and studying, we know there's that test at the end of it. It's a bit easier than on the wards. You realise how much you don't know. The tests and objective questions, it's getting harder every time".

"You've got to pass this and you've got to pass that, they act as if you don't care really".

"We had one exam at the end of introductory course and one just before Christmas. You've got to keep up to date. I got so depressed after the last exam, I made a complete hash of it".

A number of other quotes indicated that these exams brought about considerable stress. One student when asked if she had thought about leaving said:-

"No not really, I just worry about exams but other than that no. I don't think I'll pass, I feel thick".

Others when asked what upsets them commented in the following way:-

"I've been doing revision for the intermediates, and exams. You don't know if you're going to have a job at the end of it, the three years. I don't think I'll pass the intermediates, they have such a high fail rate".

"Exams get you nervous".

"School, three whole weeks, I'll never last especially when we've got an exam coming up and you haven't worked hard enough for it".

One student even associated tests and exams with a certain sort of deceit which the tutors engaged in.

"I absolutely hate school. We get all these little tests and they're not going to count. Then next morning there's all the marks written down in a book. Below 50%, three of those and you're out, the strain causes you not to do well in the exams".

It seemed strange to find so much consternation over examinations. It was perhaps because they were associated with knowledge which was not relevant in clinical practice. One student hinted at this opinion when talking about the benefits of Nurse Tutors teaching on the wards.

"They can see you in your own environment. You're more relaxed on the ward. They can see you as a Nurse, exams don't make you a good nurse"

The sense of injustice seemed to be enhanced by the idea that lack of knowledge was not the reason for exam failure. Rather it was to do with a lack of skill in written examination technique which was not being remedied by the teachers.

"There's too much pressure from exams, too much work, it makes you a nervous wreck. The worry over exams, it's this over fifty business. We don't get practice writing essays on the wards, we just get workbooks. We get no tuition on essay technique you know".

This last quote leads into the next emergent issue, in that it indicates that it may be unfair to hold examinations in a system which doesn't give adequate support to the student to pass these examinations.

It appears that learning was examination led and that the exams were a source of motivation which replaced any intrinsic need to learn. The students seemed compelled to learn because of the threat of dismissal or humiliation rather than a genuine desire to become a better nurse.

iv Learning is unrealistic, irrelevant and boring

Whilst there were a few students who enjoyed coming into the School of Nursing because of the teaching they received, more were disenchanted with school work. There has been discussion earlier which suggests that some of the school work was unrealistic, particularly those aspects associated with the practice of nursing. This was easy to confirm, in the students' comments:

"Practical stuff in school is a waste of time, I think you should be taught your practical stuff on the ward. It's just a different world. They show you one thing but it's

not the way it's done on the wards, all the bits and pieces, you just can't do it all half the time, you just haven't got time".

"I think you learn a lot more on the wards. I think working, sort of, it's O.K. to look at a diagram on the board, but it's a lot easier to understand it once you get in there and see things happening. I think that all of the time we spend in school, a lot of the things are really irrelevant. They get repeated over and over again and that makes it boring, I mean, I like school, I like coming into school if there wasn't big stretches of repetitive things. I don't know, like especially in P.T.S. when we were in P.T.S. for seven weeks, you got practical demonstrations on pressure area treatment and injections, and things. It's just ridiculous, because I mean, you can't learn on a model anyway you need to get on a ward with a real person and find out. There are lots of times when we just seem to sit around. One of the things is the class is so big. It's just too many people, like, we used to get wrong for making a lot of noise".

This long quote identifies boredom and repetition as well as inappropriate learning methods inherent in this student nurse's particular learning programme. Students did, however, describe examples of appropriate learning methods which demonstrated that the curriculum could be improved.

"The surgical block we did some things that we haven't done before. We went onto the ward to look at a patient who'd had an operation and talked to him and that was really helpful. A group of us went and sat and talked to the patient. We found out what types of question we were going to ask him and we found we learned a great deal more than just taking a one off situation, you know, of a non-existent patient".

Other students described more ways in which the learning content was irrelevant.

"We used to be sat in the classroom for ages waiting for the teachers to come in, they didn't know what they were going to do or anything - and apart from that you didn't feel you were a nurse until you were on the wards. You didn't feel like a nurse at all it was like being back at school".

Sometimes the theory and practice was not linked and theory was presented after the appropriate experience.

"By the time you were finished and you were just going round and emptying drains, and all sorts, and charting it down and everything, you know, and it's not until you come back into school, like now, and you start realising what you've done and why you did it. We think that now the work we are doing now like, we've covered surgical and it's too late we should have done it before hand".

The cause of the irrelevance was often reported as being due to the tutors being out of touch with nursing.

"The tutors don't know what happens on the wards. Sometimes they're stuck in school for too long. I don't think they realise how different they are on the wards".

Other comments demonstrated the complete waste of time which can occur in the School of Nursing by attempting to teach nursing which is contradicted in practice.

"Sometimes they tell you something in school and when you get out onto the wards it's completely different, it's the opposite, and you think what was the point of the school teaching us it when you've got to do it completely different".

The most clear condemnation of school work was that it was boring.

"The school? We tend to come into 2 week blocks and a lot of the time it's quite boring really doing it in one huge block".

"We find we learn more from taking straight forward dictation, even though it might sound a bit boring. We get what we need down".

"I don't think the time is used well enough in school, I think we waste a lot of time, we could probably do what we do in the school in two weeks in about a week, because we seem to spend a lot of time not doing anything or waiting around".

It was obvious that there were sufficient comments on the state of formal teaching in many Schools of Nursing to conclude that the curriculum was badly planned and didn't seem adequately to support the practice of nursing.

To summarise this section it is possible to say that the most significant general impressions related to the Schools of Nursing were that; the main benefit of attendance in blocks of study was that students met their friends again and felt some loss of solidarity with the group when they left the study block. Whilst study and learning was seen as necessary the main expressed motivation to learn was fear of exam failure and/or dismissal.

At the same time Schools of Nursing seemed to overload students with information, and student nurses accepted this because it helped them to pass examinations. At the same time some of the information was unrealistic and irrelevant. Acquiring this information was often reported as being a boring activity either because the methods were unstimulating, there was insufficient activity or the material was repetitive. The Schools seemed to deal with the acquisition of propositional knowledge. Their attempts to deal with the skills of nursing were largely reported as a waste of time, because the wards

were not only the preferred places to learning nursing skills but they were the most influential in terms of realistic nursing practices.

This discussion enables one to turn now to the activities of those individuals who are charged with the responsibility for teaching, the Nurse Tutors.

Nurse Tutors

Whilst there were many disparate examples of valuable and ineffectual teacher behaviours, the most consistent reports precipitated two rather negative issues:

- i Going onto wards.

- ii Teaching techniques.

- i ~~Going on to the Wards~~

Over half of the students commented quite simply that tutors rarely or never go to the wards.

"Tutors should go onto the wards. All the time on geriatrics there was never a tutor on the wards. Things that they say just don't happen. There should be a lecture on geriatrics and they were supposed to come onto the wards, but they didn't".

"They don't come to the wards, I don't know whether they are supposed to but you never see them on the wards while you're on".

"The case studies help, which I suppose is one thing that you're doing when you're on the wards, but a case study every three months and not seeing your tutor at all! Then again they are tied in the school and it's very difficult for them to get on the wards, but it would be helpful".

It was obvious that student nurses would have liked the tutors to go to the wards either for support or for learning reasons.

"I think probably as a whole we like to see a bit more of the tutors and clinical teachers on the wards, to guide us I think, particularly in the first year".

"I like them to come because you can chat to them. If someone asks you you're more likely to tell them your worries".

"We have tutors come round and talk to us and I seem to learn more on the ward when they come round like a few days you know and like not ask you questions like because in school it just goes in one ear and out of the other".

"It's nice when they do come on because you can have a good old chat about what's going on, if there's any worries or anything, you know".

"So I think it would be helpful if they came more often on the wards, because I think if it was fresh in your mind, and the patient was there, I think we could discuss it and I think it would probably stay better in your mind".

It became obvious that learning by the bedside was a powerful method of learning. The tutors hardly ever did it, the ward staff didn't do it frequently enough and it was left to fellow students to help whenever it was required. It was of interest that students sometimes said that tutors did, sometimes, go onto the ward. There was some evidence that when referring to tutors they also meant clinical teachers.

A few mentioned Clinical Teachers specifically:

"If a clinical teacher or a tutor, tutors don't always come up on the wards, clinical teachers do, if they came and worked with you every morning, slowly through and you knew the patients well and they explained things to you as they went along".

"We saw the clinical teachers twice during the last allocation. The tutors I've never seen one!!.

"The clinical teachers do the practical side and the tutors do the theory. The clinical teachers are seen on the ward. Tutors don't come as often, they just come to discuss".

This last comment describes how tutors in some schools did visit wards but when they did they very rarely taught, they most often seemed to be undertaking a 'tour of duty'. Sometimes this was somewhat embarrassing.

"Tutors ask how you're enjoying the ward in the corridor and Sister and staff can hear, you can't really say you don't like it. They might get a bit nasty".

There was some indication that it may be just as well that tutors did not attend the ward frequently. It seemed that tutors may not be welcome on wards because they were seen to disrupt normal work patterns.

"I think some of the staff, when they see a tutor coming on say, oh, let's find the procedure book and make sure we are setting the trolley up correctly".

"They teach you so perfectly although I suppose it's better to learn perfectly and then adapt it to the ward. Plus as well on the wards you haven't got time to be learning with someone who is not a member of the ward. If they came up separately they would have to take you separately and they are really short staffed at the minute. With one person off

sick you're in a state where you haven't really got time to be taken away by a tutor to be taught something, cause the work would just sort of pile up".

"They do come, but it's all a bit off, sometimes there's a bit of bitchiness on the wards when they come cause they chose one of you, to work with you, to be with that morning and consequently because you work with them, that morning, you've got to do everything the proper way, which means you're going at a very slow speed, getting things done properly. But, the other nurses don't thank you for it, because all the work you should have done in the morning, consequently they have to do".

It seemed that the tutors often sacrificed the ward's pace of working to achieve an idealised form of nursing. It also seemed apparent that it was because they were not accepted members of the ward team, that the tutors lacked the sensitivity and perceptiveness to work in a similar way to the clinical practitioners, or to realise when they were becoming an irritating imposition. It was understandable that often ward staff did not relish their visits. This was rarely to be found in the behaviour of clinical teachers, who did not seem to stand on status and adapted much more readily to the clinical team work. It was apparent that all was not well with the idea of tutors visiting wards. It was more worrying that all was not well in the School of Nursing as was exemplified by comments on the teaching practices evident in the Schools of Nursing.

11 Teaching Technique

It was apparent that the lecture was the preferred form of teaching and that it was teacher centred. When asked what makes a good tutor, student nurses made the following comments:

"For a start not giving boring lectures. Make it so that they'll make it interesting so you'll listen. Being friendly having a bit of a laugh instead of being serious all the time. Just so that you're not frightened".

"It's awkward sitting after you've been pelting round the wards all day, to sit and concentrate on what they're telling you, I mean I don't find the work particularly difficult. I don't know, maybe its just the way it's given, presented to you and there's a lot of times that you're sitting and the lectures are just so boring".

"Tutors go a bit fast you're frightened to say I don't understand this and that".

"Falling asleep you don't actually grasp it first time. Some of the lecturers talk too fast. They are ahead of you before you've actually taken in what they've said previously. So you've got to go back and think about it and read up on it and do extra work".

It was also obvious that some students depended on their tutors to motivate them.

"Good tutors really work you. They understand what you're doing. They push you to work, some of us do need a lot of pushing".

Others indicated that the tutor's major function was the dissemination of information. Note-taking was a particularly valued method of acquiring information.

"Some of the lectures are better than others. Mrs X was very thorough. She really gave you the notes that you need. I think quite a lot of them believe in these discussion lectures, which is good, but I don't think any of us agree with that. I know we've discussed the discussions and we find we learn more from taking straight forward dictation, even though it might sound a bit boring. We get what we need down and study up maybe a bit more on a night. I think the discussions, we used to have a lot of them in the first couple of blocks, and I found I was missing just a bit because I'd get way off onto something else and I forgot what they were talking about".

The need for note taking was mentioned on a number of occasions and the whole learning setting seemed to be dominated by lectures, note-taking and teacher centredness. There was a dearth of imaginative teaching methods and the use of such methods seemed to be blocked by a

strongly held idea that lectures were the only relevant forms of learning in School. This was the case even though it was demonstrated earlier that lectures were often boring and there was some suggestion of information overload. One might hazard to suggest that the only way students could maintain concentration, cope with overload and promote some sense of learning, was to take notes. This was the picture which constantly came across in reports of school work. There was a strong feeling that information was being provided and collected simply for its own sake and not for its utility in nursing practice.

A number of other issues were described by students which didn't at first seem to be directly related to the learning process but were, nevertheless, relevant issues to Student Nurses. The first was related to patients.

Attitudes to patients

A third of the interviewees mentioned examples of what can simply be called poor attitudes to patients. Some extracts demonstrate straight forward neglect.

"On medical ward the patients were not looked after, the basic hygiene and that. There was a lack of organisation, they do tend to get neglected a lot".

"People can't be bothered, the S.E.N. was going to give a drug, she wasn't going to take me and she was going to the wrong patient".

"You set your own standards, like there's lots of pressure area care. Some wards they just don't do the back round and you get the students come on the ward and they run that kind of ward".

Other Students quoted examples where it appeared that the staff didn't care about the patients:

"Some of the nurses just couldn't care less about the patients at all".

"You know socially, a lot of people have social problems, they come in and still go home with all these social problems. Nobody seems to really try and help them get everything together".

Some described situations in which patients were not treated as individuals:

"On surgical they did everything for the individual on medical they were treated like a herd of cattle, they all had to do things at the same time. Nobody was like individual".

"Nurses who treat patients like numbers. They tend to think it's their aim to get them out, to get the bed empty".

Yet others described how nurses can demonstrate authoritarian attitudes to the patients.

"Like this ward I've just come off wouldn't dream of it. She says I've told you nurse not to do that just don't do it. The patient doesn't know best, you don't ask the patient".

"It must be awful being bossed around by an eighteen year old".

Interviewer: "So we boss them around do you think"?

"Oh definitely, you do, they haven't got a say in what happens. If they've got to have a bath at 2.30 pm, they've got to have a bath. They can't get out of it. I mean you go up and say to the Sister, Mrs such and such doesn't feel like one, and she says, she's having one whether she wants one or not. You know even if her relatives are there she still has to go in the bath. Then you put them in their nighties at 2.30 in the afternoon and you just got them dressed about 9 o'clock, you know it's just stupid".

Comments like this did not represent the common standards of practice but they are significant because they were not counter-balanced by comments about positive attitudes towards patients. With this in mind it seemed that examples of bad practice remained uppermost in the students' minds possibly because of their disturbing emotional links. It seemed apparent that some nurses and some wards on the 'training circuits' were not demonstrating good practice and should hardly be allowed to influence student nurses.

The next emergent theme seems to logically link with 'attitudes to patients' and it was the most consistent response to the question, what is it about the job which gets you down or upsets you?

Death and Dying

Ten students mentioned almost without hesitation that the dying patient was the thing that upset them. Equally as many again mentioned unrelated things which upset them and another third said 'nothing really'. There is nothing much that can be added to this finding except to say that it does lead into the findings of another standard question which developed. This was, who do you talk to when you're upset?

Who do you talk to when Upset?

In its simplest form the responses can be most easily presented in the form of a list:

<u>Person</u>	<u>Number of Responses</u>
Mum and or Dad	10
Peers	10
Nobody	4
Boyfriend	4

What was most interesting was that some students were eager to say who they would not go to. Five said they would not go to tutors or the school and two said they would not go to Sister or a nursing officer. It was obvious that the hospital service and the school of nursing were totally unable, or

unwilling, to give students emotional support. It seemed unanimous that work was not a place for students to offload their troubles. This was of additional significance when one related it to the reports from the 14 students who lived in at the hospital.

Living In

Half of the interviewees were selected on the basis of their living in hospital accommodation. This made very little difference to the major findings in this analysis, but it did have relevance to the issue of emotional support. It was obvious that most students who lived in hospital accommodation (n = 9), reported various unhappinesses which would seem to add to the possible stresses of hospital work and studentship. The most significant reported concerns were related to loneliness, boredom and never being away from the hospital. It seemed strange that loneliness should be an obvious feature when students were living with so many of their peers.

"I confided in nobody I just cried in my room".

"Nurses don't speak to each other in the nurses home they are all segregated from each other. I miss my family, You never seem to get away from it, the hospital, I would rather be at home".

"I quite like living in, it's sometimes a bit lonely but there is more independence".

"You never see anybody. We are all just sitting in little rooms with our 'tellies'".

In addition to loneliness students reported a sense of boredom with life in the hospital accommodation.

"I don't like living in. I lived in for six months there was nothing to do".

"If you don't get out you feel down in the dumps. You look out of the window and you see the hospital. There's nothing to do, you are sitting there twiddling your thumbs".

It seemed that a lack of any family atmosphere took some getting used to. This seemed to be exacerbated by the lack of maternal/paternal support from the hospital organisation. The effect of the 'hospital' as a stressor seems to be compounded by the feeling that the student had very little recourse to escape, to 'switch off' from the work setting.

Two of the previous quotes mentioned 'never being away from it', and there were others.

"I would never live-in - you're never away from it".

"But with being on hospital grounds you don't very often talk about the hospital, in the home probably to try and, with it being on the hospital grounds it's like being still in the hospital, so to try and get away from the hospital we don't mention it very much".

The significance of these reports on 'living-in', were that there was a strong impression that those students who live in have less opportunity to obtain emotional support in a setting which was obviously stressful and tiring. It has been shown on the previous page that the family, friends and boyfriends seem to be the exclusive sources of support. Living-in deprives many of these students of opportunities to obtain emotional release and support. The following quote aptly sums up the situation.

"There are some places where you can lie in until later on in the morning and just crawl across to the ward and when you're on nights it's good. The general condition of the home isn't very good, it's very noisy and the home sister isn't very approachable. Well you certainly couldn't approach the home sister about things, you would probably just talk with your friends or, when you got home, with your friends at home when you were out, cause it's very awkward in the homes as well, cause you think you have your friends around you all the time but you don't because they're doing different shifts and by the time they come in, they just want to fall in the bath or something and go into their rooms and just sit there like zombies".

It seemed that whilst it could be said that many student nurses were reasonably content overall, there were a large number who needed to comment on their stresses and unhappinesses. It could be argued that these were over exaggerations of trivial emotional problems. The fact is that at least a quarter of the sample mentioned thoughts of leaving the job, at some time or another. This leads one to suspect that the problems of life in the first year of training cannot be dismissed as trivial.

This item concludes the findings of the structural analysis of the audio tapes and it is now possible to summarise the findings of the structural analysis of both the transcribed parts of the tapes and the aurally analysed subsequent remainder of the tapes.

6.2.5 A COMPARISON OF THE OPEN RESPONSE STRUCTURAL ANALYSIS AND THE GUIDED RESPONSE STRUCTURAL ANALYSIS

The key emergent issues on the process of pre-registration learning have been described in the form of a content analysis of the interviews and a structural analysis of the interviews.

The structural analysis was carried out in two stages. The first analysed the free responses which were elicited from the open questions. This utilised the written transcripts of the free response part of the interviews. The second analysis dealt with the larger body of information given over as a result of more specific questioning, which occurred after the initial free response questions. It is possible now to summarise the findings of the structural analysis before it is compared to the content analysis findings. A summary table can be drawn up which collates the number of different respondents who mentioned each emergent concept at any time during the interviews. It must be clearly stated, however, that more importance was placed on the open ended responses because they were more likely to represent those things uppermost in the respondents' minds. The guided responses are valued for a different reason. They do represent responses which can be said to be influenced, to some extent, by the

interests of the interviewer, but also by the emergent themes from previous interviews, pilot interviews included. This latter effect was expected, and accepted, as that aspect of the interviews which would precipitate theory in the style of the grounded theory approach, described by Glaser and Strauss (1967)

The summary table shown below gives a total for the number of people who mentioned each issue. This was obtained by adding the number of individuals who mentioned the topic during open response to the number who mentioned the issue during the guided response, but not during the open response.

TABLE 3 A COMPARISON OF THE NUMBER OF RESPONSES GIVEN
FOR THE MAJOR EMERGENT ISSUES
FOR OPEN AND GUIDED RESPONSES

EMERGENT ISSUE	OPEN RESPONDENTS	ADDITIONAL GUIDED RESPONDENTS	TOTAL
Lack of interest in Students	13	6	19
Tiring Work	12	2	14
Examination Pressure	11	1	13
Pace of work/busy wards	10	0	10
Death and Dying	10	2	12
Living-in	9	2	11
Unrealistic in School	9	0	9
Qualified Nurses teaching	7	14	21
Information Overload	7	6	13
Sister makes you feel nervous	7	7	14
Seeing peers in Block	7	1	8
Changing Wards	7	1	8
Getting on with Nursing Staff	6	1	7
Nursing Staff clique	6	1	7
Poor quality of Nursing Care	6	7	13
School is boring	6	1	7
Sitting in the Office	4	10	14
Differences between wards	4	6	10
Tutors going to Wards	3	9	12
Practice different to School Teaching	2	12	14

Some summary observations on Table 3 are now possible. The issues can be grouped into three categories. The first includes those issues which were mentioned fairly frequently during free-response and were precipitated by as many extra respondents in the guided part of the interview. The second group includes those issues uppermost in many student nurses' minds but not significantly mentioned by respondents during guided response. The third group represents issues which were not uppermost in students minds but which became more significant in the guided part of the interviews.

Issues uppermost in many students minds and reinforced by other students guided response

The five emergent issues in this analysis were as follows:-

- i Lack of interest in students.
- ii Qualified nurses teaching.
- iii Sister makes you feel nervous.
- iv Information overload.
- v Poor quality of nursing care

Issues uppermost in many students' minds

Five issues can be identified in this group:-

- i Tiring work.
- ii Pace of work/busy wards.
- iii Death and dying.
- iv Unrealistic in school.
- v Living-in.

Issues which became relevant as a result of guided response

- i Practice in ward different to school teaching.
- ii Sitting in the office.
- iii Tutors going to wards.

The issues originating from guided response were important because they may have been issues which the students felt strongly about but which could not come to the fore until they became more relaxed. It is of particular interest that two of these items may have been withheld until later in the interview because of the occupation of the interviewer. These were the items called 'practice in wards different to school teaching' and 'tutors going to wards'. With this in mind, they are accepted as being probably as significant as those issues which are classified as uppermost in the

student nurses' minds. It is now possible to compare these summary findings with those of the content analysis.

6.2.6 A COMPARISON OF THE CONTENT AND STRUCTURAL ANALYSIS FINDINGS

The discussion at this point describes the results of a comparison between qualitative and quantitative results. This was undertaken by taking each of the quantitative findings and drawing in the qualitative results to provide a more complete understanding of their relevance.

The Significance of fellow Students

It was shown in the content analysis that fellow student nurses were the most frequently mentioned single category leaving aside self. It was also suggested that this may be due to the intentional interviewing strategy which encouraged the respondents to give the opinions of their colleagues as well as their own.

The structural analysis can, however, support the issue of peer significance in two relatively important ways. The peer group was important mainly because of the emotional support which it gave and the practical help given when learning the realities of nursing on the ward. It is difficult, however, to suggest, as a result of this analysis, that the peer group was a problem in the process of nurse learning. In many respects it was one of the most important elements in the student nurses' learning process during the first year of the course.

The Significance of the Ward Nursing Team

The quantitative analysis demonstrated that the trained nurses were the next most significant group of peers and when added to the specifically mentioned members of the ward team (the Sisters, Staff Nurses and Nursing Auxilliaries), they were the most frequently mentioned group, even when compared with fellow students. The significance of the ward/department nursing team was amply supported by the structural analysis. The importance of this group was demonstrated by a number of emergent issues, and these can be briefly described in the following way.

The difference between the attitudes and behaviours of teams and individual nurses was obvious, there being a strong indication that as many qualified staff were helpful to the students as those that were not. It was obvious however that the unhelpful qualified nurses were not uncommon and they left a greater impression on the students than the helpful nurses. The content analysis demonstrated that they were the most significant feature of the learning process in the first year. They were most significant because they show obvious disinterest in the student nurses. They were too busy or unwilling to teach and ward teaching was lacking. This perception was intensified by the student nurses' stated desire to receive tuition from the qualified nursing staff and the strong student opinion that they learned more on the ward than in the school. The Sister was a significant member of the ward team and she made most of an impression in two ways. She was often reported as having a significant effect on the student nurses' anxiety state. At her best, she put the student nurses at ease, but at her worst, she made the student nurses feel downright nervous. A

similar number of Sisters seemed to bring about a relaxed atmosphere as those who caused fear, but the latter caused most consternation. Because half the sample reported this, it seemed that every hospital had a number of Sisters who made student nurses nervous. The second way in which Sisters made a specific impression was related to communication between the student nurse and the sister. The good Sister works with patients and with the student nurses. The unpopular Sister sat in the office and didn't come out onto the ward, her staff were quick to copy this behaviour.

The Significance of the Ward

The ward was the third most frequently mentioned item in the quantitative analysis. It was mentioned more often than the School of Nursing and this was consistent with the qualitative finding that student nurses reported that they learned more on the wards than in the School of Nursing. The amount of learning which was achieved on the ward was, however, dependent on the pace of work. If the pace was too excessive learning was inhibited because of the precedence the work took. If, however, the pace was slow, learning was inhibited because involvement in nursing activity was limited and reduced the opportunity for participation and rehearsal. Similarly, work could be so tiring that it inhibited learning both during and after work. The effects of clinical work spilled over into the students' free-time both mentally, emotionally and physically. An additional constraint on learning was obvious and took the form of a disjunction between what happened on the wards and what was taught in the school. It was easy to demonstrate that the students learn what happens on the ward, rather than, what is taught by the school, as far as nursing skills are concerned.

The Significance of the Patients

The patients were important in the content analysis because they were mentioned less frequently than fellow students, the nursing team and the ward. The most significant impact which the patient had on student nurses was when they were the recipients of poor nursing care. These incidents, whilst neither common nor uncommon, left lasting impressions on the students and it was possible to suggest that poor nursing practice made a lasting and disturbing impression. It did so because it clashed with the student nurses' basic need, and taught ethic, to help people. Patients were also significant in that their death brought about a deep emotional impact on the first year students.

The Significance of the School of Nursing

The School of Nursing appeared to make only a small contribution to the learning process, yet it did cause some problems. The most important was that skill teaching in school was inappropriate to practice and the acquisition of knowledge was too intense.

The school did not teach procedures which were achievable in clinical practice and it seemed most likely that this was because teaching was too idealistic and out of touch with reality. This was supported by the general finding that tutors rarely or never went to the wards and hardly ever practiced nursing. In addition information overload occurred both in the School of Nursing and during clinical practice. In block a great deal of information was presented in a short time. During clinical practice,

pressure was applied to either study or complete written work, often after an exhausting contribution to the nursing service. In essence students often utilised days off, or holidays, to complete such work. The prospect of exam failure was an obvious threat.

6.2.7 A SUMMARY OF THE MAJOR FINDINGS OF THE OPINION SURVEY

1. The clinical nursing team members were the most significant influence on the learning process during the first year of the course.
2. The ward (clinical environment) was described as the place where the most relevant learning occurred.
3. The learning process in the clinical experience was often marred by poor working relationships, disinterest in the students, inadequate teaching, the greater demand for work, stress and poor nursing practices.
4. Patients were not uppermost in the students' minds. They came second to peers, the nursing team and the ward.
5. The Ward Sister was the most influential team member, as a model, as a determinant of team style and as a determinant of emotional climate.

6. Schools of Nursing seemed ineffective in providing learning which was relevant to nursing practice.
7. Learning in the School of Nursing seemed to be restricted to the acquisition of information which was often boring, repetitive and irrelevant.
8. It was not uncommon to find examples of information overload during the course.
9. Tutors rarely or never visited wards to teach or practice as nurses and often when they did they caused disruption to the normal ward work.

6.3 CONCLUSIONS ON THE OPINION SURVEY

It was argued in Chapter Two that the major issues of educational philosophy relevant to this thesis were the purposes of learning, the prevalent forms of knowledge and the nature of teacher/student relationships. These issues were the key to an analysis of the pre-registration preparation of nurses as an 'education'. Chapter Three indicated that pre-registration preparation was not an educational experience and that this was not conducive to the production of an independent, critical practitioner. More specifically nursing curricula did not emphasise interpersonal and technical 'know-how' and the nature of teacher/student roles were not compatible with the development of patient-centred practitioners.

The opinion survey provided additional data to substantiate these proposals and this can be discussed in relationship to the three issues: purposes, forms of knowledge and teacher/student roles. At this point it became obvious that the forms of knowledge and teacher/student roles reflected on the purposes of education and because of this they will be discussed first.

6.3.1 The Prevalent Forms of Knowledge

Six of the findings of the opinion survey qualified the propositions laid out in this thesis.

The first was the finding that the School of Nursing (academic establishment) was ineffective in providing learning which was relevant to clinical practice. This suggested that the knowledge acquired in the School was unsuitable or of limited value to clinical practice. The literature survey concluded that there was a bias towards propositional knowledge, particularly in the task-related area (Habermas' instrumental/work area). There was every indication, in the opinion survey, that these forms of knowledge were the domain of the School of Nursing. This was supported by the finding that learning in the School was confined to the acquisition of information, and that there was evidence of information overload. 'Information' was taken to be a concept synonymous with that of propositional knowledge.

The mismatch between 'school learning' and clinical practice was further confirmed by the finding that the clinical team and the ward were uppermost in the students' minds and that the clinical setting was seen to be the

place where the most relevant learning took place. One could conclude that educational methods and resources were largely directed to the acquisition of propositional knowledge, particularly in the task-related area of cognitive interest. The students, however, seemed to be indicating that the clinical experience, which takes up the largest part of the curriculum, was most relevant and the most poorly organised in terms of teaching. The literature survey had come to the conclusion that the curriculum was not educative because most of the relevant learning (ie in clinical practice) occurred in a situation in which teaching was unintentional and student initiated. It was tentatively concluded that the development of task-related propositional knowledge was highly organised and resourced. The development of 'know-how' and the interpersonal and self awareness domains were left to the 'ad hocery' of the clinical setting. It seemed that resources were being devoted to those forms of knowledge which were of least utility to nursing practice. This contention was supported by the finding that nurse tutors rarely or never visit the clinical setting. This was surely an indication that substantive teaching posts were devoted to the development of propositional knowledge and not to 'know-how'. A consequence of this was that the student nurses divided knowledge into two types according to purpose; knowledge for passing exams and knowledge for helping patients. The literature search gave the first indication that this was the case.

It seemed that an analysis of the extant forms of knowledge had revealed a division between propositional knowledge and practical knowledge, as well as between task-related knowledge and interpersonal/self-awareness knowledge. Given that the clinical experience was seen, by students, to be

the most relevant learning, it was concluded that 'know-how' and interpersonal/self-awareness learning was most relevant to the development of a nurse practitioner, but it was not dealt with properly. This supported the assertion that the pre-registration preparation of nurses was not an educational experience in that it did not promote the development of a critical, independent practitioner.

6.3.2 The Nature of Teacher/Student Relationships

The literature analysis had concluded that rapport between students and their teachers (both academic and clinical) was poor and that relationships were superficial, transient, functional and impersonal. It was also found that nursing curricula subsumed under a training paradigm. This meant that mechanistic 'views of man' prevailed and that knowledge was limited to the development of an instrumental practitioner. A further point which related to teacher/student relationships was that there existed elements of indoctrination and formal authority.

The results of the opinion survey supported some of these propositions. The most significant was that the learning process in the clinical setting was often marred by poor working relationships, disinterest in the students, inadequate teaching, stress and poor nursing practices. The discovery that clinicians were uppermost in students' minds and that the ward sister was the most influential clinical team 'teacher' points to the singular significance of teacher/student relationships in the clinical setting when compared to those between nurse tutors and students in the academic setting. The finding that nurse tutors rarely or never went to

wards, suggested that student contact time with this group of teachers was small in comparison with clinician/student contact time throughout the course.

It became apparent that student nurses were being shaped more by clinicians than by nurse tutors. The clinician/student relationship was the most pervasive and influential. Since the nurse tutors did not participate in clinical practice it seemed that their relationship was of minimal significance. There were, however, numerous examples in the students' reports that nurse tutors and clinicians held similar attitudes when it came to their relationships with students. The nature of such relationships was characterised by the mechanistic view of man. The teacher was the repository of all knowledge, highly skilled and an authority figure, the student was none of these. The teacher attempted to improve the behavioural response of the student nurse and external regulation was the main means of achieving this.

The conclusion which could be drawn from the survey findings on teacher/student relationships may now be stated in brief. The clinician/student relationships were the most influential during the pre-registration preparation course and the nature of these relationships was characterised by a mechanistic view of man. Not only was a mechanistic approach obvious, it seemed also true that relationships in the clinical setting were often poor. Student anxiety was rife and there was evidence of staff disinterest in the students, both as learners and individuals.

6.3.3 The Purpose of Nurse Education

Having found support for the notion that the pre-registration preparation of nurses was not an educational experience, it is now possible to discuss the findings in the context of the proposition that this was not conducive to the production of a critical, independent practitioner.

The literature analysis had revealed that the curriculum did not hold the patient as the central referent in the process of learning. It also seemed that the curriculum pursued purposes other than patient care, ie control of nurses and patients, work completion and the provision of a cheap, safe workforce. It is also worth repeating that much of the knowledge purveyed by the School of Nursing was found to be of no relevance to patient care.

The opinion survey had demonstrated that patients were a significant feature of their first year recollections but not as significant as the trained nursing team and fellow students. This indicated that relationships with clinicians were of more concern to student nurses than their patients. This can be coupled to the conclusion that the extant forms of knowledge were propositional knowledge and knowledge for instrumental action (task-related interests). The reluctance to arrange for the teaching of 'know-how' and interpersonal/self-awareness, indicated an additional deviation from the practitioner role of the student nurse.

In terms of the purposes of nursing curricula it was concluded that the distractions from patient care, which occurred during the course, were not

conducive to the production of an independent practitioner who performed her work in the best interests of the patient.

6.3.4 Summary of Conclusions

The opinion survey confirmed that the prevalent forms of knowledge were propositional knowledge and knowledge for instrumental action. Teaching methods and resources were not directed towards the development of 'know-how' or interpersonal/self-awareness domains of cognitive interest. The most pervasive teacher/student relationships were between clinicians and nursing students. Nurse tutors had limited impact on students and this was confined to the academic setting which was devoted to the development of knowledge for 'examination' success. Relationships between teachers and students in both the clinical and academic setting were characterised by mechanistic views of man. These conclusions about the prevalent forms of knowledge and the nature of teacher/student relationships combined with other findings to confirm that the pre-registration preparation of nurses was not an educational experience and that this was not conducive to the production of a critical, reflective and independent practitioner who performed in the best interests of her patients. Other findings suggest that the patients were not the major focus of the educational experience.

CHAPTER 7

AN EMERGENT THEORY OF NURSE EDUCATION

7.1 INTRODUCTION

As a result of the literature analysis and opinion survey, this study had substantiated the assertion that the pre-registration preparation of nurses was not an educational experience. This was stated on the grounds that the extant forms of knowledge and the nature of teacher/student relationships were not consistent with the development of an educated person. The proposition of this study did, however, moot a relationship between the development of an educated person and the production of a creative practitioner, a practitioner who could do new things and not merely reproduce what had gone before. This led to a consideration of the assumed relationship between the educated person and the nurse practitioner role. The most appropriate way of exploring this relationship was to ask what sort of educated person would produce the kind of nurse practitioner who could be most beneficial to patients? Not only was it necessary to clarify what forms of knowledge and teacher/student relationships were most likely to provide an educational experience, it was also thought necessary to develop theory on the relationships between the concepts of the educated person and the nurse practitioner.

The following discussion will propose a simple relationship between the teacher's role, the student role and the practitioner role. This relationship simply stated is that the teacher's behaviour determines the

type of educated person and that the type of educated person determines the practitioner role. It is also possible to postulate that the practitioner role determines the teacher's role, thus conjuring up a model which is cyclic. The emphasis on the teacher's role, student role and practitioner role originated from each of the philosophical themes developed in this thesis, ie teacher/student relationships, forms of knowledge and purposes of education. The teacher/student relationships reflected upon teacher roles and student roles. The prevalent forms of knowledge seemed to determine the type of educated person and the purposes of education shed light upon the type of practitioner which was required. It is this line of theory which was developed so that more conclusive statements could be made about the form which the pre-registration preparation of nurses should take.

7.2 TEACHER BEHAVIOUR AND STUDENT ROLES

The conclusions on the literature analysis and the opinion survey stated that the teacher/student relationships, during the nursing course, were characterised by a mechanistic view of man. Furthermore, it was found that whilst nurse tutor/student relationships were also mechanistic they were nowhere near as influential as the relationships between clinicians and students. It will be argued in this section that the way nurse teachers, both academic and clinical, treated student nurses had particular consequences for the development of the nurse practitioner. It was in this argument that hypothesised links between teacher behaviours, student roles and practitioner roles were demonstrated.

It had been discovered during this study (pg 259) that the pre-registration preparation of nurses was not an educational experience and that the nursing course subsumed to a training paradigm. The basis of this argument was the model of 'teaching' which was most apparent. The critical feature of such models was felt to be the interpersonal relationship between nurse teachers and nursing students as well as their respective roles. Two models of 'teaching' had been defined, pedagogy and andragogy (Knowles 1970). The former was associated with the education of the child and the latter with adult education. The mechanistic view of man, which was observed in the learning processes of the pre-registration nursing courses, strongly indicated that they were based on pedagogical principles. Given that student nurses must be 18 years of age, it was argued that nursing curricula should adopt principles of adult education. It was uncertain, however, that 18 year olds could be considered to be adult and there was some question about this. Allman (1983) argued that there was a fundamental difference between enabling the development of youth and the development of the adult. The teacher of adolescents, she argued, enables the learner to develop competencies, ideas and cognitive structures which the teacher has already developed. The process in adult education, however, involves both the teacher and student in a different form of relationship. According to Allman, adults exhibit a 'plasticity' or fluctuation over time in their intellectual competencies. The competencies of adults are not the same as those of adolescents. It has often been assumed that adulthood is a non-developmental period and as such adult-educators have often accepted that adults have reached the highest stage of child and adolescent development as outlined by Piaget (1972). This stage was that of formal operations, the ability to apply abstract formal logic. Allman questions the assumption that fully mature adult thinking is the

same as fully mature adolescent thought. It was Allman's contention that adult thinking is different because the formal reasoning of adolescence is further developed by the accumulating experiences of work and social relationships which adults acquire. As such she constructs a persuasive argument, utilising Reigel's theory of 'dialectical operations' (Reigel 1973), that mature adult thought is qualitatively different from the thinking of adolescents or very young adults. It was decided that a theory of nurse education would need to take on board the idea that young adults were involved in a transition from adolescent thinking abilities to adult thinking capacities. It was assumed that this would also involve a change in teacher/student relationships moving from pedagogical interactions to andragogical interactions as the educational programmes proceed. It was assumed that a move towards andragogy was possible during the three-year nursing course for three main reasons.

The first was that the literature analysis and opinion survey in this study had indicated that many nursing students were dissatisfied with the general tendency of their superiors to treat them like children. This was also expressed as not being valued or recognised as individuals or human beings (Dodd 1973, Birch 1978, Orton 1979, Marson 1981). This suggested that nursing students wanted to be treated as adults.

A second argument for the adoption of andragogical principles in the nursing course was found in the work of Carl Rogers (1983). It was obvious that Rogers had come to many of his conclusions on learning within a humanistic perspective which was particularly applied to the development of young people. In fact it is fair to say that he seemed to be arguing for an andragogical approach for children and young adults. It is worth

presenting Rogers' tenets and the tenets of andragogy so that the reader can understand the perceived similarities between the advocates of improvement in child and adult education respectively. Rogers' 'Freedom to Learn in the 80's' aims towards the following ideals:

- (i) A climate of trust in the classroom in which curiosity and a natural desire to learn can be nourished and enhanced.
- (ii) A participatory mode of decision-making in all aspects of learning in which students, teachers and administrators each have a part.
- (iii) An aim of helping students to prize themselves and to build their confidence and self esteem.
- (iv) Uncovering the excitement in intellectual and emotional discovery, which leads students to become life-long learners.
- (v) Helping all to grow as persons, teachers finding rich satisfaction in their interaction with learners.
- (vi) An awareness that, for all of us, the good life is within, not something which is dependent on outside sources.

(Carl Rogers, 1983)

The andragogical perspective is best described in the form of a 'Charter for Andragogy' which has been drawn up by Jack Mezirow (1981). The main

emphasis is that adult educators should adopt the following to enhance the adult students' capability to function as self-directed learners. They should:-

- (i) Progressively decrease the learner's dependency on the teacher.
- (ii) Help the learner understand how to use learning resources.
- (iii) Assist the learner to define his/her learning needs.
- (iv) Assist learners to assume increasing responsibility for defining their learning objectives, planning their learning programme and evaluate their progress.
- (v) Organise learning in terms of his/her own problems.
- (vi) Foster learner decision-making.
- (vii) Encourage the use of criteria for judging which are increasingly inclusive and differentiating in awareness, self-reflexive and integrative of experience.
- (viii) Foster a self-corrective, reflexive approach to learning.
- (ix) Facilitate problem posing and problem solving.

- (x) Reinforce the self-concept of the learner as a learner and a doer by providing for progressive mastery.
- (xi) Emphasise experiential, participative and projective instructional methods.
- (xii) Distinguish between helping the learner to understand and encouraging the learner to make a specific choice.

(Adapted from Mezirow 1981)

It was possible to identify similarities between the two lists, particularly those relating to learning how to learn, student self-direction, fostering student decision-making, experiential/participative approaches and the development of positive student self-concept. It was these similarities between Rogerian and andragogical models which convinced this author that, whatever the age of the student, nursing courses should move towards an andragogical approach regardless of Allman's perceived differences between the quality of adult and adolescent thinking.

A final concept which supported the development of andragogical approaches was that of the transitional dynamic. This concept describes the transition from external direction in learning to greater self-direction in learning. Knowles (1975) argued that this should be achieved within an andragogical approach. Cheren (1978) demonstrated that the concept had some utility in the educational process. He also concluded that there was a need to ~~make~~ the transitional factor explicit to practitioners, learners and those designing or restructuring facilitative institutions.

It was assumed, for the purposes of the current thesis, that external direction was synonymous with pedagogy and student self-direction a distinctive aim of andragogy. The concept of the transitional dynamic was believed to demonstrate two things. First that during any long-term course of education, movement from pedagogical approaches to andragogical approaches was desirable and secondly, that a move from student passive dependency to student self-direction was possible. The idea that passive dependency in student nurses is a distasteful phenomenon should, however, be carefully considered. There were arguments, arising from the training of nurse psychotherapists, that learners all begin on a new learning dimension in a state of passive dependence on the teacher (Burnard 1985). Burnard explained that the role of the teacher was primarily to facilitate the move from a state of necessary passive dependency towards increasing self-direction.

The summary argument for this discussion on teacher/student relationships is that self-direction should be the main pursuit of an adult approach to nurse education. The nursing student begins in an expected state of passive dependence and teachers must adopt andragogical rather than pedagogical principles in order to move students towards a state of self-direction.

7.3 FORMS OF KNOWLEDGE AND THE EDUCATED PERSON

Exploration of the extant forms of knowledge indicated two things. Firstly, that nursing curricula were not practice focused (limited planning for know-how) and secondly, that they did not develop interpersonal or self-awareness knowledge.

The assertion that nursing curricula were not practice oriented was supported by the conclusions that there was an over-emphasis on propositional knowledge (as opposed to practical knowledge) and that learning in the clinical setting was of poor quality and poorly resourced.

There was, however, a strong argument that forms of knowledge relevant to 'know-how' should be brought to the fore and that this was equally as relevant, if not more relevant, to professional education than propositional knowledge.

Schön (1983) postulated an increasing crisis of confidence in professional knowledge. He argued that the professional hand in the solution of public problems and newly invented technologies has often brought about side effects which were worse than the problems they were designed to solve. There has been a public loss of faith in professional judgment. The long-standing professional claim to a monopoly of knowledge and social control was being challenged because it did not live up to the values and norms which professions ascribe to (Schön 1983). This raised the question of the adequacy of professional knowledge for the needs and problems of society. There seemed to be a mismatch between the forms of professional knowledge and the changing characteristics of the practice setting. Practice settings were becoming more complex, uncertain, unstable, unique and value ridden. The attributes of the practice setting were seen to be central to the world of professional practice. Professionals were seeing that this complexity was not amenable to the skills and techniques of traditional expertise. It had also become apparent that professionals were increasingly asked to perform tasks for which they had not been educated. Even if they were fully prepared by their initial qualifying course, the

rate of social and technical change, described by Knowles (1970), would make their initial preparation obsolete as the years progressed. Schön said that professions were now confronted with an "unprecedented requirement for adaptability". In terms of the appropriate forms of knowledge, Schön argued that the dominant epistemology of professional practice has been that of technical rationality. In this paradigm professional practice consists of instrumental problem-solving which is made rigorous by the application of scientific theory and technique. This is synonymous with Habermas' (Mezirow 1981) work area of cognitive interest which includes knowledge for instrumental action. The findings of the literature analysis and opinion survey in this thesis (pg 259) support the assertion that the pre-registration preparation of nurses subscribes to technical rationality as the dominant epistemology for nursing practice. The findings clearly indicated that nursing courses over-emphasised and over-valued propositional knowledge as well as the cognitive interests in the work (instrumental) arena. The basis of instrumental cognitive interest, according to Habermas, was specialised scientific knowledge. An interpretation of Schön's argument was that professions were fixed in the Habermas' instrumental arena of cognitive interest. The existence of this in nursing curricula was strongly supported by the literature search and opinion survey. From this work it was possible to conclude that knowledge for interpersonal action and emancipatory action (Habermas in Mezirow 1981) submitted to the dominant epistemology of technical rationality. Glazer (1974) argued that professions may be categorised into two forms: 'major' or 'minor'. The minor professions are described as non-rigorous and dependent on representation from the academic disciplines. This rang true of nursing practice as did his contention that minor professions suffer from shifting and ambiguous ends. They are unable to develop a base of

systematic, scientific professional knowledge. It became the contention of the current thesis that nursing was a minor profession typified by the features forwarded by Glazer (1974). This led to the conclusion that technical rationality, on its own, was ineffective for the development of a critical nurse practitioner. One can describe Schön's perceived limitations of technical rationality in the following way.

Schön proposed that professional practice was a process of problem-solving. These problems were characterised by uncertainty, complexity and uniqueness. In order to utilise existing theory or technique the problem solver must be able to map scientific categories onto the practice situation. The problem solving process involves a definition of the situation and this may, or may not, match the categories of applied science. This was thought to be a distinguishing feature of nursing practice. The conclusion was derived from an analysis of medicine as a profession (Friedson 1975), particularly those arguments relating to the relevance of applied science to the practice setting. Friedson argued that applied science was becoming a mask for privilege and power rather than, as professions claimed, a mode of advancing the public interest. He also argued that the 'practice, exercise, or application of expertise is analytically distinct from expertise or knowledge itself' (Friedson 1975, p 337). This knowledge or expertise associated with applied science, he argued, was 'extremely limited as a reality: it is locked up in books or heads and has no link with activities of practice'. The reader should note at this point the similarities between Habermas' instrumental (work) arena of cognitive interest, Schön's technical rationality, Moore's propositional knowledge (1982) and Friedson's concept of expertise. It was assumed, for the purposes of this study, that they were all referring to one and the

same form of knowledge which pertained to man's propensity for reflective thought rather than the purposeful action which he engages in. This is highlighted so that it can be clearly understood that, for the purposes of this study, these authors were all emphasising the salience of reflective thought in the traditional education setting. Returning to the theme which is developing here, there evolved an accumulating argument that the body of knowledge should be seen to be distinct from the activity of creating the knowledge (research) as well as the activity of applying it to the problem situation (practice). Schön argued that when a problem is constructed by a professional practitioner, it may not benefit from the existing body of knowledge because the problem is often unique or unstable. Friedson further argued that the basic knowledge upon which medical practice is founded is not as objective and reliable as is often assumed by the professional. The experiential foundation of practice is socially organised and this form of knowledge is essentially social in character. He argued that a large part of therapeutic practice was no more than a set of 'occupational customs which are no more codified and no more put to systematic empirical test than most social customs' (Friedson 1975, p 343). The 'art' of the profession does not rest on a body of scientific knowledge.

In the context of nursing it is possible to conclude that the current thesis can support the contention that the extant forms of knowledge are not conducive to the development of a professional practitioner. Indeed the nursing preparation programmes emphasised technical rationality by directing resources (teachers and technology) towards its development. The development of practical problem solving was largely left to the unplanned, most poorly resourced and largest component of the curriculum,

the clinical experience. As a result, student nurses become the sort of educated people who devalue clinical activity as an arena for the acquisition of knowledge. They could not accept that forms of knowledge other than the technical rational are legitimate areas for learning. If student nurses are not exposed to other forms of knowledge it is unlikely that they will become conscious of those forms. Furthermore this student consciousness for other forms of knowledge is unlikely to be developed if those forms of knowledge are not mapped onto the individual's experience of the practice setting. These were not ill founded assertions. The literature analysis supported the existence of 'anti-academia' in nursing students (Pepper 1977, Dodd 1973, Lancaster 1972). There was also confirmation that student nurses did not accept that interpersonal and self-awareness learning was legitimate. Particularly when it does not help them to pass examinations (Dodd 1973, Abdel-Al 1975, Clinton 1981).

Many students noticed that what they were taught in the academic setting did not help them in the practice setting (Melia 1981, Clinton 1981). All of this had been confirmed by the opinion survey in the current study. In essence student nurses did not develop practical knowledge because they were pursuing the knowledge of technical rationality. This was why some nurse researchers had concluded that nurses who passed the formal examinations were not necessarily good practitioners (Bendall 1973, Birch 1975, Birch 1978). Nurse educationalists need to redefine the required forms of knowledge if a professional practitioner is to be developed.

It is argued in this thesis that the approach of nurse educators and curriculum planners to the forms of knowledge, should begin to include forms of knowledge previously not accepted as legitimate forms of knowledge.

This specifically includes practical knowledge or know-how, Habermas' practical arena of cognitive interest (interpersonal communication) and his emancipatory arena of social self-awareness and 'world view'. In terms of Schön and Friedson's analysis, this includes knowing how to solve problems in the clinical setting, whether this can utilise the existing technical rational knowledge available to nurses or not. In addition it is proposed that the appropriate technical/propositional knowledge be selected on the basis of its relevance to the everyday practice of nursing, not to theoretical constructions of what nursing should be. This was exactly the approach to knowledge 'management' which was proposed by Schön (1983). He distinguished between knowledge-in-action and reflection-in-action, both of which relate to learning which is relevant to clinical professional nursing practice. Knowing-in-action refers to that characteristic mode of practical knowledge which is typified by knowing how to do things, lack of conscious awareness of having learned these things and an inability to describe the knowing which the action reveals. It became the contention of this thesis that it was this knowing-in-action which was typical of nursing curricula and that it occurred because learning in the clinical setting was poorly resourced, poorly understood, badly organised and rarely monitored. This led to the question of an alternative approach. What was the educational approach which would ensure that know-how was developed, that this know-how was brought to the consciousness of the practitioner and that the appropriate technical rational knowledge was selected for this purpose? Schön (1983) had provided such an alternative which he described as the development of reflection-in-action. This idea arose from the recognition that another form of knowing can exist in practice. He quotes phrases such as "thinking on your feet", "keeping your wits about you" and "learning by

doing" to support the existence of a conscious awareness of the action/problem solving process and its context.

In this way, domains of knowledge other than the technical rational would be developed and made explicit to the learner in the clinical setting. There would also be a means by which students could select the technical rational knowledge which was relevant to their own nursing practice.

This discussion has presented the argument that the clinical experience provides the most valid forms of knowledge and that this should be formally acknowledged by the application of educational principles which are appropriate to this setting. It was also argued that learning in the classroom setting should include the development of forms of knowledge other than the technical rational associated with applied science.

This latter argument originated from the work of Jack Mezirow (1981) and related to the areas of cognitive interest proposed by Habermas which were described earlier in this thesis (pg 33). It has been concluded in the current thesis that the area of cognitive interest which was most obvious in the nursing course was Habermas' 'work' area which incorporates knowledge associated with the empirical-analytic sciences. The literature and opinion survey confirmed that little attention is paid to the 'practical' area, which in Habermas' terms involves clarifying the conditions for communication and intersubjectivity. This was taken to be that knowledge related to interpersonal skill and social understanding. It was accepted that the earlier work in this study had shown that this 'knowledge' was inadequately developed in nursing curricula. The suspicion that there was no learning in the emancipatory area of cognitive interest

provided the greatest concern for the quality of nurse preparation as an educational experience. Mezirow (1981) argued that the most distinctively adult domain of learning, the knowledge for emancipatory action, is probably the least familiar to adult educators. It is the contention of this thesis that this area is unknown to nurse educators. It was this conclusion which contributed to the growing argument that the pre-registration preparation of nurses was not an adult educational experience. Mezirow (1981) described this form of learning as perspective transformation. 'Perspective transformation is the emancipatory process of becoming critically aware of how and why the structure of psycho-cultural assumptions has come to constrain the way we see ourselves and our relationships, reconstituting this structure to permit a more inclusive and discriminating integration of experience and acting upon these new surroundings' (Mezirow 1981). Mezirow contended that this is a central function of adult education. It involves a process of becoming more conscious of the different social, structural and historical factors which determine our behaviour. The learner adopts alternative 'world views' or perspectives which allow a greater understanding of the self and his/her own behaviour. Perspective transformation involves the acquisition of knowledge for emancipatory action. It should be re-emphasised at this point that each of the areas of cognitive interest, described by Habermas, has its own techniques of interpretation, methods of inquiry, and forms of assessment. As such the acquisition of emancipatory knowledge is dependent on a realisation by both teachers and students that the knowledge presents itself in different forms, requires different 'teaching/learning' methods, and is measured in different ways to the knowledge associated with the

empirical-analytic sciences. Having accepted Mezirow's contention that perspective transformation, and thus emancipatory knowledge (self-knowledge and reflection), were the most distinctive epistemological elements of adult learning, it was possible to argue that they should be evident in a professional nurse education. This proposition was particularly convincing because the emancipatory area of cognitive interest, and thus perspective transformation, requires self-reflection. This equated with Schön's argument for developing reflection-in-action in the professional practice setting. The inclusion of perspective transformation in classroom teaching could not only be seen as an antidote to the dominant epistemology of technical rationality, it was also compatible with the development of reflection-in-action in the clinical setting.

In summary, the development of theory on the forms of knowledge in the pre-registration preparation of nurses concluded that there was a need to develop a reflective practitioner, if adult professional education was to be achieved. In the practice setting this required the development of reflection-in-action so that the student nurses could develop 'know-how' by being conscious of those forms of knowledge which may only be acquired in practice. These forms of knowledge are attained by participation in the problem situations of the real world not by accumulating propositional knowledge from existing bodies of knowledge. This requires an involvement with and a consciousness of the personal, cognitive and behavioural elements associated with the student's own problem situations in the real practice setting. In this way the student nurses will develop a personal repertoire of problem-solving knowledge before their registration rather than afterwards. In addition, the classroom setting could compliment this

by developing emancipatory knowledge, as well as instrumental and interpersonal knowledge. This is achieved by perspective transformation, whereby students will experience problem posing and reflection, in a classroom setting. The skill for achieving self awareness and 'world view' can then be utilised in the clinical setting to promote the quality of reflection-in-action.

7.4 THE PURPOSE AND AIMS OF NURSE EDUCATION

The previous two sections have argued that the nature of teacher/student relationships and the extant forms of knowledge, existing at the time of this study, indicated that the pre-registration preparation of nurses was neither an adult education or a professional education. In order to achieve this, andragogical approaches to learning must be adopted and the dominant epistemology of technical rationality must be superseded by forms of knowledge associated with interpersonal relating and problem solving ability. In this way, the purpose of producing a self-reliant (independent/adult), professional (critical/reflective) practitioner will be achieved. These purposes must be transposed into educational intents or aims if they are to be achieved. A consideration of the aims of pre-registration preparation brought forth the question of the relationships between the purposes of producing a self-reliant practitioner and the approaches of andragogy and the development of reflection-in-action. A number of models of education had been considered in this study and it was thought possible to hypothesise relationships between the teacher's role, the student role and the nurse practitioner role within one model. The emergent model proposed a cause and effect relationship between the forms

of knowledge, teacher behaviour, student development and the resultant practitioner. Each preceded the other in a cause and effect relationship. It was supposed that the forms of knowledge which were valued would determine the teacher behaviour. This was supported by the work of Schön (1983) and Friedson (1975). The work of Knowles (1970), Rogers (1983), Allman (1983) and Mezirow (1981) supported the contention that teacher behaviour determines student behaviour and thus the nature of the educated person which is produced. It was proposed in the current study that the nature of the educated person determined the type of nurse practitioner. It was also possible to postulate technical/occupational and professional parallels to each causal factor in these relationships.

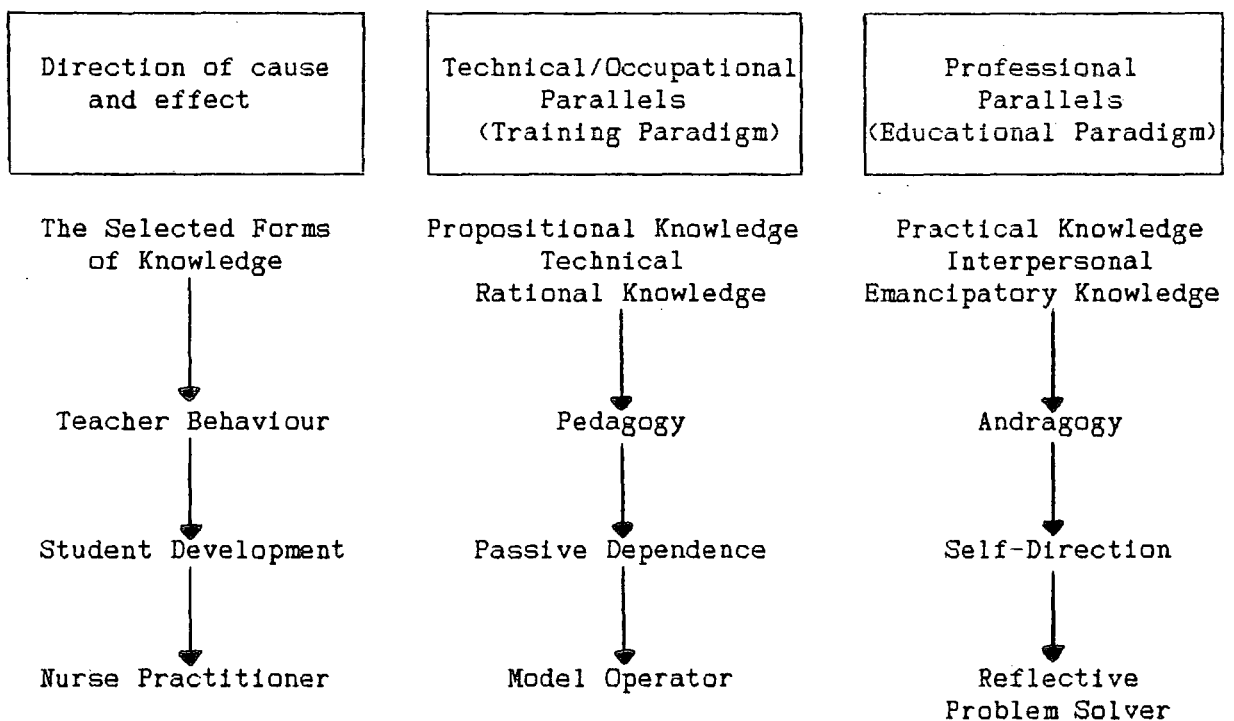


Figure 5 A Theory of Cause and Effect in Nurse Education

Figure 5 demonstrates how the hypothesised cause and effect relationships relate to the training paradigm (technical/occupational) which exists in nurse education and the educational paradigm which is proposed for nurse education.

Having developed arguments related to the forms of knowledge and teacher/student relationships, it was the link between studentship and the practitioner role which was of most interest to this author. It was felt that the influence of the selected forms of knowledge had been demonstrated by other researchers (Schön 1983, Friedson 1975, Mezirow 1981). The ways in which teacher behaviour produced passive dependence or self-direction have also been explored. There was, however, insufficient evidence that teacher/student relationships and practitioner roles were linked and that 'education' had direct consequence for the quality of clinical practice. It was decided to look towards the development of an empirical rationale to strengthen the proposed theory of nurse education described in Figure 5. This investigation is described in the final part of this thesis which adopts an experimental paradigm to demonstrate cause and effect relationships within the clinical setting.

7.5 SUMMARY

An exploration of the extant forms of knowledge, the nature of teacher/student relationships and the purposes of education indicated that there may be a causal relationship between the forms of knowledge and teacher behaviours, between teacher behaviours and the student nurse's role, and between the student role and practitioner role. If pre-

registration preparation was to be an adult professional education then the dominant forms of knowledge should be related to know-how and this should be developed by reflection-in-action in the clinical setting. In the classroom reflection-in-action should be developed by emphasising knowledge for interpersonal communicating and emancipatory action. The teacher/student relationships should promote student self-direction, the teacher utilising andragogical principles as the nursing course progresses. The adopted forms of knowledge and changed teacher behaviours would produce a reflective student and a self-directed student. In turn this would lead to the production of a reflective practitioner and a self-reliant practitioner. The relationships between forms of knowledge, teacher behaviours and student roles had been demonstrated by other education researchers. The relationship between nurse teacher behaviour, student role and practitioner skills needed to be proven to substantiate the assertion that the 'educational' approach determines the type of practitioner produced.

CHAPTER 8

THE EXPERIMENTAL STUDY

8.1 INTRODUCTION

This part of the thesis describes the experimental confirmation of one cause and effect phenomenon which was proposed in a 'theory of nurse education' in the 1980's. This theory had been constructed by utilising data from literature analysis and opinion survey.

It was discovered, as a result of the previous work in this study, that the clinical experience was the most influential part of the pre-registration curriculum in terms of the production of competent nurses. It was further accepted that the academic aspects of the curriculum, under the control of the School of Nursing, make a limited contribution to the production of nurse practitioners. The work of Schön (1983) and Friedson (1975) had also supported the assertion that practice was a key element of professional education. Because of these two reasons the experimental work dealt exclusively with learning in the clinical setting.

It had been proposed that the teacher behaviours which prevailed in the clinical practice had direct consequences for the student role and the nursing student's ability to develop practitioner skills. For the purposes of this study it was accepted as proven that the clinical practice was the most influential determinant of practitioner abilities and that the qualified nurses in the practice setting were considered to be the most influential teachers of nursing. With this in mind, it was found necessary

to identify a cause and effect relationship between a 'teacher' variable and a 'nursing studentship' variable in the clinical setting. An experimental paradigm was adopted for the remainder of the study for three main reasons, the emphasis on survey methods in this and previous research and the power of experimental methods to determine cause and effect.

i **The Prevalence of Survey and Case Study Methods in Previous Research**

An analysis of the literature abstracts in Appendix I, confirmed that almost all of the research work on nurse education in Great Britain had been confined to survey methods and to some extent case study methods. Only three examples could be found of experimental methodology and these were Pomeranz (1973), Abdel-Al (1975) and Alexander (1980). A third study by Quenzer (1974) utilized the social experiment but was not abstracted because the study was carried out on Swiss nurses.

It seemed that there was no developing tradition of social-experimentation and it would be considered useful to attempt to stimulate more interest in experimental methods and thus begin to redress this imbalance. Entwistle (1973) stated that experimental methods attempt to 'examine complex inter-relationships between measures (variables) and unravel the directions of causality'. It is suggested here that the lack of experimental methodology in nurse educational research means that our understanding of nurse education is dominated by descriptive work which rarely substantiates any causal relationships in the phenomena under examination. Another researcher

has, more recently, called for research to be carried out in nurse education for these very reasons (Clinton 1981).

- ii This study has used survey methodology and the experimental approach would enrich the study.

Survey methods had been used to analyse the literature and collate student nurse opinions. They were used in this study because the main aim had been to generate theory (pg 106). These methods were historical and descriptive. The requirement at this stage was to try to confirm an element of the theory by determining cause and effect. It seemed to be a valuable dimension to add to this study. The use of the experimental method would enable one to be more predictive and thus build on the previous work. The adoption of an experimental approach would also provide another benefit, which was that of quantitative analysis. The utility of qualitative analysis has been described earlier in this thesis (pg 106). Qualitative methods provide a rich source of data. The data, however, may be complex and broad ranging. It may also be in many different forms. The advantage of qualitative data is that it is more likely to provide information which is characteristic of the subject under consideration. Quantitative data however, is additive and exact. It utilises numerical values to arrive at conclusions about the subject of the study. It is obvious that quantitative analysis achieves more exact results at the expense of a wider understanding of the phenomenon in question. The most favourable approach is to utilise both where ever possible. This study had begun by utilising qualitative analysis in the literature review. The opinion survey utilised a form of

quantitative analysis and qualitative analysis to elicit conclusions about pre-registration training. The majority of this analysis was qualitative and took the form of a structural analysis. A smaller but major element involved quantitative data and took the form of the content analysis of the opening interview questions. The use of an experimental design would add an additional quantitative dimension to this study.

iii The Power of Experimental Methodology to determine Cause and Effect

The concern of survey work is to look at an existing phenomenon without attempting to influence the factors which characterise the situation. Experimental methods, however, attempt to manipulate and control the main features of the situation (variables), in an effort to discover what outcomes ensue from changes in those variables. The advantage of the experiment is that it is possible for others to reproduce the experiment and thus verify the effect. It is also susceptible to statistical testing because of its quantitative emphasis. In this way results could be evaluated in terms of their occurrence by chance. The use of the experimental method would serve to substantiate or refute one element of the emergent theory by the use of a more disciplined hypothetico-deductive approach. It was decided, therefore, that one hypothesis should be tested using the experimental paradigm to determine at least one cause and effect. The first stage of this process was to develop an operational hypothesis.

The operational hypothesis required that the variables be carefully identified. The independent variable would need to consist of behaviours characteristic of teachers in the clinical setting. The dependent variable would need to be a practitioner skill which could be developed within student nurses and had some relevance to clinical practice, particularly patient care. This would allow the results to be interpreted in terms of the development of nursing 'know how'.

8.2.1 The Independent Variable - Teaching Behaviours of Ward Sisters

The selection of the Ward Sister, as the focus for the independent variable, was considered desirable because of the amount of previous research which had been undertaken with respect to her leadership and teaching behaviour. This study had demonstrated that students perceived the Sister as the most significant individual in the clinical nursing team (c.f. sections 3.3.11 and 6.2.7). Other studies have also confirmed this (Lelean 1973, Pembrey 1978, Fretwell 1978, Briggs 1972, Kershaw 1978). There was also evidence in these studies to suggest that she influenced the student nurse training programme directly, by her relationship/attitude to the student, and indirectly, by the way she manages the nursing team. Her attitudes and skill were transmitted to team members. There was also ample research work which demonstrated the existence of 'preferred' teaching behaviours and undesirable behaviours which were commonly displayed by Sisters (Fretwell 1980, Orton 1979, Ogier 1980, Marson 1981). Orton described learning climates which, at the extremes, she labelled low

student oriented (LSO) and high student oriented (HSO). Orton also demonstrated a correlation between the concept of 'climate' and associated Ward Sister behaviours. The concept of climate was derived from organisational sociology and the HSO climate and LSO climate was characterised by observable Ward Sister behaviours. These behaviours were synonymous with teaching behaviours because the climates were defined in terms of their influence on the student nurse. Fretwell (1980) also worked on the identification of 'good' and 'bad' ward learning environments. She was able to describe elements of the formal teaching situation on the 'ideal' ward. Marson (1981) identified behaviours which students said helped them to learn from their work experience. She used Rackhams (1977) method of analysing and categorising person to person verbal interactions, and could place the consistent behaviour of various nursing grades along an autocratic/participative dimension. It was possible then to specify the independent variable as one which was dichotomous and held at one extreme behaviours which were high student oriented and at the other low student oriented (Orton 1979). Other research work by Ogier 1980, Fretwell 1980 and Marson 1981 could be used to confirm the salience of behavioural patterns which made up each pole of this variable.

The high-student oriented behaviours which were subsequently identified (pg 320) were thought to be synonymous with an andragogical approach to learning in the clinical setting and the low-student oriented behaviours were not. The HSO behaviours demonstrated a recognition of the student as a unique human being, praise and development of positive self concept, opportunity for questioning and teacher participation in ward work which indicates a facilitative style. The HSO behaviours also develop a degree

of learning-in-action. The learning being organised, valued, related to patients and cognisant of the student nurse's personal and practice problems. Low-student oriented behaviours were thought to be none of these things being typified by the external regulation of the student nurse's behaviour, telling rather than discovery and a lack of recognition of the student as a unique individual. These LSO behaviours were not thought to be typical pedagogical behaviours in themselves, rather they reflected a set of behaviours which exist in the absence of andragogical approaches and in a clinical setting which assumes that teaching is about telling and that knowledge is given as theory rather than acquired in practice. The HSO behaviours were believed to be consistent with andragogical approaches to learning and the LSO behaviours indicated a propensity towards pedagogical approaches.

The two extremes of 'teaching behaviour' had some face validity, and a degree of construct validity; as such they were accepted as suitable independent variables to represent the effect of the teacher's behaviour on the student role. This would now need to be applied to the dependent variable, a suitable practitioner skill necessary for patient care.

8.2.2 The Dependent Variable - Nurse Practitioner Skill

The dependent variable required the identification of a suitable skill which was required of the qualified nurse practitioner and which had potential for development in the student nurses during their clinical experience. It was also believed that the experimental study could throw light upon arguments relating to the development of a reflective professional practitioner if it could be demonstrated that the chosen skill

was relevant to this purpose of education. Schön (1983), Friedson (1975) and Mezirow (1981) had mentioned the central role played by clinical problem posing and solution in both adult education and professional education.

Other writers had supported the need for a problem-solving approach in nursing (Roper 1976, Darcy 1980, Goble 1981, Gott 1982). The problem solving approach had been promoted in nursing in the form of the 'nursing process'. The General Nursing Council Syllabus (1977) also supported, and many would say, initiated this promotion (see appendix IV). Attree (1982) provided a succinct review of the literature which confirmed that the nursing process was a problem-solving concept. Research by Crow (1980) further supported this argument, as did earlier commentators on nursing care (Little and Carnevali 1971, Johnson and Davis 1975).

Johnson and Davis further described the problem-solving process in five stages:

- i Assessment
- ii Problem statement
- iii Decision making
- iv Action
- v Evaluation

One American author had demonstrated that the decision making process could also be broken down into discrete steps synonymous with the nursing process (Schaeffer 1974). It was the contention of the current study that decision-making is a skill which contributes towards, and is a precursor to, problem-solving. Problem-solving, by definition is dependent on an appropriate solution. The problem-solving process is cyclic until a terminal solution has been achieved in practice. Decision-making, however, depends more on commitment to choice rather than the isolation of an adequate solution in practice. Whilst the concepts are very closely related in practice it was felt that decision-making was the concept more suitable for the experimental design. There was support for this in the early writings of American nurses. Kelly (1966) argued that the observational role of the nurse involved three operations, observation, inference and decision-making. More recently Bloom (1980) had presented an argument which supported a general relationship between social conformity, acquired decision making responses and consequences for patients:

"The inability of some groups to form a stable status hierarchy early in their experience resulted in lack of leadership consensus among their members. Lack of consensus was particularly problematic for the groups in the Three-Characteristic condition and had measurable consequences. If the patient care decisions of many groups had actually been implemented, the patient would have been discharged from the hospital - negatively affecting care and, possibly their chances for survival. Members were unable to deal with the task at hand due to their overriding concern with

the way they socially presented themselves within their group".

(Bloom 1980)

There was also support for the assertion that both problem solving and decision-making are educable abilities. Attree (1982) forwarded the argument that education, rather than training, was required to prepare nurses as problem solvers. Munro (1982) summoned a similar argument by referring to Gagnes' assertion that 'individuals differ in decision making and this is a function of their previous experience and success with similar decision situations'.

The choice of decision making, as the dependent variable, was made on the assumption that it was an educable ability which had potential consequences for the patient. It was of particular interest because it was a psychological concept which described an internal state which was likely to affect performance. It was still relatively complex as an experimental variable and it was found necessary to investigate the concept further, so that the variable could be fully operationalised. A model of decision making processes would need to be adopted and this is the subject of the subsequent discussion.

8.2.3 Decision Making Processes

The psychology literature supported the contention that decision making was a complex human process. It involved a consideration of external (non-cognitive) factors and internal (cognitive) factors. Bower (1982)

confirmed this when she recommended that approaches to decision making should involve a consideration of three main factors:

- i The context or setting in which the decision is to be made.
- ii The values, attitudes and motivations of the decision maker.
- iii The properties and characteristics of the decision to be made.

This encouraged the author to adopt an information processing approach to the psychological study of decision making.

By accepting Bower's model it was necessary to explore the cognitive process, the problem itself and the effect of context on both of them. (Figure 6)

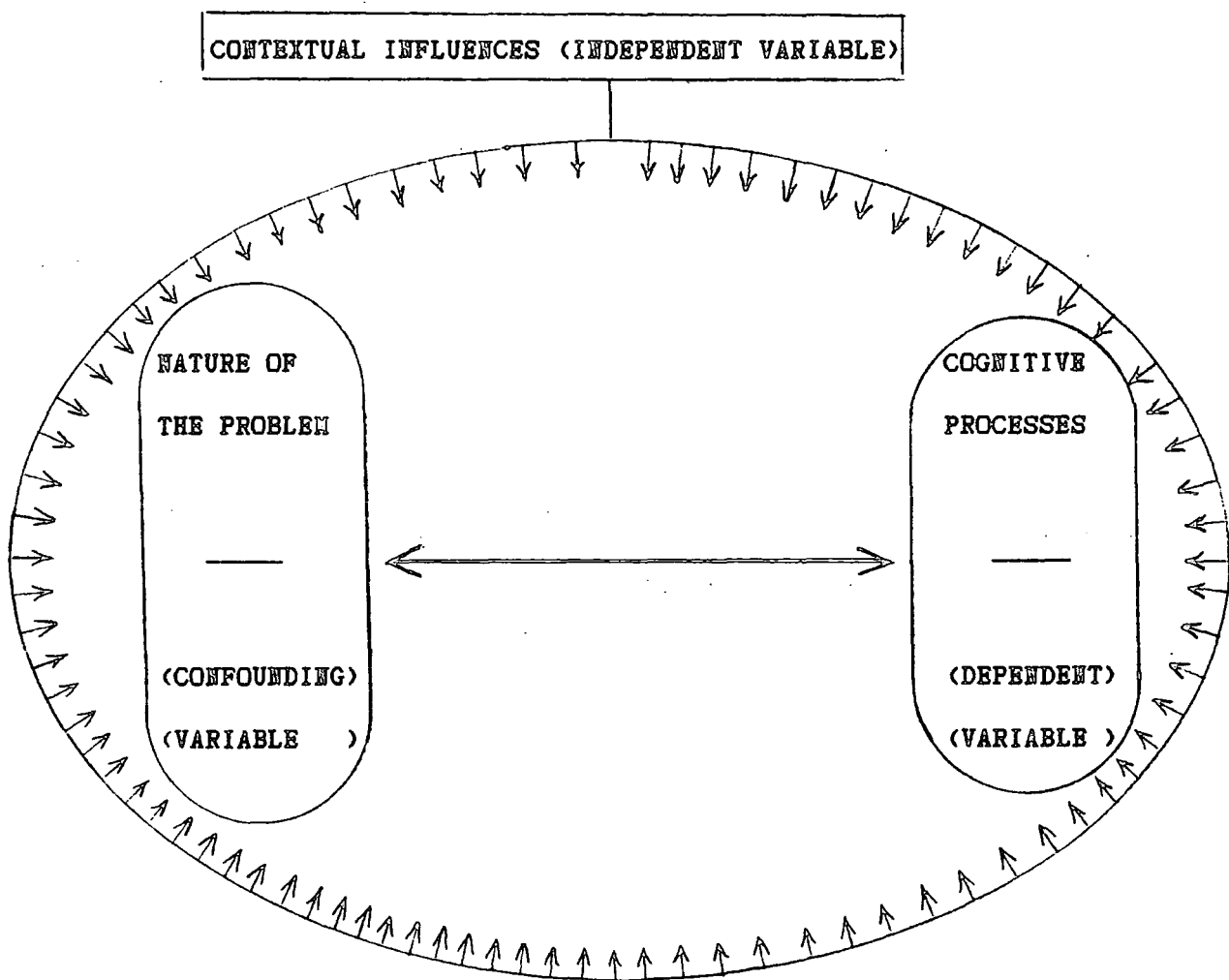
The independent variable, defined as the ward sisters teaching behaviours, could be viewed as being synonymous with the context or setting.

The decision making process could thus be considered to have two main components, the problem characteristics and the internal cognitive processes.

The cognitive processes were most closely related to the specification of the dependent variable and the adopted model of cognitive information

processing will be described here. The problem situation was seen as a third variable which would need to be standardised as a confounding variable, and will be discussed later (pg 303).

FIGURE 6 A MODEL OF DECISION-MAKING VARIABLES



A Model of Cognitive Decision Making Processes

The cognitive elements of decision making are conceptual and not amenable to direct observation. In order to enable the formulation of an operational model it was advisable to adopt a descriptive, rather than a normative, approach (Castellan et al 1977). The cognitive elements of the decision making process were variously described by different authors but the following were most commonly agreed:-

i Defining Objectives or Purpose (Gelatt 1962).

The decision making system is seen in its early stages to be predictive. In essence the decision maker judges the goal at the outset.

ii Collection of Information

This was one of the most consistent features of decision making models. It involves the compilation of a data base, related to the problem, by undertaking operations such as cue sensing, cue interpretation and inference drawing (del Bueno 1983, Berlyne 1960). The process is said to involve various aspects of information overload. Such as errors, omissions, queing, filtering, approximation and fleeting.

iii Generation of Options

A decision has been described as the last step in the process by which

an individual chooses one alternative from several in an effort to achieve a desired objective (Follett 1982).

iv Estimation of the Consequences of each Option (Gelatt 1962)

Decision making is said to involve estimations of uncertainty and risk. Uncertainty being defined as lack of knowledge of the outcomes of action. Risk being the lack of control over the outcomes of action. It assumes that the decision maker has knowledge of the outcomes of action even though he cannot control them (Follett 1982). There is also an affective and attitudinal influence on this stage of the process. Emotional arousal and predetermined automatic response are likely to influence the evaluation of consequences. Another perspective has been the mathematical approach to the estimation of consequences, and this approach suggests that the expected value of each course of action would be determined by multiplying the utility of each possible outcome by its probability and summing (Wallsten 1977).

v Selection of an Option

The next step involves the selection of one of the alternative courses of action. This often depends on the type of problem and the contextual constraints. Various strategies have been described for selecting an alternative, they include:-

- (a) Optimising strategy
- (b) Satisficing strategy

- (c) Opportunistic strategy
- (d) Do nothing strategy
- (e) Strategy of solving for the critical limiting factor
- (f) Maximax strategy
- (g) Maximin strategy
- (h) Strategy of mini regret
- (i) Precautionary strategy
- (j) Evolutionary strategy
- (k) Chameleon strategy

(Follett 1982)

Clearly the process of selecting an option involves the adoption of at least one of many possible strategies.

Cronbach and Glaser (1957) suggest that the selected alternative may be terminal (final) or investigatory (calling for additional information). The investigatory selection brings about a cyclic process, requiring more data gathering and decision making, until a terminal decision is made.

vi Action to Implement the Selected Option

As indicated in the last step, investigatory selection suggests that some forms of action help to make a better decision. This is because test and check behaviour can generate a lot more data which enables a more informed selection of the appropriate option.

These processes are incorporated and summarised in a model described by Gelatt (1962), shown in figure 7.

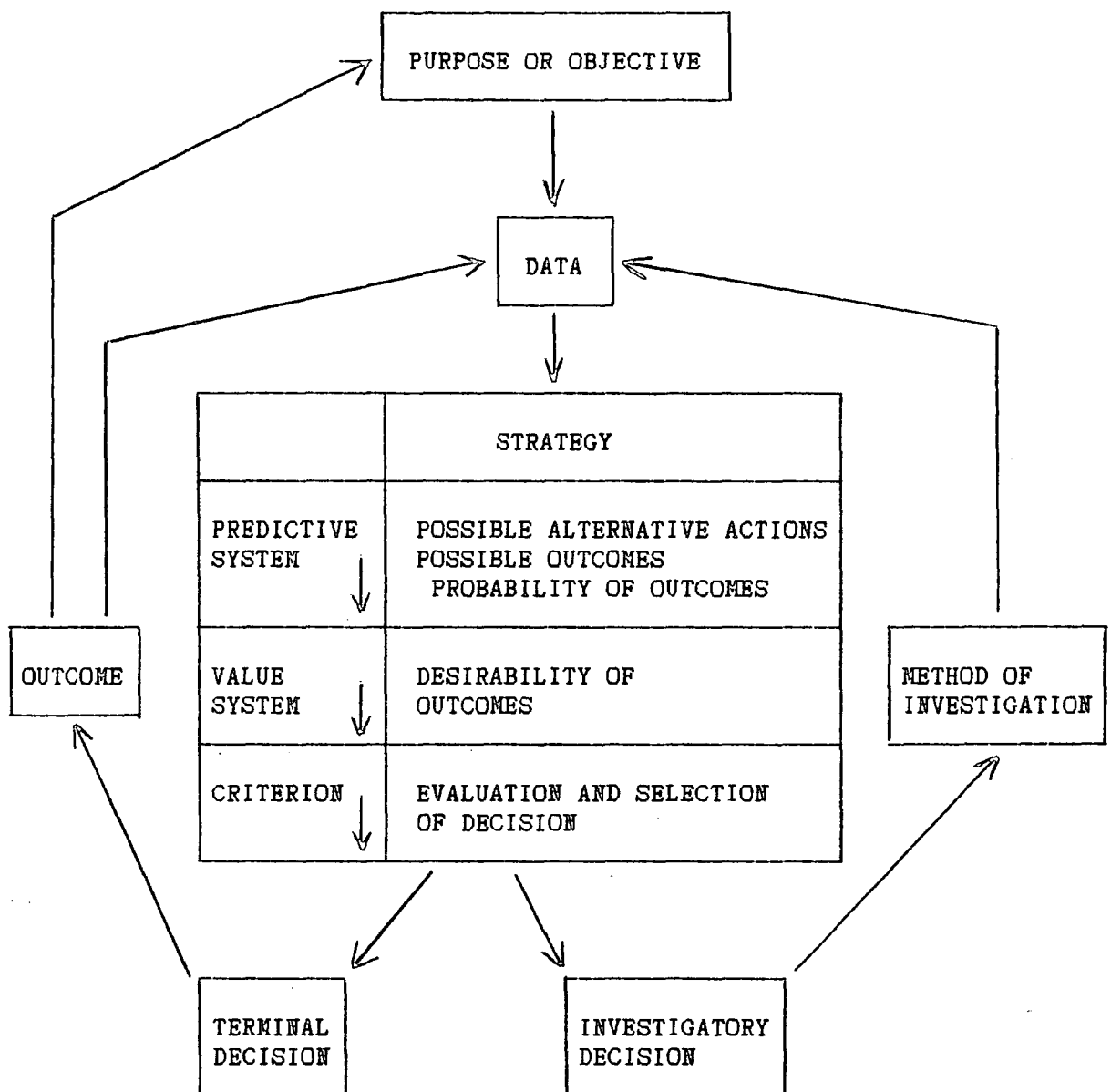


FIG 7 A MODEL OF COGNITIVE DECISION-MAKING PROCESSES (GELATT 1962)

There are one or two critical points one can make about Gelatt's Model which may have implications for this study.

The first concerns the general idea that the process is cyclic until a terminal decision is achieved. Work by Festinger (1964) suggests that

individuals often feel obliged to live with a final decision. In such circumstances Festinger suggests that the person adds to the data base, *ex post facto*, so as to justify the choice. He can even modify the purpose or objective in retrospect to fit the selected alternative. This seems to be primarily due to the influence of emotion which is best associated with the value system of Gelatt's Model. A second observation is also related to emotional factors, but to those which are unknown to the decision maker. Freud's discovery of unconscious motivation suggests that the decision maker may not be aware of, or in control of the content of many of the factors in the strategy unit of the model.

Bearing these points in mind it was considered that Gelatt's Model did adequately describe a process of decision making appropriate to the dependent variable, but it was a descriptive approach and it offered a description of the decision making process as a complex set of variables rather than a single variable situation. This would add to the predictive power of the experimental results. The work of Festinger and Freud, however, encouraged one to be cautious about offering simple explanations of the cognitive change which may be occurring in the human being during the experimental process.

It was necessary, however, to have a more detailed description of the information processing mechanism embodied in the strategy system of Gelatt's Model. This would enable the experimenter to understand in greater detail some of the variables which could be controlled. Wallsten's process theory (1977) provided insight into the potential workings of the strategy part of the decision making process.

Wallsten's Heuristic Process Theory

Wallsten's Theory (1977) originates from the use of algebraic models of the decision making process. It is a theory which attempts to describe a strategy whereby data is combined to ascertain which of two or more hypotheses are preferred for the terminal or investigatory decision. Wallsten's theory considers that the data base is a complex multi-dimensional stimulus. The many dimensions in the data base vary in salience for each individual person.

'A salient dimension is one which a subject is likely to attend, and which is likely to control his behaviour'.

(Garner 1974)

Other researchers, referred to by Wallsten and working in the field of human learning (Trabasso and Bower 1968) and animal learning (MacKintosh 1965), have demonstrated that saliency depends on a number of factors,

The:-

- i Perceptual characteristics of the dimensions
- ii Range of possible dimension values
- iii Previous experience
- iv Subjects set.

Wallsten suggests that the most salient dimensions provide an 'anchor' for the judgement which is made. The decision making process works through these dimensions sequentially. The most salient dimension brings about

initial option formation regarding any two hypotheses. The next salient dimension is then considered and a modification or adjustment of the initial option takes place. This process is repeated until the person considers that he is ready to select one of the hypotheses. The theory does not assume that the person always attends to all dimensions in the data base.

The essential points of Gellatt's Model and Wallsten's Heuristic Theory enabled one to identify certain critical features which were required in the presentation of the decision making variable. They are outlined below.

Multi-Dimensionality of the Data Base

This confirms that the decision to be made, in the experimental condition, should be complex rather than simplified. The nature of the problem to be presented should be similar to that presented in the real life setting. This should allow for a number of dimensions to be added to the decision makers data base before the decision is made. The presented problem, whilst requiring standardisation across subjects, also requires some degree of complexity. The nature of nursing requires that the most relevant decisions are made about patients, and as such, the individual patient, and his case information, can provide numerous dimensions which would be utilised in the decision makers data base. In addition to this, one expected that the experimental condition would require that a critical incident would initiate the nurses' decision making process. It was concluded that a patient's problem situation would be an adequate way of ensuring that there was multi-dimensionality in the data base which was utilised by the decision maker.

The Saliency of Dimensions

The belief that the saliency of data base dimensions is important, gave support to the general idea that the context, as well as the problem characteristics, should be complex. There should be a variety of information, thus increasing the probability that there were a number of dimensions varying in saliency.

The data base should not only be complex but should vary sufficiently in terms of importance, to the subject, to ensure a decision making process more representative of the everyday nursing situation. It was concluded that a description of the patient and his current state, along with a description of the problem situation, would be adequate to produce a data base that ensured the varying saliency of decision making 'dimensions'. It was thought necessary to look at some of the determinants of saliency in an attempt to control for some of the irrelevant or confounding variables.

Perceptual Characteristics of Dimensions

If the perceptual characteristics of dimensions were to be controlled, as a confounding variable, they had to be kept constant in the presentation to each subject. Each subject would need to receive the problem data in exactly the same way. This reinforced the decision to select the experimental paradigm for this stage of the study.

Range of Possible Dimension Values

It was thought that this had been adequately covered by the measures adopted to ensure the salience of dimensions.

Subjects Previous Experience

This had important implications for sampling and would be adequately handled in the sampling procedure. The major requirements would be that all respondents had similar work experience, this being most relevant to the type of decision being made. Fortunately, the registered nurse preparatory courses were designed in such a way that students would all have similar experience, albeit in different places. The course designs for the survey sample demonstrated that all subjects would have attended a school of nursing for at least ten weeks, 6 weeks of which would be introductory block. All would have had experience on a medical and a surgical ward, along with at least one other ward.

This could not be specified and would not be the same for all students. It was most frequently an elderly care ward. This was supported by data originating from the student nurse interviews described earlier.

Accepting that an individual personal experience is unique anyway, it was felt that this was the best way of controlling for variations in work experience. Life experience or non-nursing experience was more difficult to control. It was expected that control for personality variables would be the best that could be achieved. Matching or randomising would need to be utilised to cope with this.

The Subjects Set

The most important determinants of set were thought to be concerned with the potential artificiality of the experimental situation. The experimental setting would have to create sufficient 'atmosphere' to involve the nurse in a decision making process sufficiently akin to the real nursing situation. It was thought that the experimental condition should present a clinical setting, which was standardised, and a stimulus sufficient to generate some recall and imagination in order to create a 'reality set' away from the work setting. Castellan (1977) provided evidence that such an experimental setting would give valid evidence about the real setting. He concludes that one aspect of the decision making task is that the cues upon which judgements are ultimately based are not completely valid. The subjects use cues which are probabilistic. He further suggests that there is an inherent randomness in the sequence of events that prevent the person from using sequential, or time dependent patterns, in the learning processes associated with decision making. This, along with the recent discussion on cue saliency, suggested that the use of a video presentation was a satisfactory way of presenting the experimental situation and that the artificiality of the situation would not detract from the validity and reliability of the results.

Having isolated the major variables, it was necessary to clarify the proposed relationship between the variables.

8.2.4 The Relationship Between Variables

The definition of the independent and dependent variables confirmed that the model illustrated in Figure 6 (pg 292), provided a sound basis for the experimental design. The independent variable was contextual and could be represented by the teaching behaviours of the ward sister. Other aspects of the context represent potential confounding variables and required control. The dependent variable was the decision making process, a conceptualisation of the processes which take place inside the individual (student nurse) and objectified in the form of Gelatts' Model. The nursing problems, which student nurses were required to make decisions on, represented the major confounding variable. These problems could be as variable and unique as any single life circumstance. They could depend on the patients disorder, stage and severity of illness, his personality, the treatment prescribed, as well as, the previous experience of the patient and nurse. This list names only a small number of factors which may add to the uniqueness of every problems which nurses may need to make decisions about. It was concluded that this variable would need to be standardised and the same problem situations would need to be presented to each subject.

It was believed that the independent variable would demonstrate teacher behaviours which could be defined in terms of pedagogical and andragogical approaches. The alternative approaches could then be applied to the dependent variable which was clinical decision-making. This clinical decision-making would be demonstrated in the responses of student nurses and thus represented an element of the student nurse's learning repertoire which was relevant to an adult and professional education. Because the skill was associated with qualified practitioner behaviour and with patient

centredness, it could be argued that the student role had consequences for the practitioner role.

8.3 THE EXPERIMENTAL DESIGN

8.3.1 The Operational Hypothesis

The basis for the experimental design was the operational hypothesis and this was stated in the following way:-

The terminal decisions made by junior student nurses, after being presented by a series of patient problems, will be more patient-orientated in a group which is exposed to a sister demonstrating 'high student orientated behaviours' (HSO) than a group which is exposed to a sister demonstrating 'low student orientated behaviours' (LSO).

In the tradition of the experimental paradigm it was required that this hypothesis should be stated in the form of the null hypothesis, and one would have to work on the assumption that:-

The students exposed to a sister exhibiting 'HSO' behaviours would not make decisions which were more patient orientated than a group exposed to a sister demonstrating 'LSO' behaviours.

This null hypothesis would have to be rejected, in a statistical sense, in order to demonstrate that the operational hypothesis had been substantiated.

It was important to emphasise that this hypothesis was undirectional, (one-tailed) because this would have important implications for the statistical analysis. A unidirectional hypothesis is more precise about the probability that any observed difference occurs randomly by chance than a bidirectional (two-tailed) hypothesis.

8.3.2 The Experimental Conditions

The simplest experimental design was thought to be the most achievable in the circumstances available. This involved a 'treatment' situation followed by an 'observation' of the outcome (Pilliner 1973). In the context of this study it required that the presentation of the independent variable was followed by a measure of decision making. Initially it was planned to operate a more effective sequence of 1st observation, treatment and 2nd observation. This would require the use of a pre-test and post-test for the measurement of the decision making variable. There were a number of reasons why the use of a pre-test was though inappropriate. The first was that it was not a requirement to measure overall decision making ability. It was more relevant to identify the focus of the terminal decision under different experimental conditions. Secondly, it was found impossible to develop sufficient valid items to construct a pre-test which was different to the post-test. It would be necessary for the two tests to be different because it was thought that the subjects performance would be invalid if they had seen the problem before set and context had been

created. Finally, it was felt that the use of identical pre-test and post-tests would be inconsistent with the operation of the decision making process. Terminal decisions are always made with the benefit of hind sight and never with the benefit of more experience. This study was only concerned with terminal decisions and not with the investigatory decisions as shown in Gelatt's Model. The investigatory decision is one which is made in the expectation that more data will be gathered so that a terminal decision can be made. It was thought that a pre-test, utilising the same items as the post-test, would encourage the use of the investigatory decision making loop and thus add an unnecessary variable to an already complex situation.

It is also common to use a control group in experimental work. This provides a means of comparing the experimental group with a group which has not been affected by the experimental conditions. It was difficult to use a control group in this situation because the subjects would be making decisions in the absence of a standard context. Subjects would be from a number of different hospitals and their recent experience would compound the likelihood of their each using contexts which were at variance with the contexts of their fellow subjects. The use of a control group could have been attempted for safety sake but this would have increased the number of experimental conditions. The timing of the experiment was a critical factor in gaining access for fieldwork. Ultimately this would affect representativeness, if all the sampled schools of nursing did not participate. The advantages of a control group were felt to be negligible in this situation.

It is not uncommon for psychologists to utilise a design which compares the effects of two experimental conditions (Greene and D'Oliveira 1978). It is this approach which was chosen. The experimental design can be simply summarised as:

Group X = Experimental condition 1	-----	Post-test A
Group Y = Experimental condition 2	-----	Post-test A

8.3.3 Same Or Matched Subjects

Once the experimental conditions had been defined it was necessary to decide whether the same or different subjects should undertake each of the experimental conditions. Ideally the use of the same subjects would produce more significant experimental results. It became apparent, during the development of the decision-making measuring instrument, that it would not be possible to develop separate tests for subjects to complete after each experimental condition. If the subjects completed the same test twice there was a worry that order effects would invalidate the second test administration. The main consequence which was of concern was that subjects under test conditions would feel obliged to stick to their original decision. The probability that this would happen was supported by the theory of cognitive dissonance described by Festinger (1964). Having once made a choice from two or more reasonably attractive alternatives Festinger seemed to indicate that any additional information given to subjects is likely to create dissonance if it does not tally with the original choice. In simple form the individual feels uneasy if the subsequent data does not fit the original decision. Festinger suggested that there were two ways in which the individual can reduce the dissonance.

He can minimise the attractive features of the rejected alternatives and minimise the unattractive features of the chosen alternative. Alternatively he can maximise the attractive features of the chosen alternative and maximise the unattractive features of the rejected alternatives. These two strategies have the effect of increasing the desirability of the chosen alternative and decreasing the desirability of the rejected alternatives. It was expected that the subjects, if exposed to identical pre- and post-tests would suffer dissonance on presentation of the independent variable. Given that it was not possible to develop separate pre-and post-tests and thus use the same subjects for both conditions, it was found necessary to look at the acceptable alternative of matching subjects in both groups. The matched pairs design provides an alternative method of eliminating bias from individual differences between subjects undertaking different experimental conditions. Pairs of subjects are matched for what are considered to be important characteristics. It was relatively easy to match subjects for sex, age and experience by using similar selection criteria to those used for the survey sample described earlier in this thesis (pg 157). Female student nurses, 19 years of age, who have completed one medical ward, one surgical ward, one other ward and ten weeks study block experience. All subjects would meet these criteria and matching in pairs would be fairly pointless unless other important characteristics could be identified. There were no other factors which could be confirmed as crucial to this study. It was decided that eventhough subjects could be relatively well matched on basic criteria randomising would be a better way to eliminate bias.

8.3.4 Matching V's Randomisation

The matched group design, in a statistical sense, makes it possible to eliminate one or more extraneous sources of variation and in addition reduces the risk of committing type II error. Type II error involves accepting the null hypothesis when in fact it is false. The major restriction on choosing the matched group design was that one should not match on a variable which "might help" but only on those that one is sure will have a reasonably strong influence (Minium 1978). This confirmed that randomisation should be considered. The matched-groups design keeps one characteristic standard across subjects in two groups, whereas, randomisation holds characteristics constant for all subjects. Randomisation is useful for situations in which the experimenter can assign the treatment condition to each subject at will. Whilst it is a good method for the impartial assignment of extraneous influences amongst groups, it does not absolutely guarantee equality. The advantage for this study was that it affords control over extraneous influences whether or not they are known to the experimenter (Minium 1978). It was accepted, however, that by both randomising in this way and using an independent sampling design, there was an increased probability of a large standard error and thus of committing type II error. This, however, can be counteracted by increasing the sample size. More than twenty observations ensures that moderate departure from homogeneity of variance will have little effect. This is also enhanced by choosing samples of equal size. Given that there was no known basis on which to match the subjects, randomisation was chosen as the best method of eliminating extraneous sources of variation.

8.3.5 Criteria for Statistical Test Selection

As a result of the previous discussion it was surmised that the chosen statistical test needed to cope with the analysis of differences, within a design utilising two experimental conditions and different groups undertaking each experimental condition. This resulted in the conclusion that the parametric unrelated t-test or the non-parametric Mann-Whitney test should be used. It has been found that non-parametric tests, which put scores in rank order, are only measuring variability indirectly (Greene and d'Oliviera 1978). Parametric tests, however, can give a measure of the proportion of the total variance in scores which is due to differences between experimental conditions, as opposed to all the other sources of variance in the experiment. Simply put parametric tests are more powerful as long as certain assumptions about the data can be upheld.

These are:-

- i That the data is at the level of interval or ratio measurement
- ii That the data will be normally distributed
- iii That there is no significantly different amount of variance in the different experimental conditions.

It was expected that the data would be numerical on at least an interval scale, that it would be normally distributed and that randomisation would

ensure homogeneity of variance. This being the case it was decided to use the t-test (unrelated) which was the parametric option.

Having described the experimental design, some of the sample characteristics and the required statistical test, it is now appropriate to discuss the construction of the experimental conditions and the development of the dependent variable measure.

The former will be dealt with first as this incorporates the independent variable as well as the controls for other contextual factors. These include the main confounding variables in addition to the problem cues.

8.4 THE DEVELOPMENT OF THE EXPERIMENTAL CONDITIONS

The experimental conditions represented the two elements of the independent variable. The previous discussion, on those variables inherent in the decision making process, generated a conclusion that a video television film would be an ideal form of presentation. It was a desirable method mainly because it created a realistic set. It also had the potential for introducing and linking the independent variable contextual material and patient problem contextual material. Video presentation would reduce the artificiality normally associated with laboratory methods and it was an attractive form of presentation which would hold the attention of subjects. The development of a video presentation brought up a number of issues, the first of which was concerned with the specifications in the operational hypotheses. Each experimental condition needed to present extremes of the variable 'teaching behaviour'. It had already been established that the

ward sister should be the vehicle for the transmission of these behaviours. In addition it was considered advantageous if the extremes of teaching behaviour were consistent with mechanistic (training) and organic (educational) approaches. There was a need to produce two separate video films, each presenting opposite extremes of the teaching behaviour in question. It was also necessary to standardise as much of both presentations as possible. The video production would require scripting to ensure that two major components existed:-

- i A standard format/structure for both conditions
- ii Matched vehicles for the transmission of the independent variable.

8.4.1 The Standard Format

Both scripts were written on the basis of a standard sequence. The researcher had worked as a staff nurse on a medical ward for one week during the planning of this part of the study. It provided an excellent opportunity to identify the most appropriate 'clinical event' which would serve as an adequate video excerpt. This was not the prime purpose of the researchers clinical involvement but it did provide an opportunity to carry out some informal participant observation.

It transpired that the most frequent and easily definable event in terms of a clear start and finish was the 'ward report'. This most frequently took

the form of an information giving session led by a senior nurse for the benefit of the oncoming nursing team at the beginning of a period of duty. Less frequently it was given as a teaching activity. The person giving the report was most frequently the ward sister. Although the literature search and survey showed that wards varied in the frequency with which reports were given, it was also certain that all students had experienced this event on many occasions. Some wards gave 'reports' as many as two or three times a day, others once or twice a week. Daily reports were the norm. This change of shift report was found to be a useful situation because it was a structured event. It also provided information, in some detail, on the patients and thus provided an ideal opportunity for standardising the contextual information associated with the problem situation. Furthermore, it provided a realistic setting in which students commonly came into contact with the sisters on all wards. Remembering that the literature analysis and survey had demonstrated that some sisters did not work on the ward with students, it was found that even these sisters gave reports on occasions. This often provided one of the only structured situations in which students were able to learn the ward sister's leadership style and teaching behaviours. There was scant reference to the change of shift report in the literature, but one paper by Clair and Trussell (1969) proved beneficial. Although it reported an American study, the present author's experience confirmed that the setting described in the paper was almost identical to that in British nursing. Clair and Trussell (1969) described the change of shift report as:-

"An oral communication of pertinent information about patients on a particular patient care unit that emphasizes events of the tour of duty just ending".

They also confirm the sort of information which should be included in the report.

"A change of shift report should include identifying patient information, general patient information, nursing directives, and special problems."

Their study found that change of shift reports were concise and rarely thorough enough to include great detail on each patient. The salient points as identified by the senior nurse were reported and they did not seem to follow any clear cut guidelines. This seemed to confirm the observations made by this author during clinical practice. The importance and frequency of this form of verbal report was emphasised by a Kings Fund project paper (1979). This document suggested that there are time constraints on change of shift report sessions : and that two forms of report exist, the brief meeting and the extended meeting :

"All nurses need to receive a report on their patients before they start a period of duty, yet there may only be limited time available".

"While some handover reports may have to be brief there should always be regular opportunity for other more extended meetings for teaching and discussion".

It was confirmed in this paper that the nurse giving the report was a controller of the information which was given.

"The nurse giving the report will have to judge what is required by those receiving it in order for them to be safe and effective practitioners".

It seemed that the relatively brief form of meeting was the most relevant model for the experimental scenario. It would be sufficiently acceptable for the present author, as an experienced nurse, to fabricate the essential patient information.

One important question was related to the creation of set. How could one create a set in which the respondent would identify with the situation on video without dismissing it as being personally invalid? It was decided to use an indirect method of identification with the situation. This was achieved by choosing a first year student nurse as the central character in the video presentation and by instructing the viewer to concentrate on this persons perception of the situation. The necessary decision making was also indirect, requiring that the respondent should consider what decision the central character would make in the context created by the video presentation.

Having decided that this should be the case and utilising the author's recent experiences of change of shift reports, the following sequence of frames were identified for the video script.

i. The Student/Sister Meeting

This involved the student nurses entrance to the ward and her first meeting with the Sister. This first meeting was an impressionable time for the students. Key features of the Sisters interpersonal style were transmitted on this occasion. The student was often anxious and hyperperceptive when she started her first shift on the ward. It was thought that this scenario could elicit recollections of the respondents thoughts and feelings associated with her past experience of such situations.

ii. The Summoning

This sequence was brief and consisted of the Sister calling all those who had just come on duty into the office for the report.

iii. The Preliminary Comments

Rarely did the ward leader begin by reporting on the patients. Idle social conversation generally preceeded the report as team members occupied seats and settled themselves for the information giving. This provided another opportunity for the ward leader to transmit some characteristic features of her 'style'.

iv. The Patient Information Giving

This took the form of a report on each patient in sequential order as laid out in the 'kardex' filing

system. Each patients' nursing plan/report was filed in order of their geographical position in the ward, usually by room numbers.

v. **The Questioning**

It was decided to include in the sequence an excerpt which showed the key character asking the Sister a question, thus indicating a desire to understand some concept which had been presented. This was not an uncommon occurrence and it did provide an opportunity for the Sister to demonstrate her typical 'teacher' responses.

vi. **The General Information Giving**

This segment of the report consisted of the presentation of information which was not related to specific patients. Sometimes this consisted of general information about the ward such as number of patients, number of empty beds, planned maintenance and changes in routine. Other examples of general information included information passed down through line-management or from other meetings which the Sister has attended.

vii. **The Work Allocation**

The end of the report usually involved the allocation of work to the team. There were two common options for the allocation of work. One was to allocate tasks to members of the team, the other was to allocate staff to

groups of patients. The latter was a more recent innovative development in nursing. Task allocation was the more traditional method. The survey reported earlier indicated that both methods were in existence but task allocation was more obvious than patient allocation. There was however some suggestion from the survey and the literature analysis, that the more positive teaching behaviours of Sisters seemed to be associated more with the patient allocation of work than task allocation. Patient allocation also seemed to demonstrate the Sister's particular concern for patients. This was found to be one of the favoured characteristics which students reported.

viii. The Student Interview

Normally the report would finish after the work allocation. In the case of a student nurse beginning her first day on the ward, it was usual for the ward leader to orientate the nurse to the ward and the work requirements. There was also a requirement for the Sister to undertake a preliminary student interview which discussed the ward teaching plan and the students learning needs. This did not usually occur after the ward report, but it was thought to be useful for the experimental design to include a brief interview with the student. This would facilitate the transmission of her 'teacher' behaviours.

These identified components of a typical change of shift report provided a framework for a video recording script, each part describing a segment of the final video presentation. Within this framework a script was produced which would act as a working guide for the 'director' and a dialogue guide to the 'actors'. The framework enabled the production of a standard script for both experimental conditions. Within this script matched alternate dialogue would be inserted which would transmit 'teaching style'.

8.4.2 The Alternative Dialogue

Two sets of phrases would need to be produced, one set carrying one extreme of teaching behaviour and one set an opposite extreme of teaching behaviour. In order to do this some exploratory work had to be undertaken to isolate the key indicators of teaching style. It was decided to adopt the terminology coined by Orton (1979) to describe the two styles of behaviour. She utilised the terms 'high student oriented' (HSO) and 'Low student oriented' (LSO) to describe the learning climates and it is obvious, when reading this work, that climate was synonymous with behaviour.

In order to produce the HSO and LSO dialogue it was felt necessary to produce a set of rules for the construction of antithetic phrases which would transmit the key features of the teaching style. The literature abstracts were utilised for this purpose notably Fretwell (1980), Orton (1979), Ogier (1980), Melia (1981) and Marson (1982). Nine factors were isolated which had considerable support in the nursing literature. They are shown in table 4 along with the references which support each factor.

TABLE 4 KEY FACTORS FOR HSD AND LSD SCRIPT GENERATION

FACTOR	DESCRIPTION	REFERENCES
1	Involvement in teaching role (accepts or rejects)	Revans 1964, Orton 1979, Ogier 1980, Runciman 1983, Marson 1982, Fretwell 1980
2	Attitude to student role (learner or worker)	Orton 1979, Parkes 1980 Marson 1981
3	Work orientation (task or patient allocation)	Parkes 1980, Gott 1982 Marson 1981, Fretwell 1980, Alexander 1982, Bendal 1973
4	Social relationships with team (personal or formal)	Melia 1981, Marson 1981, Fretwell 1980, Ogier 1980 Abdel al 1975
5	Social reinforcement (praises or rebukes)	Revans 1964, Parkes 1980 Marson 1981, Birch 1978,
6	Communication lines : Approachability (direct or hierarchical)	Fretwell 1980, Ogier 1980, Parkes 1980, Birch 1978, Marson 1981
7	Emotional support for personal problems (concern or dismissal)	Parkes 1980, Orton 1979, Marson 1981, Dodd 1973, Ricks 1975
8	Information transmission (gives or restricts)	Parkes 1980, Revans 1964, Orton 1979, Marson 1981, Ricks 1974, Melia 1981
9	Leadership style participative or directive democratic or authoritarian	Orton 1979, Parkes 1980, Marson 1981, Clinton 1981

These factors were then converted into two dichotomous statements, one indicating a high student orientation and one low student orientation (see table 5).

TABLE 5 KEY DIALOGUE INDICATORS FOR HSD AND LSD BEHAVIOUR

FACTOR	HSD INDICATOR	LSD INDICATOR
1 INVOLVEMENT IN TEACHING	A States that this is an important part of her job B Mentions teaching programme	A States that this is the job of School of Nursing/Tutors B Says they have no set teaching programme
2 ATTITUDE TO STUDENTS	C States that student is here to learn	C States that she is here to work
3 TASK/PATIENT ORIENTATION	D States that it is important to meet patients needs, Allocates work by patient group	D States that it is important to get on with the job, Allocates work by tasks
4 SOCIAL RELATIONSHIPS WITH TEAH	E Knows nurses names F Calls nurses by name	E Forgets nurses names F Calls nurses by title only
5 SOCIAL REINFORCEMENTS	G Praises nurses in public H Makes positive statements of ability	G Rebukes nurses in public H Makes negative statements of ability
6 COMMUNICATION LINES APPROACHABILITY	I States that she should be asked questions J Gives a positive answer to questions	I States that she should not be asked questions J Responds negatively to questions
7 EMOTIONAL SUPPORT	K States that students should let her know about problems L Encourages learners to ask for help	K States that students should not bring problems to work L Encourages learners to ask tutor for help
8 INFORMATION TRANSMISSION	M Gives explanation on points she has made e.g. rules and regulations	M Gives no explanation expects acceptance
9 LEADERSHIP STYLE	N States that she will participate in ward work O Emphasises importance of students contribution	N States that she is too busy to participate in ward work O Emphasises importance of rules and obedience

Sentences were constructed for each of the indicators and given a code (see Appendix XXI). The indicators were used at exactly the same place in the video sequence and this was ensured by placing the indicator identifying letter on a script sequence sheet as shown in table 6.

TABLE 6 SPECIFICATION FOR POSITION OF ORIENTATION
INDICATORS WITHIN THE SEGMENTAL SEQUENCE OF VIDEO PRESENTATION

VIDEO SEGMENT	ORIENTATION INDICATOR UTILISED
i Student/Sister Meeting	F
ii The Summoning	
iii Preliminary Comments	G, H
iv Patient Information Giving	M, O
v The Questioning	J, I
vi General Information Giving	M, O
vii Work Allocation	E, N
viii Student Interview	A, B, C, K, L, D

Utilising the specifications described above, the indicator dialogue was incorporated into the basic script format to produce two scripts, one for the HSO presentation and one for the LSO presentation (see Appendix XXII). Dialogue is shown in lower case type and action directions are shown in block capitals.

8.4.3 Video Production - The Actors

The first task was to draw up a specification for the actors who would be required in the video. Some of the individuals would require names, others would need only role identification. The roles of actors were determined by the usual nursing team structure.

The following actors were specified:-

- | | |
|-------------------------|--|
| 1. Nurse Green | The first year student nurse, who was
was the key referrent for the
respondent to identify with. |
| 2. Sister | The key referrent for the transmission
of the 'teaching behaviour' component
of context. |
| 3. Staff Nurse Allinson | Referred to in script. |
| 4. Enrolled Nurse Evans | Referred to in script. |

5. 3rd year Nurse

Referred to in script.

6. Pupil nurse

Referred to in script.

It was crucial that Student Nurse Green and Sister were willing and capable of enacting the role. It was, therefore, necessary to identify a willing student nurse and Sister who had had some 'acting' experience. These prospective actors were approached because they had participated in hospital theatrical productions. It was felt that the student nurse should be the same in HSO and LSO presentations but a question hung over the decision to use the same Sister or different ones for the two experimental conditions. It was thought that perhaps a HSO type Sister should be identified as well as a person who was typically an LSO Sister. The anticipated problems of measurement, and the negative connotations of the LSO role, encouraged the researcher to settle for one person to act both Sister roles. The anticipated problem was that non-verbal cues and personal appearance cues may exert a more powerful influence on the viewers classification of the presented 'teaching style'. It was decided to carry on with the video production and sample opinion on the finished product.

A second consideration was the use professional actors or actual nurses. The decision to use actual nurses was made because it was thought to be easier for actors to settle into the given role, given that the simulated setting was almost identical to the real setting. All actors would wear their normal uniforms. The nurse manager in charge of the unit allowed the release of suitable actors from their current duties to participate in the filming session.

8.4.4 Filming - Location and Time

Fortunately a ward in the District General Hospital had been temporarily closed for resource reasons. The ward was fully furnished and provided an actual environment for the filming session. Filming took place on a Sunday afternoon, a time which would cause the least disruption to those wards which would release nurses who would be the 'actors'.

8.4.5 Filming Session

The author undertook the direction of the filming and a colleague kindly agreed to operate the video camera. The first hour was spent testing and setting the equipment in the two locations, the ward corridor and Sister's Office. Light and sound settings were achieved before the actors arrived.

The filming proceeded by recording each pair of segments together. It was thought that if each of the HSO and LSO segments were recorded alongside each other the actors would be able to preserve the required differences and at the same time replicate the standard script framework common to each presentation. Filming in short segments also allowed for the possibility of refilming mistakes without wasting too much of the contribution given by the actors.

The patient information was entered on a Kardex format which was familiar to the actors and this sequence was facilitated by the fact that Sister would read from these cards in the usual way (See Appendix XXIII). The information which was included is described in the following discussion on the development of the measuring instrument.

The filming was completed in one afternoon there being a negligible number of mistakes to cater for. The decision to try to simulate a real situation paid dividends in that actors were able to respond naturally even though the presence of a video camera could be inhibiting.

8.4.6 Captioning and Editing

The filmed ward report on its own did not allow for set induction. It was considered that this should be achieved by presenting the instructions to the subjects as a part of the video presentation. This would allow for the standardisation of set induction and the instructions given to subjects. With this in mind a sequence was prepared which would precede the ward report sequence. This included some action segments of Nurse Green and patients so that the set of a real ward could be created. The instructions to subjects and a description of the setting was provided by captioning using a print over facility which was available on the video camera. This also allowed for background colour variation to facilitate the subjects attending. The captioning script is shown in Appendix XXIV.

The editing of all materials from the master tape was carried out by the author and a HSO and LSO presentation was compiled. The finished products were shown to small groups of students in the authors own School of Nursing and the general consensus was that the situations portrayed were realistic and not obviously artificial.

8.4.7 Equipment used for Video Production

Video Camera

Tripod

Editing Unit

Kardex Holder

Having produced the experimental conditions, in the form of video recordings, it was then necessary to develop a measure for the dependent variable. This required the production of a set of standardised problem situations which required the subject to make decisions within the context set by the video presentation.

8.5 THE DEVELOPMENT OF THE MEASURING INSTRUMENT

The unique nature of this experimental design meant that it was unlikely that there would be a readily available measuring instrument. A search through the literature confirmed that it would be difficult to achieve concurrent validity, and construct validity would have to be achieved.

The close relationship between the individual patients context and the problem itself meant that it seemed inevitable that a measure would have to be designed by the researcher to achieve this construct validity.

8.5.1 The Concept of Patient Centredness

The first consideration was the key construct to be measured. The operational hypotheses demanded that decisions should be patient centred or

non-patient centred. Very little reference could be found in the literature to research utilising the concept of patient-centredness. One recently published paper was discovered in the American literature, this was of particular value as it related to ethical decision making (Swinder et al 1985). Swinder et al construed an argument that social organisations/bureaucracies have an influence on nursing roles. More specifically they quote the literature which supports the contention that 'there is merit in depicting an individual's decisions as reflective of his/her accommodation to social realities, individual responsibilities, and expected professional roles and codes of behaviour' (Swinder et al 1985).

They also argued, on the basis of work by Mitchell (1981), that a decision on an ethical dilemma may be influenced by two mutually exclusive sets of expectations. The needs of the patient and the needs of the physician.

In this way nurses may feel torn between conflicting responsibilities. This line of logic coincides with the operational hypothesis for this experimental design except that it is the contention of this thesis that the senior nursing staff are more influential than the physicians. The work of Swinder et al identified three categories of nursing responsibility for their data analysis:-

Patient-centred

Physician-centred

Bureaucratic-centred

Their studies produced written decisions which were content analysed in terms of the above categories. It was of interest to find that only 9% of

decisions on ethical dilemmas were patient centred, 19% physician centred and 60% bureaucratic centred.

It was clear that this work supported the premise that a nurse's clinical decisions may be patient centred or non-patient centred. It also reasonably well establishes the concept of patient-centredness in the nursing decision making process.

8.5.2 The Patient's Personal Data

Following the work of Boreham (1977), Swinder et al (1985) and Gelatt's Model of decision making, it became apparent that the measuring instrument would require that there was a specific data base available for decision making. The main information for the data base would be the patient's condition and some biographical details. In addition there would need to be some nursing prescription for the key elements of the required care. The latter would also provide a reinforcement for the potentially conflicting expectations of the senior nurse, who largely determined the nursing prescription and transmitted the treatment requirements of the doctor. With this in mind fictitious patients were contrived along with their basic details of age, sex and diagnosis. In addition a prescriptive statement on the key feature of care was developed (See Appendix XXIII).

This information was transcribed onto actual nursing Kardex documents so that the information could be transmitted, in a realistic fashion, during the video presentation of the ward report. A guarantee that most of this information would be carried over from the video presentation to the pencil and paper test was achieved by asking the audience (subjects) to take notes

on the patients as they would if they were attending the ward reports. This play had additional benefits. It gave subjects an opportunity to actively participate in the experimental condition thus minimising anxiety and maximising attending.

8.5.3 The Problem Situation

The second requirement for the measuring instrument was a description of the problem situation. It was thought that the best way to present the patients problem would be in the form of a question asked by a patient. Initially it was considered that this could be presented in the form of an actual patient asking the question by video presentation. This would create set and inject some feeling of responsibility for an actual person. It was decided not to do this for the following reason

- i The ethics and logistics of filming actual patients in a simulated situation could not be achieved within the knowledge and skill base of the author, the resources available or time constraints on this study.
- ii This second video presentation may detract from the memory of the 'ward report' presentation by processes of retroactive inhibition.
- iii The subjects would need to record their terminal decision within a pencil and paper format, and it seemed a simple enough matter to include the patients question at this stage.

It was accepted that the advantages of set creation and the engendering of personal responsibility may be lost. It remained to be discovered whether this would have any significant effect.

The Production of Problem Items

It followed that a set of items would have to be produced which were reasonably valid and reliable measures of the concept of patient centredness.

In order to do this it was necessary to generate a number of items which would be assessed in terms of patient-centredness. There arose the question of how to formulate these items?

Taking the advice of Oppenheim (1966), on attitude scaling methods, it became necessary to attempt some degree of unidimensionality, linearity, reliability, validity and reproductibility in the measure produced.

The two most commonly used forms of attitude scale were the Thurstone and Likert Scales. It was a concern at this stage of the study to identify a valid and reliable scale. The Thurstone method (Thurstone 1930) followed a procedure by which the researcher collected hundreds of statements regarding the topic under consideration. They were derived from the literature as well as direct questioning of a variety of respondents. Secondly, he asked individuals to judge the degree to which each statement expressed a positive or negative attitude toward the subject on an eleven point scale. Utilising hundreds of judges he calculated the median score

for each item and used it as a scale value for each one. Ambiguous and irrelevant items were discarded at this stage. Finally twenty to forty items were selected which covered the full range of median scores so that an attitude questionnaire could be constructed.

This did not seem to be appropriate to the job of identifying appropriate problem situations, but it did seem useful for the assessment of the degree to which each decision was patient-centred.

The Likert Method (1932) was simpler than that proposed by Thurstone. The researcher selected attitude statements and respondents were asked to indicate their agreement or disagreement along a five point scale. This assumed that the subject was indicating more favourable attitudes towards the attitude statement when they select strongly agreed than when they disagreed. The subjects score was then calculated by assigning numerical values to each of his choices on the five point agree/disagree scale. This method seemed to hold similar problems to those of the Thurstone Method. A third possible method was devised to produce Osgoods semantic differential (Osgood *et al* 1957). This method involved the measurement of several different semantic dimensions which are related to the topic in question. Each dimension is made up of a seven point scale with the two extremes of the dimension identified by single words at each end of the scale (eg Good/Bad, Strong/Weak). This, however, seemed inappropriate because the main emphasis of this study was the construction of the key measurable characteristics of a concept rather than the compilation of attitude characteristics. A fourth option was that of Scalogram-analysis (Guttman 1950). The advantages of the Guttman method were that it was possible, by using a respondent's score, to identify exactly which items had been

endorsed as valid. The items in a Guttman scale are ordinal and cumulative so that when a number of respondents have endorsed the items as valid for them it is possible to identify a numerical value for each item in terms of the number of respondents selecting it.

It was felt that in this way the degree of patient-centredness could be identified for each option for a range of problem situations.

The method adopted would utilise Guttman's approach but in addition a refinement from Thurstone's would be adopted. This involved giving each option a numerical value. A set of multiple choice questions were devised. Each presented the patients problem in the form of a question. The item consisted of this question, which was the stem, along with four options based on likely verbal responses the nurse would give to the question. These verbal responses were assumed to indicate the nurses likely behavioural response to the patients request. Sixteen items were produced on a variety of potential clinical situations based on the authors clinical experience and the previous work reported in this thesis (See Appendix XXV.

These items were judged by an opportunity sample of twenty third year student nurses. The decision to utilise third year student nurses, reaching the end of their course, was made so that the judges would be both similar to the potential respondents and experienced in nursing. In this way they could act as valid judges of what was patient-centred behaviour or not. The assessment was carried out by judges in their own time utilising something of a 'postal questionnaire' design. All subjects were working in clinical practice and all agreed not to discuss their responses with others until the questionnaire had been completed. A hundred per cent response

rate was achieved because questionnaires were personally collected by the researcher, who also had frequent contact with the judges in his usual role of teacher.

8.5.4 The Construction of the Measuring Instrument

The choices of each subject on a five point scale were transferred to a summary sheet (see Appendix XXVI). It became obvious that the greatest benefit of this method was that many items clearly gave one option which was considered patient-centred, by the majority of judges, and another option which was considered non-patient-centred by a majority of judges. Additionally each of these options could be given a numerical value by summing the scale position which all judges attributed to each option and calculating the mean. The criterion for the selection of worthwhile items was that the patient-centred option should have been given the highest value by at least 90% of judges. At the same time the non-patient-centred option would have to have been given the lowest value by over 90% of judges. In addition over 90% of judges must have given a higher value to the patient-centred option than the non-patient-centred option. In this way it was possible to identify eight items which had been judged valid measures of patient-centredness.

Each of these items was now utilised by taking the stem and the two valid options for use in a questionnaire. These were used as the dependent variable measure. Each item was labelled with the name of the patient asking the question. The information profile, to be included in each patient's ward report, was then altered so that there was a distinct continuity between the video-presentation and questionnaire (See Appendix

XXVII). The patient-centred and non-patient-centred options were randomly alternated within the questionnaire to counteract for any order effect. The sequencing of options and their relative values are given in Appendix XXVIII along with the names of patients identifying each item. It was expected that the interval values associated with each option would give a method for quantifying the swing to patient or non-patient-centred response. A copy of the finalised measuring instrument is shown in Appendix XXXIII.

The next step in the development of the measuring instrument was to test its reliability. Given the time constraints on ~~data collection~~ it was only possible to use the pilot study of the experimental procedures as a measure of reliability.

8.6 THE PILOT STUDY

The aim of the pilot study was:-

- i To test the utility of the experimental procedures
- ii To test the reliability of the dependent variable measuring instrument.

8.6.1 The Experimental Procedure

The experimental procedure consisted of seven steps. They can be most clearly described in the form of a list:

- i Explanation to the potential respondents.
- ii The random selection of responds into two groups.
- iii H.S.O. Video presentation to group one.
- iv Administration of questionnaires to group one.
- v L.S.O. Video presentation to group two.
- vi Administration of questionnaire to group two.
- vii Discussion on the research if respondents required.

The explanation to the whole group was standardised by the use of a crib sheet (Appendix XXIX). This portion of the procedure was brief. It was expected that the tutor to the group would have given the subjects some explanation based on information given in the written request for access. The whole procedure was expected to take one hour at most. The potential respondents were invited to participate and the researcher offered to explain the purpose of the work more fully at the end of the experimental procedure. In order to counter any anxiety brought about by the feeling that the respondents were being measured, it was decided to ask for their help to assess the video as a potential teaching tool. This section of the pilot procedure worked well and needed no alteration for the prospective fieldwork.

8.6.2 The Randomising of Subjects

During the pilot study it was decided to try splitting the group simply by the use of different coloured counters. The total number of counters in the 'hat' would equal the size of the group. Half the counters would be one colour, the other half another. The most convenient counters at the time of the pilot were mint imperials. This form of confectionery was about one inch in diameter and available in green and white colours. Fortuitously this method had a number of unexpected benefits. The first was that it engendered a hint of frivolity to the proceedings which dissipated group anxiety. Secondly it seemed to be an opportunity for the researcher to give the respondents something, a gift which, albeit small, developed a level of rapport with the subjects. A third benefit was that the counters were disposable and did not need to be retrieved after the procedure, thus facilitating the whole process.

8.6.3 The Video Presentation

Each group was shown either the HSO or LSO video presentation. The dialogue from the researcher before the video presentation was minimal. This involved checking that all could see the television and an encouragement to concentrate on the instructions given as soon as the presentation started (see Appendix XXX). This also worked very well and it was decided to alternate the HSO and LSO presentations for each experimental session at different fieldwork sites. A session being synonymous with a visit to one School of Nursing. The instruction to the subjects, that they should take notes as they would in a ward report, worked extremely well in that informal observation showed subjects to be behaving in exactly the same way as nurses do during the real change of shift report.

One potential problem which was discovered during the pilot run of the experimental procedure was concerned with the playback equipment. The video presentation was recorded on equipment different to that used for the playback. It was necessary to check and adjust the tracking on the playback equipment. In order to ensure that there were no problems due to the variable quality of video playback, it was decided to carry a television and VHS playback machine to all the Schools of Nursing used for the fieldwork even though most Schools of Nursing had VHS playback equipment. In this case it would be necessary to arrive at the Schools of Nursing at least 30 minutes before the experimental procedure was due to commence.

8.6.4 The Administration of the Questionnaire

This was preceded by a brief group discussion, on the video content, so that the researcher could assess the validity of the video presentation to the students' experience. This was confirmed by the two pilot groups. It also transpired that this was a useful way of encouraging the subjects to link the video presentation to their own personal experience. The dialogue for the presentation of the questionnaires is shown in Appendix XXX. The researcher spontaneously read through the questionnaire instructions with the group during the pilot study and this was adopted as procedure for the fieldwork. It ensured that all subjects spent sufficient time considering the instructions before looking at the questionnaire items. They were also given an opportunity to practice the required response with one preparatory item. In this way all subjects started to complete the questionnaire at the same time. Once completed subjects were asked to wait a moment until the questionnaires were collected in. They were thanked and asked not to talk about what they saw with members of the incoming group. They were, however, encouraged to tell their colleagues that it was easy to do if they felt that this was the case. This procedure worked well because when the second group was asked about what they knew, they clearly did not know what they would be watching.

8.6.5 The Sample

It was decided to use an opportunity sample for the pilot study. The basic criteria for selection was that subjects should be female, 21 years of age or under, undertaking the full three year preparatory course for registration as a general nurse. There were 21 respondents in all. There

was one male nurse and three subjects over 21 years of age. All willing respondents had been allowed to participate in the pilot, but the results of those four subjects, who did not fit the sample profile, were not included in the data analysis. This meant that there were now eight questionnaires from subjects who had seen the HSO video and nine from subjects who had seen the LSO video, available for analysis.

8.6.6 The Scoring and Analysis of Questionnaires

The choices for each respondent were entered on a summary sheet shown as table 7 overleaf. Each subjects response was indicated by a tick. A total score of patient-centredness was then calculated, for each subject, by summing the value for each preference as determined by the judges ratings derived during the development of the measuring instrument (see appendix XXVI). The scores for each subject in each group were then summed and divided by n to give a mean group score for HSO and LSO groups. It was clear that this simple quantification demonstrated an effect and there was some idea that the internal reliability of items could be estimated. This, however, did not prove to be appropriate because of the nature of the measurement. Three of the items demonstrated an obvious reversal of choices under HSO and LSO conditions. One item showed a consistent patient-centred choice from all subjects and three demonstrated a majority of choice for the high patient-centred option. There was only one or two deviations from this trend with the LSO video group (question 1 and 8) and one with the HSO video group (question 3). It seemed at first that this was due to the unreliability of these items. Further consideration concluded, however, that the discrimination which was required for subjects was not a normative measurement neither was there any confidence that

H.S.O VIDEO											L.S.O VIDEO											COMMENTS	
QUESTION		SUBJECT	1	2	3	4	5	6	7	8	TOTAL	9	10	11	12	13	14	15	16	17	TOTAL		
1.	ARNOTT	A	✓	✓	✓	✓	✓	✓	✓	✓	8	✓	✓	✓	✓	✓	✓		✓	✓	8	LSO Why did you not chose second*	
		B									0							✓			1		
2.	TURNER	A	✓	✓		✓		✓	✓	✓	6		✓									1	Good Discrimination
		B			✓		✓				2	✓		✓	✓	✓	✓	✓	✓	✓	8		
3.	EALS	A	✓	✓	✓		✓	✓	✓	✓	7	✓	✓	✓	✓	✓	✓	✓	✓	✓	9	LSO Why did you not chose second*	
		B				✓					1										0		
4.	HARDISTY	A				✓	✓				2	✓	✓		✓		✓	✓	✓	✓	6	Good discrimination	
		B	✓	✓	✓			✓	✓	✓	6			✓		✓					3		
5.	POULETT	A	✓		✓	✓	✓	✓			5	✓	✓	✓	✓	✓	✓	✓	✓	✓	9	Describe a bit	
		B		✓					✓	✓	3										0		
6.	TROTTER	A					✓				1			✓	✓	✓	✓		✓	✓	6	Good discrimination	
		B	✓	✓	✓	✓		✓	✓	✓	7	✓	✓					✓			3		
7.	KEANE	A									0										0	Why did you not chose first*	
		B	✓	✓	✓	✓	✓	✓	✓	✓	8	✓	✓	✓	✓	✓	✓	✓	✓	✓	9		
8.	WATKINS	A									0				✓		✓				2	Describe a bit	
		B	✓	✓	✓	✓	✓	✓	✓	✓	8	✓	✓	✓		✓		✓	✓	✓	7		
SUBJECT SCORE			34.65	36.95	31.80	28.60	26.30	34.65	36.95	36.95		29.05	31.90	29.05	28.75	29.05	31.50	23.30	25.30	29.05			
			TOTAL		266.85							TOTAL		256.90									
			MEAN		33.65							MEAN		28.55									

TABLE 7 SUMMARY OF EXPERIMENTAL PILOT STUDY RESPONSES

responses could be criterion referenced. The options could not be considered as being correct or incorrect, right or wrong. It would be wrong to remove items which were not discriminating between HSO and LSO video presentations because this would ensure an effect which was largely attributable to the measuring instrument. It was thought that the lack of sensitivity of those items which elicited patient centred responses, in the vast majority of subjects, really serve to confirm that respondents have a propensity to be patient centred. These items should be preserved in the questionnaire so that this suspicion could be confirmed by fieldwork.

8.6.7 Post Experimental Interview of Pilot Subjects

It transpired that there may be a tendency for the subjects to be generally high patient centred in their decisions. It was decided to interview a sample of the pilot group to determine why each question produced the consistent selection of high or low patient oriented responses. It would then be possible to describe some confounding variables which may be having additional effects on the decision making.

Eight subjects from the pilot group were randomly selected and interviewed within a week after the pilot experiment using an interview schedule shown in Appendix XXXI. Four subjects had seen the HSO video and four the LSO video. Only those items which consistently showed negligible difference in the responses of both groups were discussed in the interview. These were in actual fact the Arnott, Eales and Keane items. The results of these interviews are presented here in the form of a summary description of the main trends associated with each item.

Questions from Mr Arnott

Nurse, I've forgotten to fill in the record of my bowel motions today and I can't remember exactly when I went. What can I do?

What would Nurse Green say - tick one box only

- | | |
|---|------------------------------|
| - Come on I'll help you fill it in as best we can, don't worry it's no problem. | <input type="checkbox"/> HSO |
| - Well I wasn't here so I can't fill it in for you just do your best. | <input type="checkbox"/> LSO |

The general consensus of opinion on rejection of the LSO option was that it was too abrupt or rude to expect that any nurse should say this. It did seem to suggest that there was a certain level of patient-centredness below which few nurses would go. Most of the sample also commented that they would prefer a third option which was not offered. This was to ask the senior nursing staff. It seems that the items presented a forced response which encouraged the nurse to be patient-centred when in actual fact she would prefer to go and ask. It is of interest that three out of four of the problems, which demonstrated a change in selection which was influenced by the experimental condition, also gave an option which allowed Nurse Green to ask the senior nursing staff. None of the items which received consistently biased responses (High patient-centred), offered an option which involved asking senior staff what to do. The only obvious exception was the Watkins item. This option was more concerned with denying the patient until the Doctor or Sister had been informed rather than asking the Doctor or Sister to make the decision. The reference to the Doctor in this item made it difficult to estimate

how clearly the option offered an opportunity to ask the senior nurse to make the decision. Clearly those items which referred to the senior nursing staff, generated conflict situations. They were more likely to result in a clear swing in decision making which was influenced by those 'teaching behaviours' which were presented in the two experimental conditions.

ii The Eales Problem

Question from Mr Eales

Nurse, I know I'm supposed to stay in bed, but can you help sit me on the edge of the bed to pass water. My insides are bursting I can't wait.

What would Nurse Green say - tick one box only

- | | | | |
|---|--|--------------------------|-----|
| - | Come on sit on the edge of the bed before it gets any worse. It must feel terrible. | <input type="checkbox"/> | HSO |
| - | Look don't worry if you wet the bed we don't mind cleaning it up. That's what we are here for. | <input type="checkbox"/> | LSO |

This item provided some additional confirmation that the subjects would prefer to ask senior staff. It was, however, only mentioned by two subjects commenting on this problem. Many of the subjects commented that the second option was something that no nurse would do. Not only did they say that nurses do not do this, they could not even recall, or contemplate, their colleagues ever doing this. It was of interest to find, however, that one of the seventeen subjects did in fact chose this option. It seemed that the two options in this item were causing conflict in the nurse/patient relationship rather than the nurse/senior nurse relationship.

iii The Keane Problem

Question from Mrs Keane

Nurse, I know it's visiting time but my stoma has started to work. Will you help me change it?

What would Nurse Green say - tick one box only

- _____
- Wait until visiting time is over, nobody will notice if you keep quiet. ☐ LSO
 - Right then, I'll get some stuff and I'll have to ask your husband to leave for a while. ☐ HSO

The most consistent comments highlighted the relevance of previous experience in the selection of a suitable solutions to problems such as this. It seemed that students build up habits in decision-making when the problem was a regular occurrence. In the case of four of the subjects the fact that they had dealt with this situation many times predetermined the selection of the appropriate option.

Summary of Pilot Interview Findings

It was apparent that most subjects selected options on the basis of what they would do rather than what Nurse Green would do. This confirmed the expectation that subjects would strongly identify with the first year student shown in the video. The conclusions, precipitated by the interview of subjects involved in the pilot activities, indicated some of the potential confounding variables which had not been identified and could not be controlled in this experiment. These variables are summarised below. Whilst each was demonstrated, most obviously, by particular items the other items generated less frequent comments in support of the points made. The points allowed one to contemplate the effect of confounding variables even though they could not be controlled.

There is some evidence that the items which compel a consistent high patient centred response, regardless of the experimental condition, do this because:-

- i Subjects will not chose options which are too unkind or abrupt to patients.
- ii Subjects often prefered to ask the senior nursing staff to make the decision and where this was not an option, there was a great deal less conflict.

In this forced situation the independant variable seemed less \ influential because the attitude of the senior nurse did not need

to be taken into account. In the real clinical setting the option of asking is always available and thus the attitude of senior nurses is always influential.

111 The subjects previous experience of the problem influenced the response. It was easier for subjects to chose a high patient centred response if the problem was common. Conversely, the decision was strongly affected by the independent variable where the problem was uncommon in the subjects experience.

8.7 THE EXPERIMENTAL FIELDWORK

The experimental method was found to be satisfactory and a minimum amount of modification was required as a result of the pilot study. It was also decided that the questionnaire items utilised in the pilot study could also be used in the fieldwork, given that there was a greater understanding of the reasons for the subjects choices.

8.7.1 The Sample

It was decided to utilise subjects from the same Regional Health Authority as the previous survey fieldwork (pg 157). The subjects would be required to be no more than twenty years of age, female and undertaking the full three year course in preparation for registration as a general nurse. All subjects who agreed to participate and met these criteria were accepted. The groups were selected on the same basis as the survey work, requiring that all subjects had completed 12 months of the course. Intakes in the

Autumn of 1984 were identified as the target population and seven of the eight available Schools of Nursing were able to participate.

School of Nursing	Sample <i>n</i>	Available Population
1	7	11
2	16	36
3	13	19
4	8	8
5	10	10
6	5	12
7	16	35
Total	75	131

TABLE 8 FINAL SAMPLE FIGURES COMPARED
TO AVAILABLE POPULATION

The total sample ($n = 75$) represented 57% of the population which was made available for the study. The reasons for the attrition were, firstly, that subjects had had previous training either pre-registration, pre-enrolment or orthopaedic course (15%). At one School of Nursing a split allocation meant that half of the intake were unavailable because they were on community experience (15%). Others did not fit the sampling criteria being male (5%) or over 20 years of age (8%).

8.7.2 Obtaining Access

All Schools of Nursing had participated in previous fieldwork associated with this study and letters to the Directors of Nurse Education produced positive responses. It was possible in the letter to thank the Schools of Nursing for their previous help and to describe the next stage of the study.

8.7.3 The Fieldwork

All planning for the fieldwork facilitated the experimental procedure without a hitch. The randomising procedure split the sample into those who had viewed the HSO video ($n = 38$), and those who had seen the LSO video ($n = 37$).

The presentation order for each experimental condition was alternated at each experimental session. This measure was introduced to counter any order effects which may have occurred by consistently showing, for instance, the HSO video before the LSO video. The pattern of alternation and the number of subjects undertaking each experimental condition are summarised in Table 9 below.

SCHOOL	VIDEO PRESENTATION				
	HSO FIRST	LSO FIRST	HSO SECOND	LSO SECOND	TOTAL
1	4	-	-	3	7
2	-	8	8	-	16
3	7	-	-	6	13
4	-	4	4	-	8
5	5	-	-	5	10
6	-	3	2	-	5
7	8	-	-	8	16
TOTAL	24	15	14	22	75

TABLE 9 NUMBER OF SUBJECTS BY
ORDER OF VIDEO PRESENTATION

This alternation for order effect did not work out evenly. The HSO video was shown first for four sessions out of seven. It was felt that there was sufficient alternation to eliminate any serious order effect. If there were thought to be problems brought about by order effects it would be possible to analyse the results for the six sessions associated with schools 1 to 6. It is School 7 which brings about the imbalance in the sample figures and this could easily be omitted from any analysis which was dissatisfied with the order of experimental conditions as a complicating factor. This was thought to be unlikely.

8.8 EXPERIMENTAL RESULTS

8.8.1 Analysis of Questionnaires

Each questionnaire was analysed by entering the choice for each option on a summary chart and allocating a numerical value to the choice for each item. Summing the scores allocated to each item gave a test score for each subject and this was also entered on the summary chart (See Appendix XXXII).

The summary chart enables one to analyse the pattern of decision making for different problems. The test scores enabled an estimation of the overall effect of the video presentations on the decision-making of subjects in the two groups. Group scores were also calculated for each School of Nursing, primarily to facilitate the calculation of a mean group score and subsequently to analyse the differences in scores by School of Nursing as an *ex post facto* finding.

The mean test score for subjects who viewed the HSO video was found to be 29.85 (range 14.55 to 36.95). The group viewing the LSO video produced a mean test score of 27.04. This indicated a definite overall effect on the subjects decision making. The unrelated *t* test gave a value for *t* of 3.035 and this gave a significance level of $p < .005$ for the one-tailed hypothesis.

8.8.2 Ex Post Facto Quantitative Findings

Table 10 below shows the test scores broken down by each School of Nursing.

TABLE 10 SUMMARY OF EX POST FACTO RESULTS
OF THE EXPERIMENTAL WORK

	HSO VIDEO SUBJECTS			LSO VIDEO SUBJECTS				
SCHOOL OF NURSING	<i>n</i>	GROUP SCORE	GROUP MEAN <i>H</i>	<i>n</i>	GROUP SCORE	GROUP MEAN <i>L</i>	<i>H</i> minus <i>L</i>	<i>P</i>
1	4	128.45	32.11	3	75.65	25.21	6.90	0.025
2	8	230.50	28.81	8	205.50	25.68	3.13	0.05
3	7	197.31	28.18	6	157.00	26.16	2.02	0.20
4	4	135.25	33.81	4	98.50	24.62	9.19	0.025
5	5	145.20	29.04	5	144.75	28.95	0.54	Not Sig
6	2	70.60	35.30	3	82.45	27.48	7.82	0.05
7	8	227.20	28.40	8	236.65	29.58	-1.18	Not Sig
TOTAL ▶	38	1134.51		37	1000.50			
		Total Scores Mean 29.85			Total Scores Mean 27.04			
		<i>P</i> < 0.005						

It is apparent from this table that the subjects from one School of Nursing showed a reversal in the overall effect, the LSO group scoring higher than the HSO group. Removing this group from the analysis increases the difference in mean score for the other Schools of Nursing. The mean for the HSO group becomes 30.24 and for the LSO group 26.33. This result is significant at $P < .005$. When the LSO group mean is subtracted from the HSO group mean the differences within each School of Nursing shows a variable pattern. Some differences between two means indicate that the effect was more pronounced in some Schools of Nursing than others. School 4 shows the largest effect, a difference of 9.19 ($P < 0.025$), School 5 shows a negligible difference and School 7 a negative difference. It is also apparent from table 10 that some Schools of Nursing achieved considerably higher means than others even though all mean scores for HSO and LSO groups are above the mid point (22.40) for the maximum and minimum possible test score.

The fact that the highest scoring HSO groups also have less subjects than the lower scoring HSO groups encourages one to consider whether these effects are statistically significant. A *t*-test analysis of each group shows that these low scoring group scores give respectable significant levels (see table 10). The reversal in effect for School 7 was not a significant finding.

8.8.3 Analysis of response patterns to individual test items

The Arnott Item

This item showed that the LSO video presentation increased the likelihood that subjects would chose the low patient centred option (see Appendix XXXII). More than twice as many subjects (9) in the LSO group chose the low patient centred option than the HSO video group (4). The majority of subjects were, however, prone to chose the high patient centred option regardless of experimental condition, (HSO group 34, LSO group 28). In this case most respondents still took the patient centred option even though Sister stressed that 'he must maintain his own chart' during the ward report.

The Turner Item

This item demonstrated an overall tendency for subjects to chose the low patient centred option (HSO group 24, LSO group 34). The HSO video, however, encouraged more subjects to take the high patient centred option (14) than the LSO video (3). The main feature of the low patient centred option is that it allows the subject to take the option of asking the senior staff rather than making a decision in the interests of the patient. It is probable that LSO subjects were more strict, simply because the Sister encouraged a firm approach to the patients emotional state.

The Eales Item

There was a negligible difference in the responses from the two groups. The majority of subjects opted for the high patient centred choice (HSO group 33, LSO group 31). The instruction in the ward report that he should stay on complete bed rest made no difference to the response patterns.

The Hardisty Item

This item showed that HSO video subjects were marginally more likely to chose the high patient centred option (23/38) and LSO video subjects were marginally more likely to chose the low patient centred option (20/37). The only obvious reason for this was that Sister stated specifically during the ward report that the Doctor required that Miss Hardisty was to 'rest out of bed in a chair for the next two days'. It seems that LSO video subjects were more likely to interpret this instruction rigidly.

		VIDEO	
		HSO	LSO
OPTION	HPC	23	17
	LPC	15	20

TABLE 11 THE NUMBER OF RESPONSES TO EACH OPTION IN
THE HARDISTY ITEM

The Powlett Item

The majority of respondents in both groups chose the low patient centred option (HSO 28, LSO 34). Marginally more subjects in the HSO group chose the high patient centred option. (HSO 10, LSO 3). It is of importance to note that the low patient centred option required that the nurse should ask Sister or Staff Nurse. There were no instructions in the ward report which prescribed any specific nursing care.

The Trotter Item

This item was similar in response pattern to the Hardisty item, there being a marginally increased likelihood for the HSO video subjects to chose the high patient centred option and an increased likelihood for LSO video subjects to chose the low patient oriented option.

		VIDEO	
		HSO	LSO
OPTION	HPC	21	13
	LPC	17	24

TABLE 12 NUMBER OF RESPONSES TO EACH
OPTION IN THE TROTTER ITEM

There were no instructions prescribing nursing care which was relevant to this problem. The only noticeable point about the options was that the LSO option encouraged the patient to ask the Night Nurses if she could use her own pillow.

The Keane Item

This item brought about consistent responses from both groups. All but 2 or 3 subjects chose the high patient centred response. The pilot interviews suggest that the low patient centred option would be too distressing for the patient and no nurse would ever be likely to do this. There were, however, 5 responses which suggest that a minimal number of nurses would do this very thing.

The Watkins Item

This item showed a consistent selection of the patient centred response in both groups (HSO video 32/38, LSO video 33/37). There was no apparent reason for this even though one would have thought that the low patient centred option allowed the nurse to go and inform the Doctor and Sister. The pilot interviews suggested that this situation happened fairly frequently and the nurses were habituated to the high patient centred response. There was thus insufficient conflict brought about by the problem situation to test out the effect of Sisters behaviour on the decision making process.

8.8.4 Summary of Item Analysis

A number of items seemed to demonstrate that certain factors contribute to a general tendency for all Student Nurses to be patient centred (e.g. Arnott, Keane, Eales, Watkins items). Remembering that the responses took the form of a forced selection of one from two available options, it seemed that certain factors such as habit and affective compulsions (caring), largely determined the subjects decision. It was of interest to note that in the case of all of these items, (notably the Keane and Watkins items) the majority of respondents chose the high-patient centred option because 'nobody would ever do this'. A small number of their colleagues did in actual fact prove that some nurses may actually decide on the unfavourable low patient centred option as a course of action.

Two items (Turner & Powlett) showed an overall tendency, for the majority of respondents in both groups, to chose the low patient centred option. It was of interest to note that both of these items gave, as the low patient centred option, a choice which enabled the nurse to go and ask a senior nurse to decide what should be done.

These six items, (Arnott, Keane, Eales, Watkins, Turner and Powlett) demonstrated that there were variables which can override the effects of the experimental conditions. There was some indication that each demonstrated a variable sensitivity to the different experimental conditions. The Arnott, Turner and Powlett items, indicated that the video did have a small effect on responses. In the case of the Arnott and Turner items, the LSO video encouraged, between two to five times as many subjects, to chose the low patient centred option when compared to the HSO

video group. In the case of the Powlett item the HSO video encouraged 3 times more subjects to chose the high patient centred option than the LSO video.

The final two items (Hardisty and Trotter) showed that the HSO video encouraged more respondents to take the high patient centred option than the low patient centred option. The LSO video encouraged more repondents to take the low patient centred option than the high patient centred option. The varying sensitivity of these items confirms that other variables are affecting the final choice in addition to the independent variable. This analysis along with data from the pilot interviews (pg 342) enable fairly strong hypotheses to be formulated about the nature of these variables. This will be discussed further in section 8.9.

8.8.5 General comments from subjects during discussion of the video presentation

It was decided that a brief group discussion on the video should preceed the completion of the questionnaires (pg 339). This produced some very interesting comments related to the validity of these extreme conditions. They are reported here in order to add to a general understanding of the variables which operate in this type of social experiment. The first point of interest was that it was rare to find a Sister as bad as the one in the LSO video or as nice as the one in the HSO video. Many said that they would really like to work for the Sister in the HSO video. Even though subjects found the LSO and HSO behaviour unusually extrema, most subjects had had experience of most of the behaviours exhibited, particularly those in the LSO video. It was reported as uncommon, however, to find a single

Sister displaying all of the extreme LSO behaviour. In a few of the Schools of Nursing the students had met a lot of Sisters who were like the Sister in the LSO video. It was of interest to find that group 7, which demonstrated an inverse relationship in mean responses, found the HSO Sister too nice and rare, but the LSO Sister was more familiar and typical. It was as if students were very suspicious of the nice Sister. All of this was of significance to general theories of social perception in nursing, particularly when one considers that the same actor played both the HSO and LSO Sister roles. The only obvious change being in certain sections of the dialogue. This seemed to indicate that any qualified nurse (Sister) can adopt HSO or LSO behaviours, regardless of her personality, and thus be trained to be high or low student oriented. It can equally be argued that her daily experience can shape her student oriented behaviour.

A second major finding was that all student nurses found the presentation of the ward report to be very realistic. All had a lot of experience of this setting and a minority had also had experience of 'bedside' reports. Some said that the HSO video gave more detail than normal reports, that the Sister was not so helpful and did not normally answer questions! Change of shift reports were generally more business like (formal) than the HSO video.

8.8.6 Summary of Experimental Findings

1. First year Student Nurses who were exposed to the high student oriented behaviours of Ward Sisters made clinical decisions which were more patient centred than students exposed to low student oriented behaviours.

- ii There was a general tendency for first year Student Nurses to make decisions which were high patient centred and this was evidenced by the subjects mean scores, which were all above the mean for the test.
- iii Almost all of the subjects made at least one low patient centred decision.
- iv In every one of the eight questionnaire items at least two subjects chose the low patient centred option regardless of the video presentation observed.
- v Habit and affective compulsions played a part in the choice of options in the case of at least six of the questionnaire items.
- vi Subjects had a strong inclination to ask the Senior Nurse when in any doubt whatsoever over a clinical problem, even when this was not in the best interests of the patient.
- vii Subjects recognised all the Sisters behaviours in the HSO and LSO videos. It was less common to find that they had met one Sister who exhibited all behaviours associated with one or other of the extremes.
- viii Subjects from some School of Nursing found the LSO Sister to be more typical and had met a Sister like her. Groups from other Schools of Nursing had found HSO behaviours more common.

ix Schools of Nursing differed from each other in the extent to which subjects are influenced by the experimental conditions.

x Sisters could 'act' HSO or LSO behaviours effectively enough to alter a Student Nurses social perception, regardless of the Sister's personality.

8.9 DISCUSSION ON EXPERIMENTAL RESULTS

As a result of the experiment, the null hypothesis was rejected. It was possible to confirm that the terminal decisions made by Student Nurses were more patient oriented in the group who had been exposed to high student oriented behaviours than the group which had been exposed to low student oriented behaviours. It could be argued that if this effect can be reproduced in the artificial setting of the experimental laboratory, one must consider how much more powerful the real situation would be. The results of the experiment demonstrated that all of the Student Nurses scored above the test mean for patient centredness. This seemed to confirm that students after the first year have a predisposition to be patient centred. Whether this is acquired or inherent is imponderable. What has been shown is that the behaviour of those who control the learning climate can enhance or inhibit this predisposition. On a constant basis this could have long term learning consequences. Students may develop habitually high or low patient oriented patterns of decision making, depending on the decisions they are consistently making. There was support for the contention that Student Nurses consistently make clinical decisions by taking account of the needs of their seniors as well as the needs of the patient. It has further been demonstrated that when the option existed,

students preferred to go and ask a senior person to make the decision for them. This indicated that a habit can develop whereby the student must check that the wrath of the Senior Nurse will not be incurred if an independent decision is made. In essence the needs of the patient did not always take precedence. They do seem to take precedence where the clinical problem occurs frequently and where there is an obvious response which could never contradict the wishes of the senior staff. It was clear that sometimes this whole process can result in a low patient oriented response. An algorithm can best conceptualise the clinical decision making habits which are possible and this is shown in figure 8 below.

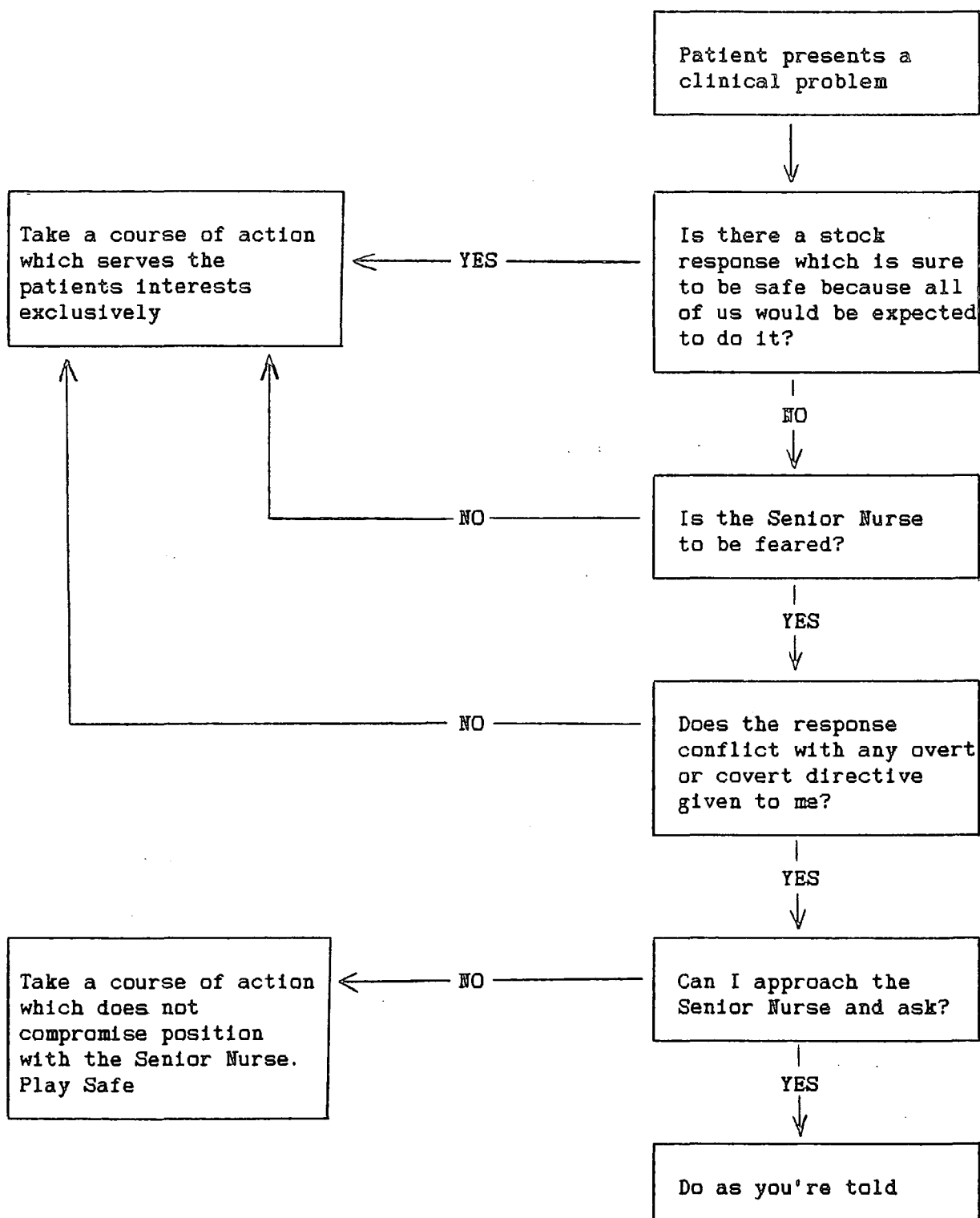


FIGURE 8 PROBABLE FLOWS OF STUDENT NURSE
DECISION MAKING FOR CLINICAL PROBLEMS

Three possible forms of terminal decision may be made only one of which is exclusively in the best interests of the patient. Of the other two, one is potentially dangerous for the patient (compromise and play safe), and the other is safer for the patient in the long term, (do what Senior Nurse says). This latter option, however, does not encourage the nurse to problem solve and it does not develop her sense of responsibility and accountability.

The experimental work supported the assertion that low student oriented behaviour can consistently encourage the student to develop non-committal or senior nurse dependent decisions. There was a finding which indicated that a student may chose an option which allowed her to ask senior staff even when it was the low patient centred option and regardless of whether the context was high or low student oriented. This suggested that there could be an overall tendency for Student Nurses to be dependent on senior practitioners. It was also consisted with the notion that the clinical element of the curriculum was low in educativeness and dominated by a mechanistic 'view of man' (training paradigm).

It has been shown that teacher behaviour can, under experimental conditions, change the patient-centredness of the student nurse's clinical decisions. The cause of the shift was related to the student nurse's tendency to put the needs of the senior nurses before the needs of the patient, when the senior nurse's behaviour was low-student oriented. This small experimental effect was presumed to be exaggerated in real life and it was argued that on a long-term basis would produce consistent clinical habits in student nurse decision-making which would be carried over to the

nurse practitioner role. It is argued here that the teacher/student relationship can affect the clinical decision-making of student nurses and that consistencies in these relationships produce nurse practitioners who make decisions in the light of this learning. Two aspects of nurse practitioner decision-making have been highlighted, patient-centredness and self-reliance. The fact that the patient-centredness of decisions can be determined by education suggests that curricula should deal with it as a central planning issue. The finding that many decisions rely on input from senior staff suggests that student nurses may not be developing self-reliance and thus do not have a tendency to self-direction as students. The relationship between teacher behaviours (Sisters) in the clinical setting and student behaviour requires additional work to build a convincing theory, but it is possible to support the assertion that these behaviours can create fear and uncertainty which in turn increases student passive-dependence typical of pedagogy. Teacher behaviour which is high-student oriented is more likely to be compatible with andragogy and thus the development of self-direction in student and subsequently practitioner roles.

8.9.1 Summary

It has been argued that the H.S.O. behaviours, demonstrated by sisters in the video (independent variable), were synonymous with andragogical teaching behaviours and the L.S.O. similar to pedagogical teaching behaviour. The student nurses were exposed to these 'teacher behaviours' on the assumption that they could determine the student response and thus the nature of the nursing experience which they received. The skill of clinical decision-making was found to be required of the professional nurse

practitioner, and the decision-making responses of the student nurses represented a learning-in-action situation which was related to patient care. As such it could be argued that teacher behaviour determines decision-making in student nurses and that this has long-term consequences for the practitioner role because it is a form of learning-in-action. The experimental results indicated that andragogical (HSO) teacher behaviours in the clinical setting are more likely to promote patient-centred decision-making habits than pedagogical (L.S.O) teaching behaviour. The second conclusion was that H.S.O. teacher behaviours are more likely to encourage self-reliance in student nurses. This self-reliance is a parallel to student self-direction and is necessary for the professional nurse practitioner role.

CHAPTER 9

CONCLUSIONS AND RECOMMENDATIONS FOR CHANGE

9.1 INTRODUCTION

This study has explored the proposition that the pre-registration preparation of nurses was not an educational experience and that this produced uncritical replicators of nursing practice. The opening quotation, attributed to Piaget, declared that the principal goal of education is to create men (and women) capable of doing new things, not simply repeating what other generations have done. This did not seem to be true of the author's experience as a nurse and a nurse tutor. It was argued that a professional model of nursing would require the development of critical, reflective practitioners, and as such an educational approach would be required which was different to that which existed in nursing at the beginning of this study. In order to substantiate these claims, the study began to examine the literature related to the pre-registration preparation of nurses from three philosophical perspectives. These were the extant forms of knowledge, the nature of teacher/student relationships and the purposes of education. The generation and analysis of literature abstracts indicated that the pre-registration preparation of nurses could be subsumed under a training paradigm and this did not constitute an educational experience. The conclusion was made on the grounds that the extant forms of knowledge seemed to emphasise propositional knowledge and

knowledge for instrumental action. Forms of knowledge which developed know-how, interpersonal relating and self-awareness were less evident.

A second finding which indicated that pre-registration preparation was not an educational experience was that teacher/student relationships seemed to be dominated by a mechanistic view of man. The student nurses seemed to be adopting a passive, dependent role. The opinion survey confirmed the findings of the literature analysis. It also revealed that the most pervasive teacher/student relationships were those associated with the clinical setting. The clinical setting was reported to be the most valid learning experience, yet it was also poorly organised and inadequately resourced. There was also some support for the assertion that patients were not the major concern during clinical experience. This indicated that nurse education may determine the patient-centredness demonstrated by qualified nurse practitioners.

A theory of nurse education was proposed which suggested that a cause and effect chain existed which began with the selected forms of knowledge, the forms of knowledge determined the teacher's behaviour and in turn the student nurse's role, the student's role being a precursor to nurse practitioner style. It was believed that the effects of the selected knowledge on teacher behaviour, and the effects of teacher behaviour on student roles, had been demonstrated by other researchers in the field of education. It was the link between student role and practitioner role which was thought to require more empirical support. An experiment was undertaken to test the relationship between teacher behaviours, student response and professional practitioner skill. Clinical decision making was

selected as the indicator of professional skill because it was a key component of the problem-solving approach to nursing practice.

As a result of the experimental work it was concluded that the 'teaching behaviour' of qualified nurses could determine the patient-centredness of student nurse decision-making and their tendency to self-reliance. It was proposed that a consistent training paradigm produced nurse practitioners who were low in self-reliance. In addition it increased their tendency to compromise the needs of patients in deference to the needs of their senior colleagues. It is proposed that this study substantiates the notion that the extant forms of knowledge determine teaching behaviour which, in turn, determines student behaviour and that is a precursor to qualified nurse practitioner behaviour. The links between the educational experience (rather than a training experience) and the production of a critical self-reliant nurse practitioner have thus been explored.

Three issues have been a major feature of this study and are worthy of further substantiation given the long gestation period of this thesis. Other work has been carried out by nurse researchers which is relevant to the conclusions related to the major issues. The following discussion will describe parallel work related to the main themes of this study which are:-

- (1) The extant forms of knowledge in pre-registration learning programmes
- (11) The nature of nurse teacher/student nurse relationships

(iii) The purposes of nurse education.

9.2 PARALLEL WORK RELATED TO THE EXISTENT FORMS OF KNOWLEDGE

It was concluded that propositional knowledge and instrumental knowledge, both of which are thought to be synonymous with the technical-rational knowledge of the applied sciences, are the dominant forms of knowledge during the pre-registration preparation of nurses. A lack of interpersonal knowledge and knowledge for emancipatory action have been identified, both of which are necessary for greater social skill and self-awareness.

Burnard (1987) has also proposed that three areas of knowledge should be included as a basis for experiential learning in nurse education. These are propositional knowledge, practical knowledge and experiential knowledge. Practical knowledge deals with the acquisition of skills and experiential knowledge with direct personal encounter with a subject person or thing. This distinction between practical and experiential knowledge has not been made in the current thesis but it does parallel Habermas' instrumental (work) and practical (interpersonal) areas of cognitive interest respectively. The main support in Burnard's paper comes from his call to accept as valid, forms of knowledge other than propositional or technical-rational knowledge.

Burnard supports the assertion that these forms of knowledge require different approaches to teaching (Burnard 1985, 1987). He emphasises that the tutor must bear in mind the uniqueness of the student's personal experience as well as the need to draw together some sort of consensus

reality for the application of new ideas to the clinical situation. This reinforces calls for the development of andragogy (Knowles 1975, Mezirow 1981, Allman 1983) as well as the development of reflection-in-action (Schön 1983). Burnard, however, makes his observations on the development of experiential learning from a psychiatric nursing perspective. It is the contention of the current thesis that Burnard's assertions are equally applicable to general nursing and practice professions in general.

The conclusion that propositional knowledge, and more precisely technical-rational knowledge, is the dominant epistemology in pre-registration learning is demonstrated by Akinsanya (1987). He bases his work on the widespread notion that the technical-rational knowledge of life-sciences is an essential prerequisite to professional competence. He says that a high level of knowledge of physiology is perceived as essential for taking and recording of blood pressure, temperature and pulse and that a knowledge of applied anatomy and physiology was inseparable from these practical nursing activities. Others have also held similar convictions. Lewin and Jacka (1987) have made similar assertions. In the introduction to their study on classroom instruction and clinical opportunity in student nurse training, they say that without theoretical instruction the student will learn little from her clinical encounters. It is the contention of the current thesis that theoretical knowledge (technical-rational and propositional), whilst necessary, has its limitations in enhancing clinical learning. Other forms of knowledge, which may not be available in the classroom setting, are of equal, if not greater, relevance. These forms of knowledge are related to interpersonal communication and self-awareness and are constructed in a personal form which cannot be acquired from propositional knowledge bases

(Schön 1983, Friedson 1975 and Burnard 1985, 1987). One of the reasons that Akinsanya (1987) proposes the importance of life sciences is that tutor students and pre-registration students perceive them to be necessary for the performance of nursing functions. This is hardly surprising if they have no perception that other forms of knowledge exist or any experience of the learning methods which develop them. The students in the current study were equally emphatic that learning in the clinical setting was most relevant and this does not bode well for the utility of technical-rational/propositional knowledge no matter how well it is taught.

It is argued that the value placed on technical-rational and propositional knowledge excludes any perception that forms of knowledge related to interpersonal communication, self-awareness, critical thinking, reflectivity and self-reliance, are forms of knowledge at all. There is ample evidence, complimentary to this thesis, that interpersonal learning is a deficit in the curriculum (Macleod-Clark 1983, Faulkner 1985, Birchenall 1983). It is also interesting that Wattley and Müller (1987) demonstrate an acceptance of the dominant propositional and technical-rational knowledge forms by stating that nursing students have to be taught psychology and that this in some way is believed, by the training validating bodies, to improve nursing practice. Because of this they embark on a study which answers questions about what to teach, how to teach, when it should be taught and by whom. The overview to their paper, however, states that though it is argued that the inclusion of psychology in the curriculum will equip nurses better for their jobs, there are problems in supporting this viewpoint because it is difficult to evaluate in a concrete way the contribution that psychology makes. This can be

explained in terms of the current thesis on the grounds that learning psychology in this way develops propositional knowledge and technical-rational knowledge which will never be incorporated into nursing action simply because it can only be incorporated into the nurse's know-how by giving her a language and conceptual framework which can increase the quality of her reflection. It cannot replace the personal knowledge necessary for interpersonal and emancipatory action. This is one of the reasons why nurse education suffers a theory and practice gap. The extant forms of knowledge are exclusive and have limitations for the development of know-how.

It is of further interest that Wattley and Müller (1987) acknowledge this by quoting a British Psychological Society report which states that nurses are taught 'watered down academic psychology' when what they really want help with is dealing with very stressful human situations. Melia (1981) relates a quote from one of her student interviewees which supports this assertion.

"We get psychology lectures but nothing really on how to just sit down and speak to somebody."

Melia (1981)

The promotion of technical-rational knowledge in nursing is still based on claims to professionalism. Both Akinsanya (1987) and Wattley and Müller (1987) demonstrate this conviction yet for some time it has been argued that the ownership of technical-rational knowledge is not a precursor to professionalism per se (Friedson 1975). The use of such knowledge may increase the nurse practitioner's ability to mystify her patients, and thus

achieve power over them, but it does not determine her competence (Friedson 1975).

The concurrent nursing research supports the contention that the dominant epistemology in the pre-registration preparation of nurses is technical-rationality and that this emphasises the value of propositional knowledge as opposed to know-how. There was also confirmation that forms of knowledge related to interpersonal communicating are not developed. This is directly related to the mistaken belief that technical-rational knowledge is a necessary precursor to all nursing skills. The decision-making model described in the current experimental study (pg 296) demonstrates how a knowledge base is a necessary but small part of one professional practitioner skill. This knowledge base is not just made up of technical-rational knowledge, it also requires personal knowledge about interpersonal communicating and 'world view' self-awareness. This type of knowledge has been called tacit knowledge, knowledge which is not usually given in the scientific literature but is known by the experts in the discipline. Carroll (1988) has investigated the role of this 'tacit' knowledge for problem-solving in the clinical setting. She argues the importance of problem-solving and decision-making for the professional nurse practitioner. She states that tacit knowledge is a vital part of the clinical decision-making process and contends that this must take account of the 'dynamics of the environment and its effects upon the decision-maker's problem-solving process'. This reinforces the arguments, forwarded in the current thesis, that:

- (i) Forms of knowledge, other than the technical-rational, are necessary for professional clinical practice
- (ii) That knowledge for emancipatory action is required and that perspective transformation is necessary in nurse education.

It also points to a new conclusion for the current experimental work. This is that the teaching behaviours of clinicians (HSO and LSO) may also affect the student nurses' decision-making ability by inhibiting their opportunity to acquire tacit knowledge. This suggests an additional link between the forms of knowledge and teacher/student relationships. The selected forms of knowledge determine the teaching styles which become part of the educational culture. The suggestion that LSO (low-student oriented) teacher behaviour (inclinations to pedagogy) prevents the acquisition of tacit knowledge fits well with this proposition. Hurst (1985) confirms that pedagogy is a distinctive feature of the pre-registration preparation of nurses. In calling for a progressive nurse education he describes traditional nursing which is characterised by a medical model 'recipe' approach to human problems. This is applied to patients and students alike. The counterpart in nurse education of the 'recipe' approach to nursing is said to be the lecture which is the principal means of imparting knowledge. This method has a side effect of enhancing the teacher's status. The outcome of this approach, he argues, is that it detracts from the patient's individual needs because of the emphasis on disease.

The conclusion from the current thesis and other nursing work is that the extant forms of knowledge (technical-rational, propositional and instrumental) determine particular teaching behaviours which are

pedagogical and have been represented by the LSO behaviours of clinical staff in the experimental study. The ubiquitous nature of these teaching styles means that if other forms of knowledge are adopted for pre-registration preparation, a large scale re-education programme will be required for tutorial and clinical staff. The 'traditional' nurse teaching methods are inappropriate for the development of forms of knowledge associated with know-how, interpersonal communicating and emancipatory action. The current thesis has argued that these are inadequately developed and in the case of emancipatory action, not developed at all. In order to achieve this, teachers will need to develop adult learning approaches and skills to develop reflection-in-action and perspective transformation, both in the clinical setting and the classroom otherwise Hurst's (1985) 'traditional nurse education' will be maintained. The idea that the 'traditional approach' detracts from the patient's needs combined with the findings in the current thesis, that curricula do not hold the patient as the main focus in the educational process, substantiates the need to ensure that the forms of knowledge selected for the nursing course are appropriate if patient care is to be maintained at a high quality. The idea that the quality of education has direct consequences for the quality of care has been recently forwarded as a justification for independent peer group audit of Schools of Nursing (Wicklin and Kenworthy 1987). This is particularly important when one considers that there is a 'them and us' situation between the clinical setting and the School of Nursing, the School of Nursing tending to maximise its strengths and minimise its deficiencies (Wicklin and Kenworthy 1987). The findings of the current thesis suggest that Schools of Nursing value technical-rational, propositional and instrumental forms of knowledge. They are deficient in

developing forms of knowledge which are tacit, involve know-how or relate to interpersonal or emancipatory action. The work of Wicklin and Kenworthy suggests that Schools of Nursing are capable of devaluing and ignoring these forms of knowledge. The current thesis substantiates this claim and underlines the student nurse's perception that learning in the clinical setting is the most valid learning for 'nursing'. This seems to indicate that those forms of knowledge which are most useful in the production of a nurse practitioner are largely ignored. Eraut (1985) confirms that this is a common occurrence in professional education when he says that:

"Knowledge of the kind that does not normally get included in syllabi will not be considered, as attention is focused on the listing of topics of specialisms. To question about the significance of a quality like 'getting on with people' the usual response is to treat it as an unchanging personal attribute or to assume that it will be acquired on-the-job with no need for any special provision. In special circumstances it might be academicised and included as 'interpersonal skills' or 'psychology'.

Eraut (1985)

If nursing is to produce professional practitioners they must become critical, reflective and self-reliant. If this is to be achieved other forms of knowledge must be developed in the curriculum. In addition, methods must be identified for utilising only those forms of technical-rational knowledge which are relevant to clinical practice. It is an argument in this thesis that this process does not begin in the classroom, it begins at the bedside. Furthermore, it is futile developing technical-rational and propositional knowledge if it has no immediate relevance to the student nurse's experience. It is argued here that technical-rational knowledge should be adopted to increase the quality of the student nurse's reflective ability. It should only be utilised to enhance the student's

ability for theoretical reflectivity in the classroom and in the clinical setting. In simpler form it enables the student to build a conceptual framework and language which may be utilised to increase the quality of theoretical reflectivity. Other forms of reflectivity exist and these include affective reflectivity, discriminant reflectivity, judgmental reflectivity, conceptual reflectivity and psychic reflectivity (Mezirow 1981). All of these are immune to the influence of technical-rational knowledge and require experience in the real world to acquire the professional tacit knowledge which develops know-how, interpersonal communicating and critical self-awareness. The selection of technical rational knowledge must then be made initially on the basis of relevance to nursing experience and in the later stages of the course on the basis of the students' perception of their needs.

9.3 PARALLEL WORK RELATED TO THE NATURE OF TEACHER/STUDENT RELATIONSHIPS

This thesis has argued that teacher student relationships, during the pre-registration preparation of nurses, are mechanistic and pedagogical in nature. The experimental work has provided some evidence to link the nature of these relationships with the student nurse's role and subsequently the type of practitioner produced. Pedagogy, it was argued, develops passive-dependent learners and eventually passive-dependent practitioners. Andragogy develops self-directed learners who become self-reliant practitioners. Finally it has been found, in the current study, that the relationships between clinical practitioners and student nurses

are the most influential during the nursing course and are most significant in shaping the nurse practitioner. A number of recent papers have confirmed that relationships in the nursing setting are mechanistic and that teaching approaches are pedagogical in nature (Burnard 1985, 1987, Hurst, 1985, Stephenson 1984, Birchenall 1983). Stephenson (1984) has also demonstrated how the perception of the tutor's role, from both tutors and students, is instrumental in nature. There is an emphasis on the transmission of knowledge, 'getting the job done' and structuring of teaching. Birchenall (1983) has criticised a system which continues to rate the disciplinary function of a teacher as primary to the supportive function. Davis (1983) has confirmed that student nurses adopt a passive role. He says that, 'programmes are devised and recruits are required to follow the path laid out for them' (Davis 1983). Indeed Davis argues that the nature and quality of the student nurses' relationships with their significant others, is one of the most important elements of learning in the nursing curriculum.

The current thesis has also argued that the relationships between student nurses and clinical staff are most influential in shaping the professional nurse. Davis (1983) confirms that student nurses consider the sister and staff nurse to be the most important resource people, nurse tutors being much less significant. Ward staff were seen as important for problems related to ward work, knowledge acquisition, examinations and assessments. The reason for this has been explained, in the current thesis in two ways. The first is that the clinical experience is the most pervasive and relevant aspect of the nursing course. Contemporary researchers confirm this to be true (Davis 1983, Reid 1985, Robertson 1987, Lewin and Jacka

1987) particularly in terms of practice performance. The second proposed reason that ward staff/student nurse relationships are most significant is that nurse tutors rarely attend wards and less frequently participate in clinical practice. This has still been the case during the course of the current study (Davis 1983, Reid 1985, Miller 1985, Robertson 1987). The conclusion of the opinion survey that clinician/student relationships in the ward are of concern to students has also been supported (Davis 1983, Birchenall 1983, Stephenson 1984, Reid 1985). It seems that these relationships are of concern to student nurses, because they are relevant to their learning needs and their emotional well being. There is evidence that the clinical staff enable student nurses to learn by utilising particular 'teaching skills' and by creating the correct sort of 'relationship' environment. Both of these have been found to be problematic in the clinical setting. Reid (1985) has found that a 'miniscule' amount of overt teaching could be observed in the clinical setting, only 2% of nursing activity was devoted to teaching. This occurred mainly because the contact time between ward nurses and student nurses was low. Learners worked with their peers most of the time. Staff nurses expressed a common assertion that the student nurses were taught simply by working with them, yet this only happened for a couple of hours a day at most. Reid also found that sisters and staff nurses had had little or no formal preparation for their role as teachers. The minimal contact time between students and qualified nurses and the lack of formal preparation for teaching roles provide adequate explanation for the poor quality of learning in the clinical setting. In terms of teacher/student relationships there is supportive evidence to suggest that, in the clinical setting, relationships are mechanistic and insufficient in terms of contact

time. Even then they are still found to be the most relevant teacher/student relationships in the nursing course. Even ward sisters and staff nurses wish that they had more time to teach (Reid 1985). It is apparent, however, that what student nurses need in the clinical setting is more than the acquisition of skills and knowledge. It has been discovered that some clinical teachers (from the School of Nursing) feel that they bridge a gap in providing emotional support for students (Robertson 1987). When asked what they do for student nurses which the ward staff could not, they say counselling, particularly for work problems, patient relationships and staff relationships, listening and help with emotional problems. This suggests two things which support the contentions of the current thesis. One, that there is a deficit in the type of individual support which is consistent with andragogical teaching approaches, and two, that forms of knowledge for interpersonal communicating and self-awareness are not developed. Other researchers have reported similar findings. Faulkner (1985) has found that nurses in both hospital and community settings have serious difficulties in the structured utilisation of interpersonal skills as a part of a therapeutic process. Macleod Clark (1983) has found that surgical nurses did not recognise the importance of nurse-patient communication. The fact that these skills are important in nursing practice has been affirmed by Ashworth (1980) and Reynolds and Cormack (1987).

A major contention of the current thesis is that andragogy, an adult approach to learning, is the means by which nurses acquire the distinctive knowledge forms associated with interpersonal communicating and self-awareness. Others support this contention by proposing experiential

learning in nursing (Burnard 1985) and the development of counselling skills in teachers (Birchenall 1983, Stephenson 1984). Hurst (1985) has written in particular about the teacher/student relationship requirements of 'progressive education'. He says that the teacher's role must be facilitative and student centred, encouraging an open critical approach. Of more importance to the current thesis is Hurst's contention that progressive education reduces the theory practice gap, is more patient-centred and encourages higher order thinking. The last two are relevant to the validity of the experimental work and the argument for the development of other forms of knowledge described in the current thesis.

9.4 PARALLEL WORK RELATED TO THE PURPOSES OF NURSE EDUCATION

The major contentions of this thesis on the purposes of nurse education are that it should produce a critical, reflective and self-reliant nurse practitioner. It has also indicated that this is required if a professional nurse is required. A further contention is that a patient-centred nurse should be produced. The points made on the incorporation of forms of knowledge related to know-how, interpersonal communicating and emancipatory action (self-awareness) and that pre-registration learning should utilise principles of adult learning (andragogy), are also the basis of an argument to develop critical, reflective and self-reliant practitioners. What has been said, in parallel research, about the purposes of the pre-registration preparation of nurses? A number of papers have suggested changes aimed to produce nurses who are professional. Akinsanya (1987) has argued for the improved teaching of life sciences for the professional development of the student nurse. A number of papers call

for a professional approach, the RCN Commission on Nursing Education (1985), the Royal College of Nursing (1983) and the UKCC Project 2000 (1986) have all called for pre-registration preparation to produce a professional nurse. It is a UKCC Project 2000 topic paper which confirms that a professional preparation should develop particular faculties in the student (UKCC 1987). This paper states that the pre-registration programme should develop a critical, self-determining, thinking practitioner. How this may be done is not clear in that paper but is the subject of discussion later in this thesis (pg 388).

A second purpose of nurse education has been described as patient-centredness. There seems to be little argument with the proposition that nurse practitioners should be patient-centred. This is taken so much for granted that there is no discussion in the nursing literature on this purpose. The current thesis has, however, argued that nursing curricula may not be patient-centred, and that mechanistic teacher behaviours may inhibit patient-centredness in student nurse decision-making. Other authors have pointed to these possibilities. Hurst (1985) has described how traditional nurse education detracts from the patient's individual needs because of the focus on disease. Robertson (1987) has reported that ward staff teach diseases rather than care. Reid (1985) has shown that nurses only spend 37% of their time with patients and of the 2% of nursing activity spent on teaching only a quarter was patient-centred. This means that 4% of nursing activity on the wards that she studied was devoted to patient-centred learning.

Reid also found that when students had free time on the ward from work they rarely devoted this time to the social or emotional needs of patients. It is clear that pre-registration preparation devotes the smallest amount of time to patient-centredness. It may be talked about but it is not practiced. Other authors highlight ways in which teacher/student relationships may affect the students' attitudes to patients. The principal argument appears to be that the interpersonal and helping relationship between the learner and teacher has implications for patient care because a similar relationship exists between the student nurse and her patient. Stephenson (1984) has argued that professional organisation in a School of Nursing encourages high client loyalty whereas a bureaucratic organisation would be high on loyalty to superiors. The nurse tutor who exhibits a good counsellor-client relationship with her students resolves her role conflicts by resisting bureaucratic expectations. In this way the teacher models caring behaviour which may be transferred to the nurse/patient setting. There is also evidence that nurses are generally not patient-centred in their thinking and that the clinical setting is bureaucratic in nature. Jan Reed working on patterns of care plan writing, has found that practitioner rationales for doing nursing assessment are almost always legal and administrative and rarely patient-centred (PhD Thesis for completion in 1989, Newcastle Polytechnic). There is a common assumption that the promotion of nurse education simultaneously enhances the quality of care (Nicklin and Kenworthy 1987), but it must be reaffirmed that the quality of care engenders in the student a conception of patient-centredness which may affect the quality of nurse education.

There is, in this discussion, support for the assertion that patient-centredness is a key purpose of nurse education and that this is developed in clinical practice. In terms of nurse educational programmes two things can detract from this, mechanistic teacher/student relationships (pedagogy) and an emphasis on technical rational, propositional and instrumental forms of knowledge. The proposed relationship between forms of knowledge, teacher behaviours, student roles and professional attributes seems to hold strong support in the recent nursing literature. The literature has confirmed that change is required in each of these areas. The following section will make some proposals for change and discuss them in the light of a recent change strategy, UKCC Project 2000, which has been adopted by the Nursing Body.

9.5 RECOMMENDATIONS FOR CHANGE IN THE EXISTANT FORMS OF KNOWLEDGE

The main recommendation for change is that pre-registration educational programmes for nurses should begin to plan for the deliberate inclusion of other forms of knowledge to counterbalance the technical-rational, propositional and instrumental knowledge which dominate the nursing curriculum. The required forms of knowledge are know-how, interpersonal communicating and emancipatory knowledge. A second recommendation is that technical-rational knowledge should be selected on the basis of job analysis and student perception whenever possible. Each of these points will be described here in greater detail.

9.5.1 Developing Know-How

It has been shown that learning in the clinical setting has been poorly resourced and badly organised when compared to classroom instruction. It is also believed that the clinical setting is the main source of those forms of knowledge which are lacking. In terms of resources two things should be achieved. First, the nurse practitioners, who supervise student nurses, must have an adequate preparation to act as facilitators of learning. This recommendation is not new but it is worthy of repetition because it has not been wholly implemented by those who manage the clinical learning environment. A second, and complimentary solution, is to deploy more qualified nurse teachers in the clinical setting. This does not mean that extra resources should be found. A reduction in the promotion of unnecessary and irrelevant technical-rational knowledge will free nurse tutors to attend the clinical setting and free student nurses of the information overload which they experience.

Organising the clinical setting to develop professional know-how is somewhat more complex and does depend on the development of andragogical (organic) teacher/student relationships between nurse practitioners and student nurses. The work of Schön gives an indication of how know-how can be acquired in the clinical setting by developing reflection-in-action (Schön 1987). Schön says that when someone learns a 'practice' it can be achieved in three ways. The person may learn the practice on his own, he may enter an apprentice system or he may enter a practicum. It is argued in the current thesis that the first two are unsatisfactory for professional nurse preparation, the practicum being most suitable for

professional education. The practicum is simply a setting designed for the task of learning practice. Schön indicates that when a student nurse enters a practicum she must learn to recognise competent practice, appreciate where she stands in relation to it, and identify ways in which she can acquire the competence. This is achieved through learning by doing, interaction with 'coaches' and fellow students and 'background learning'. Schön suggests that there are two different perspectives to learning which may be applied to the practicum. If professional knowledge is seen in terms of facts, rules and procedures applied non-problematically to instrumental problems, then the practicum is merely a form of technical training. This seems to be the current position in nursing. If, however, one sees professional knowing as 'thinking like a nurse' then the student learns what Schön has described as "the form of inquiry by which competent practitioners reason their way, in problematic instances, to clear connections between general knowledge and particular cases" (Schön 1987). In this setting, facilitators of learning, emphasise the rules of inquiry. There are some similarities here to the 'learning how to learn' described by Rogers (1983). This is the essence of reflection-in-action, the way in which student nurses will develop new rules and methods for their own practice. The key to reflection-in-action is problem posing by teacher/facilitators, the students and their peers. Problem posing is a precursor to decision-making and problem-solving. It defines the nature of the unique and real problems experienced by the student nurses, and also makes explicit the forms of knowledge associated with these problems. One way in which this can be complimented in the classroom is by the problem posing involved in perspective transformation (Mezirow 1981, 1985). This

is also the principal way in which knowledge for emancipatory action can be developed.

9.5.2 Developing Knowledge for Emancipatory Action

Mezirow argues that this is the cardinal dimension of adult development. This form of knowledge is acquired by perspective transformation, a process described by Mezirow as 'A structural change in the way we see ourselves and our relationships. We move away from uncritical, organic relationships toward contractual relationships with others, institutions and society. Perspective transformation reformulates the criteria for valuing and for taking action.' (Mezirow 1978). This can be achieved in the classroom and involves a number of forms of critical reflectivity. Each should be included if nurse teachers are to develop a full range of knowledge for emancipatory action. Mezirow (1981) gives the following types of critical reflectivity:

- | | |
|-------------------------------|--|
| (a) Affective Reflectivity | - Awareness of our emotions and feelings about our thoughts and actions |
| (b) Discriminant Reflectivity | - Assessment of the efficiency of our perceptions, thoughts and actions |
| (c) Judgmental Reflectivity | - Awareness of our own value judgments associated with our perceptions and actions |
| (d) Conceptual Reflectivity | - Becoming aware of our own awareness |
| (e) Psychic Reflectivity | - Recognising our habit of making judgments about people on the basis of limited information |
| (f) Theoretical Reflectivity | - Becoming aware of a set of taken-for-granted cultural or |

psychological assumptions which explain personal experience less satisfactorily than another perspective with more functional criteria for seeing, thinking and acting.

It is theoretical reflectivity which is most central to the process of perspective transformation according to Mezirow (1981). The nurse teacher who is required to develop knowledge for emancipatory action will need to achieve the process of perspective transformation and Mezirow (1981) describes the particular features of this process. The dynamics of this process will develop a reflective ability in the classroom setting which is compatible with reflection-in-action in the clinical setting.

The dynamics of perspective transformation included the following:

- (i) A disorienting dilemma
- (ii) Self-examination
- (iii) A critical assessment of personally internalised role assumptions and a sense of alienation from traditional social expectations
- (iv) Sharing one's discontent with others with similar experience
- (v) Exploring options for new ways of acting
- (vi) Building competence and self-confidence in new roles
- (vii) Planning a course of action
- (viii) Acquiring knowledge and skills for implementing one's plans
- (ix) Provisional efforts to try new roles and to assess feedback
- (x) Reintegration into society on the basis of conditions dictated by the new perspective.

(Mezirow 1981)

The processes outlined above are likely to develop know-how and knowledge for emancipatory action. Another requirement is to develop know-how by developing knowledge for interpersonal communicating. This will be discussed in less detail here because these forms of learning are more familiar to nurse educators and are well documented elsewhere (Burnard 1985, French 1983, Neeson et al 1984). The most important aspect of learning for interpersonal relating is learning by involvement with others. The student nurse must participate in group activity in the classroom and reflect on the dynamics of the group interaction which they experience. In the clinical setting she will develop the forms of knowledge required for interpersonal action by reflecting on her encounters and experiences with individuals (eg patients) and groups (eg the ward team) in that setting. This will depend on developing the process of reflection-in-action in the clinical setting.

There are some nurses who would argue that junior nurses cannot do this because they have not developed the ability. It is suggested here that the student nurse should begin by utilising knowledge-in-action and listening to qualified nurses reflecting on their own practice. Qualified nurses should model reflection-in-action during the early stages of the course and encourage student nurses to reflect as the course proceeds. The only difficulty with this suggestion is that qualified nurses are a product of a training system which has not developed their ability to do this. If professional education is to be achieved in the clinical setting then qualified nurses will require post-registration education. Teaching and assessing courses for supervising practitioners will need to develop skills other than the group presentation skills associated with the training

paradigm. They will need to develop skills for adult learning (andragogy) and develop teacher/student relationships which facilitate the acquisition of the forms of knowledge for know-how, interpersonal communicating and self-awareness. The recommended changes in teacher/student relationships are described in the following section.

9.6 RECOMMENDATIONS FOR CHANGING THE NATURE OF TEACHER/STUDENT RELATIONSHIPS IN CLASSROOM AND CLINICAL SETTINGS

Given that the pre-registration preparation of nurses has been characterised by teacher/student relationships which are typical of pedagogy, the simplest suggestion is that teachers should adopt the principles of andragogy outlined on page 255 of this thesis. This required the development of a self-directed learning. It has already been proposed in the current thesis, that student nurses necessarily begin in a state of passive-dependence. Given that it seems impractical to expose passive-dependent neophytes to expectations of self-direction in the early stages of a course, it is proposed that nurse education follows the recommendations of work by Cheren (1978) on the facilitation of the transitional dynamic. This involves a move towards greater self-direction as the course of learning proceeds. His main recommendation is that the transitional dynamic should be made explicit to practitioners, learners, teachers and curriculum planners. In essence reflectivity and self-awareness will enable the student nurse to identify her initial state of passive dependence and the ways in which she can become more self-reliant as the course proceeds. If this is to be achieved it will be necessary to redefine the learning process. The traditional definition of learning

emphasises content, the subject or topic to be acquired. Adult forms of education emphasise 'learning how to learn'. It is the process of learning which becomes explicit and the content takes on less importance. The required teaching behaviour must be facilitative rather than directive aiming for the development of human potential rather than the acquisition of propositional knowledge. Student competence will be defined in terms of increase in potential and this can only be determined by student self-report and teacher counselling skill. This causes considerable problems where curricula are defined in terms of content, particularly during the later stages. If student nurses are to become self-directed learners the final year of the course, at very least, cannot be described in terms of medical, surgical or elderly care experience or physiology, pathology or nursing science. The curriculum must be described in ways which allow student nurses to identify and undertake the learning which they need on an individual basis. This means that the final year of training must be extremely flexible if self-direction is to be encouraged. Nurse teachers and clinical supervisors will need to help student nurses achieve their personal learning requirements rather than ensure that they conform to a specified programme of knowledge and skill transmission. This approach requires the teacher to adopt helping skills such as genuineness, acceptance and respect, associated with some models of counselling (Egan 1975).

The development of self-directed learning will require that nurse teachers and supervising practitioners be retrained in those helping skills which are appropriate to adult learning. Once again teaching and assessing

courses for clinical practitioners must prepare them to meet these requirements, as must updating courses for qualified nurse teachers.

9.7 A COMMENT ON THE PURPOSES OF NURSE EDUCATION

It is proposed that the major purpose of nurse education should be the development of a professional person. This requires that the individual nurse be a critical, reflective practitioner who is self-reliant. In addition, the person should be able to change nursing practice for the benefit of the patient, not replicate traditional practice without question. The concept of patient-centredness must be reassessed in terms of the purposes of nurse education. It may be that patient-centredness is taken so much for granted that nurse teachers and nurse practitioners believe that the sheer quality of care will automatically instil it in the student nurses. It is possible that hospital experience, without reflective learning, is such that it may detract from a patient-consciousness in student nurses. This aspect of nurse education is worthy of additional research.

9.8 SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

It has been concluded that at the time of this study the pre-registration preparation of general nurses subsumed under a training paradigm and was not an educational experience. The evidence for this was that the programme of learning did not develop forms of knowledge for know-how, interpersonal learning or emancipatory action (self-awareness) and that the teacher/student relationships were characterised by pedagogical approaches.

Students were passive-dependent, uncritical and non-reflective. This is inconsistent with a professional model of nursing.

A cause and effect relationship has been hypothesised and has found support in the literature and empirical work. The evidence suggests that the selected forms of knowledge elicit particular teacher behaviours which determine the student role which in turn is a precursor to nurse practitioner role. The experimental work demonstrated that the teacher behaviours in the clinical setting can influence the development of patient-centredness and self-reliance in student nurses. The effect was small and the confounding variables may have been inadequately controlled.

Parallel research work in nurse education seems to support the major proposals in this thesis.

The following changes in nurse education have been recommended:

- (i) Pre-registration course curriculum planners must identify strategies for identifying the relevant technical-rational knowledge for the curriculum
- (ii) Forms of knowledge for know-how, interpersonal relating and emancipatory action must be developed
- (iii) That critical reflectivity be developed by perspective transformation in the classroom and reflection-in-action in the clinical setting

- (iv) Curricula should aim to develop self-direction in student nurses by adopting adult learning approaches (andragogy) and utilising the principle of the transitional dynamic
- (v) Curriculum planners must pay particular attention to the patient-centredness of learning outcomes and processes
- (vi) Qualified nurse practitioners who are mentors to student nurses in the clinical setting must receive adequate preparation for this role and this should include adult learning approaches and counselling techniques
- (vii) Qualified nurse teachers must have the opportunity to participate in re-education programmes which develop adult learning approaches and skills to achieve perspective transformation and the transitional dynamic
- (viii) Qualified nurse teachers must be deployed in the clinical setting by reducing their commitment to technical-rational information transmission and the subsequent information overload experienced by students
- (ix) That the purposes of nurse education, as opposed to training, be described in terms of the production of a self-reliant, critical, reflective and patient-centred practitioner and that this be made explicit to all levels of nursing.

CHAPTER 10

DISCUSSION ON THE RELEVANCE OF THIS STUDY TO THE THEORY AND PRACTICE GAP, UKCC PROJECT 2000 AND FURTHER RESEARCH

10.1 THE THEORY AND PRACTICE GAP

As a consequence of this study it is possible to make some comments on the nature of the theory and practice gap which has been widely reported in nurse education (cf page 20). The reasons for the gap may be briefly discussed in terms of the forms of knowledge, the nature of teacher/student relationships and the purposes of education.

A primary feature of the theory and practice gap is the division of labour related to the development of the different forms of knowledge. In its simplest form it can be said that qualified nurse teachers develop technical-rational knowledge and the development of know-how is left to the influence of clinical practitioners who are often more pre-occupied with the delivery of nursing care. They have also been poorly supported and resourced for their teaching responsibilities. The theory and practice gap is not only brought about by a division of labour, it is exacerbated by the finding that the two groups of nurses who control the knowledge domains rarely meet and rarely work together in the implementation of the curriculum. The literature analysis and opinion survey has demonstrated quite clearly that nurse tutors rarely went to wards and that clinical staff rarely had the opportunity to learn what was required of them in the clinical setting. The theoretical knowledge acquired in the classroom was

found to be inaccurate and of little relevance to the clinical setting. When skills were taught in the School of Nursing they were often impractical or out-of-date. They were not consistent with what was actually done in the clinical setting. This is an effect which seems entirely due to the division of labour. The student nurse seems to be participating in two separate learning programmes, each under the control of a different group of nurses, each with different purposes and values. The student nurses had to satisfy the academic requirements of their nurse teachers and this learning was geared to passing the formal state examination. Learning in the school was for passing examinations not for nursing care. Learning to become a nurse, however, was under the control of the clinical practitioners who were subject to demands other than the educational needs of the student nurses. Student nurses cannot ignore either culture because they must survive the demands of both in order to eventually register as nurse practitioners. It is proposed that it is this requirement to satisfy the needs of two opposing groups of nurses which causes the greatest conflict and anxiety for student nurses. If this is the case it is worthwhile asking why the two groups of nurses hold different values and purposes. It has been suggested that nurse teachers, incorporated in the institution of the School of Nursing, are the 'front line' of a professionalising elite (Pepper 1977, Gott 1982). This emanates from a political leadership which, incidentally, values the educational approach as a means of acquiring professional status. The clinical practitioners, however, have been found to display occupational or bureaucratic ideologies which value the practicalities of nursing, the medical ethos and local health care requirements. These differing aims are the source of potential conflict as the emerging educational paradigm of

the professionalising elite conflicts with the training paradigm evident in the clinical setting. It is for this reason that the recommendations of this thesis should be adopted. If the paradigm mismatch between School and clinical practice is not alleviated then the theory and practice gap and the conflict which it brings about will not be alleviated. If nursing wishes to adopt an educational paradigm as a means for achieving full professional status then the learning in the clinical setting must be typified by adult learning approaches and the development of critical reflectivity. Resources must be reallocated and qualified nurse teachers must teach in the practicum (Schön 1987) and, as such, maintain their practitioner skills. If student nurses are developed as self-directed learners then they will be capable of taking the technical-rational knowledge available in the science knowledge bases (including nursing science) and utilising it as part of reflection-in-action in the clinical setting. This is the reality of the application of theory to practice. It is not the contention of this thesis that theory or practice assumes greater importance in the development of the professional nurse practitioner. It is not suggested that the dichotomy of theory and practice can be eliminated. The evidence of this thesis suggests that the theory/practice problem is one of the structural relationship between the extant theory and existing learning experiences in the clinical setting. One can no longer say that theory must be applied to practice. Both the theory and the practical learning components of the pre-registration preparation of nurses must change. Each must reflect the other in terms of selected knowledge. The learning processes for both must be complimentary and based on the same models of learning. The impending changes in nurse education outlined by the UKCC Project 2000 Report (1986) suggest that

great care should be taken to ensure that the theory/practice gap is not widened. The nursing leadership must monitor the theory/practice gap and watch the ways in which it is being tackled. They must take cognisance of research in nurse education which makes specific reference to the problem and ensure that strategies are adopted which improve the structural relationship between theory and practice. The ways in which the theory/practice problem is tackled must be carefully evaluated as the structure of nurse education changes into the twenty-first century.

10.2 THE IMPLICATIONS OF THIS STUDY FOR UKCC PROJECT 2000 (1986)

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting has the function of establishing and improving standards of training and professional conduct for nurses, midwives and health visitors. The council, as a part of its function, agreed the following terms of reference:

"To determine the education and training required in preparation for the professional practice of nursing, midwifery and health visiting in relation to the projected health care needs in the 1990's and beyond and to make recommendations."
(Pg 3)

The discussion in this report on the 'current context and the case for change' makes a number of comments of relevance to this thesis. Many pertinent points may be found in the discussion on 'deficiencies from an educational point of view'. In the earliest part of this discussion the report confirms the dependence which the health service has on student nurse manpower.

"Although the figure has dropped somewhat in recent years, those in training currently contribute around 20% of the nursing and midwifery staff in hospitals, and are obviously integral to service delivery. Time and again, enquiries have pondered the wisdom of this service/education link, suggesting modifications and sometimes a total break".

(Pg 9)

This reaffirms the impact which issues of curriculum may have on the health service. Indeed the report describes Council's concern that clinical practice is an ineffective part of the curriculum, a point which this thesis can throw some light upon. The report says:

"More recently writers such as Ogier (1981), Orton (1981), Fretwell (1982, 1985) and Gott (1983, 1984) have questioned how much the student can learn and does actually learn during the ward assignments which are still so considerable a part of initial preparation in nursing. The recently published work of Reid (1985), in Northern Ireland, has underlined this further with its detailed documentation among other things, of the small amount of teaching learners receive on wards, the inattention to learning objectives and the disillusionment of the learners themselves."

(Pg 9)

Findings of this thesis can take issue with some of the sentiments expressed in this passage. The first is related to the question of how much student nurses can learn, and actually do learn during ward assignments. It is a proposition of this thesis that there are difficulties in identifying what student nurses learn during their ward assignments for two major reasons. The first is that there is likely to be a bias towards propositional knowledge when assessing the learning which has taken place. As Eraut (1985) pointed out practical knowledge is often dismissed as irrelevant (cf page 378). It is suggested here that 'formal' teaching on the wards, is more likely to be assessed in terms of the acquisition of propositional knowledge, the 'know-how' of nursing being

devalued and taken for granted. Added to this is the problem of curriculum planning. It has been argued in this thesis that the 'ward assignments' are the most poorly organised and monitored aspect of the curriculum even though they make up the most substantial part of the course. If the clinical experience is a relatively neglected element of curriculum planning, and if it is separated from that part of the curriculum organised by the School of Nursing, it is hardly surprising that nurse teacher researchers do not identify all the learning which occurs in the clinical setting. This is because their values and purposes are different to those of nurses in the clinical setting. In brief the socialisation of neophytes into the real world of nursing is largely ignored by curriculum planners, and on those occasions that it is acknowledged, it is seen to be some sort of nuisance which confounds the planners' attempts to provide an 'educational' curriculum. The educationalists must begin to recognise that the major part of the curriculum is a socialisation into nursing in the clinical setting, otherwise they will never solve the problems of the theory and practice gap. This cannot be achieved by devaluing the forms of knowledge associated with clinical practice.

An additional point made by the report, when commenting on deficiencies from an educational viewpoint, is that only 65% of those individuals who start training in England and Wales ultimately reach the register. It is possible to suggest, as a result of the current work, that this one-third loss is largely due to the conflict between service and education which is a conflict between training and educational paradigms operating at the same time. It is argued that student nurses have left nursing because of the stress caused by their need to live a double-existence in order to appease

two groups of nurses with opposing values and purposes. It is strongly asserted that it is the nature of the theory and practice gap in nursing, above all else, which is responsible for the loss of one-third of students during pre-registration training.

The Project 2000 Report also discussed attempts at better integration of theory and practice, and says:

"The weight of the research evidence and the growing body of opinion suggests that the system must be seen as fundamentally flawed". (Pg 10)

"The service/education compromise which shapes initial preparations in nursing inevitably has negative effects on the overall pattern". (Pg 10)

This thesis has mentioned a number of ways in which this situation may be remedied. The development of know-how, interpersonal knowledge, emancipatory knowledge, reflection-in-action, critical reflectivity and adult learning approaches are all ways in which better integration of theory and practice can be achieved.

If there must be a change in the system then moves could be made which are more specific than those recommended in the report. The report discusses the proposed changes in the system, but does not come out with a major recommendation on what should be done other than, improve the education (to degree level) and conditions for teachers, and provide better facilities to link theory and practice. The report's major recommendation on this point is vague:

"The full range of means to achieve the appropriate concentrations of educational resources should be

considered, including re-establishments, partnerships and consortia etc."

(Pg 70)

The major concern about the linkage with higher education is the exacerbation of a theory and practice gap which already exists. It is vital that such links with higher education ensure that the education in the practicum is fully developed and resourced. It will be disastrous if student nurses are exposed to the ethos of higher education and then plunged into clinical settings which, by tradition, are subsumed under a training paradigm. The key to UKCC Project 2000 implementation is not just the linkage with institutes of higher education or the replacement of lost student nurse manpower, but the ability of clinical settings to provide learning which is compatible with the development of a professional practitioner. Neglecting this will be costly as Project 2000 may result in the production of highly qualified, uncritical replicators of clinical practice who are less patient-centred than their predecessors.

It must be accepted that linkage between education and service does not need to be a problem. The Project 2000 Report makes particular reference to the problems of the traditional relationship between education and service:

"... the current system of preparation, so closely linked to service, isolates the majority of its students and staff from broader fields of education."

(Pg 10)

It is argued, as a result of this study, that a major problem with the traditional education/service relationship is that the service component has never been perceived as the primary learning experience and has never

been adequately planned, or resourced as a learning setting. This will not change by simply uncoupling education from service. The recommendation that student nurses be supernumery to the manpower requirements of clinical setting seems to be a logical move in this direction. This alone will not produce a professional education as perceived by Friedson (1975) and Schön (1987). The provision of additional manpower will be required to achieve education in the practicum. In addition, clinical staff will need to be developed in the art of adult learning and reflection-in-action if they are to be facilitator mentors to the Project 2000 student nurses. If teaching skill is not deployed in greater quantity in the clinical setting, student nurses will not only miss the educational opportunity in the clinical setting, they may not be allowed to participate in practice as members of a nursing team. The utilisation of clinical practice in an educational programme must be maintained because it is the primary influence on the development of the nurse practitioner.

The professional development of the nurse practitioner is a key feature of Project 2000 particularly those elements requiring problem solving ability and critical thinking.

"New approaches to teaching and learning have been developed using multimethod techniques to enhance the development of problem-solving skills; experimental courses have been established which give nursing students greater opportunities to improve their creativity and their thinking ability in problem-solving in clinical situations."

(Pg 20)

This study wholly supports this contention except to say that nursing has a long way to go to develop the appropriate methods for achieving this. It has been argued that problem-solving ability and critical thinking require

the development of self-direction and forms of knowledge accessible only in clinical practice.

The report also makes recommendations for the preparation of teachers who participate in Project 2000 educational programmes. The first recommendation is that practitioners should have formal preparation for their teaching roles in practice settings. This recommendation finds a great deal of support in the current study and other research. It must be said, however, that the type of preparation must be very different to that which has existed previously. There is every indication that it has always been based on processes of pedagogy and this will need to be abandoned in favour of andragogy. The same also applies to qualified nurse teachers. The Project 2000 recommendation for nurse teachers is that 'moves should be made to establish teaching qualifications at degree level for teachers of nursing, midwifery and health visiting'. There is no evidence to suggest that this will improve pre-registration preparation programmes. What is more important is that qualified nurse teachers are prepared to develop know-how, interpersonal knowledge, emancipatory knowledge, reflection-in-action and self-direction whether it be at the level of initial teacher training or post-qualification continuing education. The latter is particularly necessary for those nurses who are already qualified as teachers. It must also be remembered that degree level qualification may increase the status perception of the nurse teacher and provide additional inhibitions to her participation in the practice setting. Degree status does not ensure that nurse teachers will develop a professional education. It seems more likely that they may develop more of a commitment to the promotion of technical-rational knowledge.

UKCC Project 2000 is a breath of fresh air but its exponents must ensure that the clinical setting and the patient remain central to the process of learning. The nursing students believe this and so do the majority of practitioners. It is hoped that this thesis will convince the reader of the reasons for this position. There are a number of possibilities for additional research which have been precipitated by this study. They are outlined below as a conclusion to this report.

10.3 SUGGESTIONS FOR FURTHER RESEARCH

These suggestions for further research are enumerated and grouped under headings which indicate some commonality. The headings and groupings are relatively arbitrary.

10.3.1 The Purposes of Nurse Education

Most of the research which should follow this study relates to the assertions that nurse education should develop critical and self-reliant practitioners and that this process should be patient-centred. Study should be undertaken to:-

- (i) Determine, in more detail, the nature of poor attitudes to patients in the clinical setting, building on the work of Stockwell (1972).
- (ii) Identify the effects of poor patient care on the student nurse's learning.

- (iii) Further substantiate the causal relationship chain from forms of knowledge through teacher behaviours, student response and practitioner outcomes.

10.3.2 The Student Nurse's Clinical Experience

The following have been indicated by the literature analysis and opinion survey and work should be undertaken to:-

- (i) Identify the positive and negative effects on learning and the student nurse's emotional state of frequent changes in clinical placements.
- (ii) Determine the effects of student nurse turnover on clinical nursing teams and the best forms of induction into nursing teams for student nurses.
- (iii) Review the criteria for the selection of clinical areas for pre-registration educational programmes, taking particular account of the teacher/student relationships and the quality of patient care.
- (iv) Identify the emotional needs of student nurses and the support systems which should be developed to meet these needs.

- (v) Confirm and further identify the reasons why patients are not uppermost in the student nurses' minds and the relationship this has to the 'qualified staff' being uppermost in their minds.
- (vi) Identify ways in which sisters and staff nurses can identify themselves as high or low student oriented and methods to develop high student orientation by continuing education.
- (vii) Confirm and elaborate on the factors which influence patient-centred decision making in both student nurses and qualified nurse practitioners.

10.3.3 Curriculum Design

The following are recommended particularly with respect to curriculum and the role of the school of nursing. Research should be undertaken by nurse educationalists to:-

- (i) Identify the causes of information overload on student nurses and determine systems which identify situations of information overload and achieve appropriate curriculum changes.
- (ii) Identify the most appropriate technical-rational knowledge for the nurse curriculum by job analysis.

- (iii) Analyse the degree to which individual nursing curricula are patient-centred by referring to the statements on outcomes, methodology and evaluation which are given in each curriculum.
- (iv) Test out methods for the development of transitional dynamic, differentiating between the needs of adolescent learners and the needs of mature learners.
- (v) Design teaching methods which develop:
 - (a) perspective transformation and critical reflectivity in the classroom;
 - (b) self-directed learning (self-reliance);
 - (c) reflection-in-action in the clinical setting;
 - (d) problem-solving and decision making in the clinical setting.
- (vi) Identify and describe the tacit knowledge which is precipitated by clinical practice and ways in which this can be made explicit.
- (vii) Monitor the effects of UKCC Project 2000 developments on the theory/practice gap.

10.3.4. The Current Study

Additional work should be undertaken to build upon the methodology adopted in this study. It would be advantageous to this thesis to see additional work on:-

- (i) The development of a more sophisticated measuring instrument to measure the patient-centredness of clinical decisions for future experimental work.
- (ii) The nature of the variables which influence the patient-centredness of the nurse's clinical decisions. This should be attempted with qualified practitioners as well as student nurses.
- (iii) Replication of the experimental design in this study.

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LITERATURE ABSTRACTS

A HISTORICAL REVIEW OF RESEARCH INTO PRE-REGISTRATION LEARNING PROCESSES

The main Criteria for the selection of the following papers were as follows:

The papers should:-

- a. Be carried out by British Nurse Researchers and/or include subjects and situations from Great Britain.
- b. Make relevant comment on the Process of the pre-registration preparation of nurses.

On reading the literature attention was paid particularly to research methodology and the findings; so that emergent themes and trends in these areas could be itemised. In each case the author and main research area will be given. A full reference is given for each paper in the reference list given in this thesis.

McGhee (1961) The Patient's Attitude to Nursing Care

This author, whilst working with the Nursing Studies Unit (Edinburgh) reported work on patients' opinions of hospital life. Some 490 patients

were interviewed in their own homes and analysis of the data was carried out by classifying items under the following categories:

1. Structure.
2. Equipment.
3. Amenities.
4. Noise.
5. Food.
6. Nursing Care.
7. Medical Care.
8. Communication.
9. Other.

Items 6 and 8 are of most importance to the process of Nurse Training. This analysis of nursing care begins by describing the nursing population of the hospital under study. Of the 787 nurses two thirds of this total complement were student nurses (548). The fact that the student nurses first requirement is to work was indicated by this finding. One source of information on the training system comes from patients reports. It is evidenced by their observations that young nurses carry out skills for which they have not been prepared. One patient qualified this by making the following comment.

"Remember I'm not blaming the nurse but there is something wrong when a young nurse is asked (or told, I suppose) to do something she knows only from books".

There are a number of indications that patients' needs are sometimes not met because student nurses are too busy and unable to settle or form

relationships before moving onto their next experience. Some expressed a view of the, "dissatisfaction that constant change must cause to the young nurses themselves". The patients also reported that job allocation and adherence to routine often brought about neglectful behaviour. The effect of this sort of learning experience was described by a patient who was a Lawyer by profession:-

"The Nurse's saintly standard of submissiveness makes life very difficult for the patient..., let the Matrons throw away their moulds for setting Nurses in..., moulds tend to harden and that's what's happening to Nurses... they're human beings, not concrete."

Patients seemed also to be aware of the methods used to teach Student Nurses. McGhee describes this in the following way:-

"There was a 'Mouth Round', conducted by a Student Nurse, in the Ward, at a routine time. The same Nurse could later attend to a patient who was vomiting, but did not relate her two tasks. This example was given by one patient of many who questioned the methods of teaching Student Nurses. In those wards where the Ward Sister openly made time to teach and supervise the nurse training this was remarked upon by patients, who felt more confident than patients in wards where Nurses were told 'What to do but never How to do it'".

The Chapter on communication describes the patients' awareness of rank and authority which is enhanced by the wearing of uniform. Patients were also critical of what seemed to them to be unnecessary ward routines. Also described is the Ward Sister's prime effect of creating the ward atmosphere and its potential effects on staff, patients and visitors. The negative effect she can sometimes have is demonstrated by this example. On one

particular day a bed, having once been made, had to be stripped and made again under the Sisters direction. The reason was to ensure that the ward identification marks on each blanket correspond.

"The patient interprets this, not as good training for the young nurses, but a petty tyranny and 'more concern for the bed than the person in it'".

Yet McGuire also found examples where the Sisters' influence had a positive effect on the patients. Patients commenting on the importance of her human understanding give some insights into the process of learning.

"The Sister who publicly reprimands a junior nurse, whether the reprimand is justified or not, is condemned by the patient for her lack of human understanding. 'We can all make mistakes', these nurses are only human and you get sick always hearing them being told What to do but never How to do it".

Her summary comments on the system of nurse training indicated that there was:-

1. A high mobility of student nurses causing relationship difficulties and low job satisfaction.
2. Duty assignment rather than patient assignment was a barrier to optimum patient care.
3. 'Abuse of Authority' by trained staff.

It is interesting to note that this paper makes no mention of Schools of Nursing or Nurse Tutors.

Menzies (1961) The Functioning of Social Systems as a Defence against Anxiety

This paper - was primarily concerned with the problems posed by the ward allocation of trainee nurses. Menzies compiles a case-study at one London hospital on the basis of formal interviews with 70 Nurses, observational studies and 'informal contacts'. An initial point of interest is the raw manpower figure of 700 nurses, 500 of which were student nurses. The service dependence on learner nurses is again an obvious feature of the late 1950's.

She says:-

"Student Nurses are, in effect, the Nursing Staff of the hospital at the operational level and carry out most of the relevant tasks".

She emphasises the high level of tension, distress and anxiety among nurses. Using a psycho-analytic interpretation she suggests that anxiety is transferred from patients and relatives to nurses and the hospital system. It is suggested that the net effect of the system is that it "Attempts to protect the nurses from anxiety by splitting up her contact with patients".

The author suggests that these things were achieved by a number of defence mechanisms, one manifestation of which was the elimination of decision making by ritual task performance. She also pointed to some waste of human potential which has important consequences for the learning process.

"We were struck repeatedly by the low level of tasks carried out by nursing staff and students in relation to their personal ability, skill and position in the hierarchy".

"They feel that their superiors have to undertake their tasks and make decisions for them".

She also comments on the training system in the following way:-

There is an implied belief that

"Responsibility and personal maturity cannot be 'taught' or even greatly developed - the training system is mainly orientated to the communication of essential facts and techniques, and pays minimal attention to teaching events oriented to personal maturation within the professional setting".

Other examples of the relative simplicity of the learning content can be found and constantly show that the price to be paid for the students' labour is their exposure to unstimulating repetitive activity aimed mainly at protecting the whole hospital organism from excessive anxiety, tension and conflict. In addition the students were probably deprived of help when they did experience difficulty.

"The training - system, orientated as it is to information-giving, also deprives the student nurse of support and help".

Having indicated that a third of students did not complete training, Menzies shows that the learning process did not necessarily match the learning abilities of the students:-

"It is our distinct impression that among the students who do not complete training ~~there are~~ a significant number of the better students i.e. those who are personally most mature and most capable of intellectual, professional, and personal development with appropriate training".

Revans (1964) Standards for Morale

Revans is not a Nurse but his report, which is a series of research projects on all aspects of hospital life, cannot be ignored because of the number of findings related to the process of nurse learning. His analysis of ward activity and his development of attitude surveys provides particularly fruitful data in the area of nurse learning in the 1950's.

He makes the point that the less formal aspects of training are of particular importance to the Student Nurse. He suggests that theory and practice are of importance in the following way:-

"In the solitary darkness of her first Night Duty her approach to what needs to be done, of what she knows about it, and of how she does it may be very different from her confident exhibition under the academic cross examination of her Sister Tutor".

In free interviews he found that Student Nurses commented on interpersonal relations twice as frequently as their experiences of formal work.

Revans considered two questions:-

1. What are the relations between Ward Sisters and the Sister-Tutor?
2. How does the Ward Sister spend her time?

On the former he found that relations varied greatly between hospitals. Sisters felt training schemes were too theoretical (50%) and some thought they actually glamourised the ward task. In some hospitals relationships were good, in others he says:-

"We found the division between Ward Sisters and the Tutors such that the Sisters were never invited to visit or to Lecture in the Training School, nor did the Sister-tutors ever visit the wards to observe the progress of the Students".

In these situations both operated independently and all this without the Ward Sisters being taught how to teach or assess the Students; or being able to use the expertise in the hands of the Tutors of the Training School.

With respect to the second question Revans analysed over 200 hours of the activity of 7 Sisters at one hospital. What he found most striking was the small amount of time spent in conversation with the 1st year Student Nurses. This amounted to 1% of the Sisters' time and most communications lasted less than half a minute. She did however spend nearly 2 - 3 times more time with 2nd year students and 3rd year students. Total conversations with her sub-ordinate nurses only accounted for between 5 - 7% of her time as compared with 26 - 59% spent on Administration.

"Hence the planned or even the adventitious induction of the Student Nurse must occupy only the most marginal amount of the average Ward Sister's attention, since over half of the conversations that the Sister can be observed to engage in with her are little more than direct instructions and their acknowledgement".

Later Revans describes how Student Nurses could be left alone on Night Duty as early as their 1st year of training. He reports a fear of making mistakes and unreasonable responsibility coupled with difficulties in relating to Senior staff.

"They had in theory, only to ask if they didn't know, but in fact they were unapproachable; one could not ask them anything.

Not all students were unhappy with this state of affairs, some actually relishing the responsibility.

More specific comment was made on the subject of training. Matrons felt that the theoretical aspects of the syllabus were too intensive causing 'Mental Indigestion'. According to the teaching staff liaison between tutorial and ward staff was poor, instruction was lacking on wards and patients were not included in the learning of diagnosis or treatment. Differences between school and ward clinical practices were also reported.

"Sisters and Staff Nurses knew that their methods were not always those given in the School; what was demonstrated in the School could not, it was said, always be performed in the ward".

The need for increased co-operation between Tutors and Ward Sisters was also identified:-

"Dealing with dummies in P.T.S. was very different from dealing with sick people in bed on the wards. The methods used by some Sisters were obsolete and ought to be discarded. In spite of this, Tutors, it was said, were not encouraged to visit the Wards".

Revans also reported the shock which Nurses experienced when going onto the wards for the first time; this being accentuated by the over glamourised images of nursing given in the School. Sisters became impatient of the junior nurses inexperience.

"Probably some of these very blunders stemmed from fear of the Sister who would give them no consideration if they made a mistake".

"What really shocked and confounded them was that they sensed so little understanding; they felt offered so little help that they gained confidence neither in themselves nor in their seniors. The only sympathy and support they recognised was from their struggling colleagues in the same Training School set...".

Revans however makes some interesting points about the ward as a learning environment. He argues very strongly that this is the most important learning experience.

"It may strike some as novel to suggest that patient care is, for the nurse and patient alike, essentially a learning process, something normally thought of in the remote and sheltered confines of a School Classroom".

He also points to a fundamental flaw in the learning process which is attributed to the authoritarian attitudes of the Hospital.

"But learning processes, at any level in this life, are more than obedience, however disciplined, however submissive, however unqualified, to instructions, however clear, however appropriate, however authoritative".

Revans also makes a similar point to Menzies (1961) by suggesting that the outstanding social need of the hospital is the relief of anxiety. "The Hospital is an Institution cradled in Anxiety".

As a consequence of this, interpersonal relationships were seen as an important influence on student nurses and problems with these relationships an important factor in the learning process. One example of the effects of anxiety and insensitive relationships was demonstrated in the common responses to the student nurses' questioning. This was neither encouraged by Senior Nurses or greeted with any willingness to provide answers on those occasions when it did occur. He was at pains however to point out that in his analysis the problems were not due to the professional culture but to the attitudes of senior staff in particular hospitals. He also underlines the significance of the Sister in determining the ward 'Atmosphere'.

MacGuire (1969) Threshold to Nursing

This paper abstracted sixty research reports published between 1940 - 1968, primarily to discover patterns of recruitment and withdrawal in nurses. Her paper will be dealt with in two ways, firstly, her conclusions will be described here and then certain papers abstracted by her will be described in a little more detail because they particularly help to elucidate the nature of learning processes in nurse training.

Perhaps one indicator of tension in student nurses is the finding that 'Personal reasons' were the biggest single category of reasons given for withdrawal. One could interpret this vague category as either a consequence of poor data recording or a category which conceals a more realistic, "I would rather not say", category. This however is speculative at this point because the data in these early studies are not accurate enough to allow adequate inference.

On experiences in training, MacGuire found that a common student complaint was to do with discrepancies between what was taught in the formal school of nursing situation and what they found in the ward situation. She also concluded that students experienced their relationship with the hospital as lacking in regard for them as individuals. In addition it was demonstrated that 'Little' formal teaching takes place in the ward situation.

Some of the papers which she abstracted inquired into experimental training schemes. These were training schemes which were mainly shortened courses (2 years instead of 3), University programmes or integrated courses for State Registration, Health Visitor and District Nurse qualification in conjunction with further/higher education. In any event the commonality is that they were perceived to be academically more demanding.

Very little is concluded about the learning process except in an indirect way. It is of interest to find that whilst examination performance generally improves and can be achieved in a shorter period of time, performance in tests of practical skills was the same for students on experimental courses when compared to students on the traditional course. This is of interest mainly because it highlights the ways in which nurse learning is evaluated and achievement is measured.

A few of the papers abstracted by MacGuire are worthy of further description. They are presented in the following pages.

Hutty (1965) Student Nurses: First Year Problems

Using interview, observation and test data from 77 entrants to one Hospital Training School, Hutty discovered quite a number of features of the

learning process. Students tended to form attitudes towards their tutors on the basis of the possibility of asking questions and obtaining helpful responses to them and secondly being treated as human beings. The most important factor which influenced the student's adjustment to ward work was their relationship with the Sister. Arbitrary authoritarianism was the major dislike of students. At the hospital in question the students reaction to ward work was favourable and the induction routine operated by the Sisters was appreciated by the students. Many commented that ward work was better than they had expected but found one adjustment problem to be moving from 'ideal' procedures to the flexibility of procedures as practised on the wards. There were occasions (on Night Duty or students with previous nursing experience) when students appreciated greater responsibility and freedom to plan their own work. She also found that the curriculum as devised caused problems in preliminary training school for new entrants with less than 2 GCE 'O' level passes, but more able students who had had previous experience and 2 'O' level passes or more, actually found the programme boring. Finally Hutty argued for better communication between Tutors and Ward Sisters and training in Teaching methods for the latter.

MacGuire (1961) From Student to Nurse: Part I The Induction Period

MacGuire used interview and questionnaire methods to survey the opinions of some 309 girls from five Schools of Nursing. Almost without exception students were able to describe satisfactions they had derived from their first few weeks of ward experience. Less than half expressed dissatisfaction which related mainly to accommodation, food and inter-personal relationships. One factor which added stress to adjustment to the

ward situation was the breaking up of the group bond and support developed in the preliminary training school block. During Preliminary Training School it was found that discipline was externally imposed and rather authoritarian.

"All discipline tended to be justified by recourse to the 'Life or death of the patient' argument which the students were not able to accept".

In conclusion MacGuire suggests that the P.T.S. did not adequately prepare student for ward experience.

MacGuire (1966) From Student to Nurse: Part II Training and Qualification

In this paper the interview method was used to collect the data and the sample was the same as the previous paper. During this work MacGuire found a demotivating effect of training:

"In general the level of satisfaction expressed by the students in relation to various areas of their work, professional education and living conditions decreased over time".

It was also concluded that 'the ability of the hospitals to present their training programme as a logical and meaningful progression towards qualification lay at the bottom of their success or failure in retaining students'. Remember that at this time the wastage rate was nationally running at 33% and more in some hospitals.

Ministry of Health et al. (1947) Report of the Working Party on the Recruitment and Training of Nurses

The researchers used questionnaire, interview and intelligence tests in this project. A stratified national sampling procedure was used, including 184 hospitals and providing a sample of 6,600 nurses who completed questionnaires. The researchers found once again that most nurses left training during the first year. 44% of nurses resigned and 21% presented miscellaneous reasons other than sickness (11%) exam failure (8%) discharged (9%) and marriage (8%). Hospital discipline and attitudes of senior staff were the commonest reasons for leaving. Job analysis showed that 60% of student time in nursing practice was repetitive and did not contribute to the learning of nursing skills. In addition they found a discrepancy in the reported qualities needed in a nurse between Ward Sisters, Tutors and Matrons.

Oppenheim and Eeman (1955) The Function and Training of Mental Nurses

The authors looked at the time spent by nurses in carrying out various tasks. Using time-sampling in two London mental hospitals they observed the following about the student nurses work. Students were often transferred from ward to ward. There was very little spoken teaching in the ward setting and there was a great deal of reliance on the nursing notes as a teaching device. They found that there was very little correlation between Ward Sisters assessment of students and their examination success. The authors felt that an intensive course lasting six months could probably achieve the theoretical requirements. "Much of the work of the Junior Nurse did not contribute directly to her training".

Pomeranz (1968) St George's Hospital. Experiment in Nursing Education.
Interim Report

Pomeranz studied 116 girls in the 3 Autumn intakes of one School of Nursing from 1965 to 1967. Half had been allocated to the usual three year course and half to a two year experimental course. Observation, interview and hospital records were the main methods of data collection. They found that comments on the introductory course were favourable but the main area of criticism was the instruction in anatomy and physiology and this was found to be more evident in the control group than the experimental group. Inadequate preparation for the first ward was also mentioned in the unfavourable comments. The concurrent theory and practice was seen as the main advantage of the shorter course and 'Difficulties in staff relations as being the major drawback'. The positive aspects of the three year course were reported as plenty of practical work and a slow build up of responsibility. Another dissatisfaction had to do with the lack of clinical instructors and tutors teaching on the wards.

Bevington (1948) Nursing Life and Discipline

Bevington interviewed some 525 nurses in the Training Schools of the South of England. Training was found to be largely satisfactory in four out of the five hospitals. Training on wards was felt to be less satisfactory than training overall. Relationships between learners and trained staff were reported as satisfactory but Sisters were found to spend little time teaching Students, the criticism given to Students was unconstructive and Sisters were not trained to teach. The author concluded that externally

imposed discipline was common and this tendency was not in keeping with more progressive development in Industry, Education and The Prison Service. It was concluded that the individuality of the Nurse was not valued and Students need help to 'Fully develop their personalities'.

Crichton and Crawford (1966) 'The Legacy of Nightingale'

The data in this paper came by the interviewing of 48 Matrons/Chief Male Nurses (Training Hospitals) and 74 Tutors, as well as questionnaire completion from 44 Matrons/Chief Male Nurses (Training Hospitals) 93 Matrons/C.M.N.s (Non Training Hospitals) and 76 Tutors. All worked in the Welsh Region. The attitudes of these leaders provided one or two insights into the processes of nurse training. The main feature is the differing opinions of Matrons and Nurse Tutors on various aspects of training. Matrons were more inclined to emphasise technical skills and Tutors were more disposed to social skills. Twice as many Tutors (43%) as Matrons felt that administration should be included in the training syllabus. Matrons were more inclined to advocate the maintenance of social distance between senior and junior nursing staff. Once again it was reported, by tutors on this occasion, that procedures taught in the school differed from those in the wards. It is interesting to find that they excuse this giving reasons related to inadequacies in practice (Training of Sisters and lack of equipment on wards).

In this paper there is a concluding suggestion that the distinctions between educational and training components of the learning process are poorly understood in nursing.

Manchester Regional Hospital Board (1955) The Work of Mental Nurses

Using job analysis techniques this team spent 298 observation days on selected wards at one Mental Hospital and 2 Mental Deficiency Hospitals. Four functional areas were identified, Administration, Nursing, (a. Basic and b. Technical), Supervision and Domestic.

The researchers found that students spent very little time in technical nursing. 43% of this was spent in working with patients in groups, only 12% with patients as individuals and 45% not working with patients at all. There was no observed difference in the functioning of trained staff, student nurses and untrained staff. It is also reported that allocation of duties took no account of training needs and there was a negligible amount of practical tuition given on wards.

Nuffield Provincial Hospitals Trust (1953) The Work of Nurses in Hospital Wards: Report of Job Analysis

This team asked 'What is the proper task of the Nurse'. They used continuous observation for a complete week on General and Surgical Wards in 12 General Hospitals. They collected data from some 15729 hours of observation. Also used were personal interviews, Ward Sisters diaries and special studies of wards using Ward Clerks.

It was found that Student Nurses were the biggest contributors to the workload and made up at least half of the ward staff, sometimes even three quarters. Student Nurses were found to be in charge of wards for between 22% and 40% of their time, and this was increased to 67% for 3rd year

Nurses on Night Duty. Responsibility was dictated by circumstances rather than by training needs. Direct teaching time on wards varied from 7 minutes to 11 hours per week. There was no evidence of Tutors teaching on the wards and Sisters only spent between 5% and 19% of their time in immediate association with Student Nurses. Only a small amount of time was spent by Sisters on the performance of technical procedures with Student Nurses. Practical skills were most often acquired whilst working with more senior students. The more senior the student became the more time they spent on technical nursing and ward organisation. In conclusion it was argued that nursing in hospital wards was carried out mainly by students yet the end result of training for the nurse was not nursing but administration.

The previous ten papers have been summarised from MacGuire (1969) the following are abstracted from their original sources.

Lancaster (1972) Nurse Teachers

Lancaster carried out an opinion survey of 173 qualified practising nurse tutors in Scotland, and 53 recently qualified tutors in England. They represented a 84% and 66% response to the postal questionnaire. The questionnaire asked about a variety of topics relevant to Nurse Tutors, their preparation, administrative changes, control of nurse education, educational entry standards and entry to the Common Market.

Tutors generally felt that G.C.E. entry requirements should be raised and English and Science subjects should be compulsory entry subjects. They felt that nurse tutors should be trained within the University setting and

even to Degree level. These and similar findings in the work tend to promote an educational rather than training view of nurse education.

Lancaster suggests, in her conclusion, that:

"The difficulty of relating theory to practice in basic nursing programmes seems to be accentuated by the distinction between classroom and clinical teaching respectively by the two grades of teacher, the registered nurse teacher and the clinical teacher". She suggests that if all teachers were equally involved in both classroom and ward teaching the needs of the student nurses would be better met.

Briggs Report (1972) The Committee on Nursing

This report was set up to "Review the role of the Nurse and the Midwife in the hospital and the community and the education and training required for that role, so that the best use is made of available manpower to meet present needs and the needs of an integrated health service".

In its quest to do this it commissioned a postal survey and interview survey to determine nurses attitudes to a whole variety of aspects of their working conditions. A large number of findings relate to the process of nurse education or rather training as they refer to it in Chapter III.

The committee related the comments of the Headmasters' Association who had heard of "Terrifying stories of untrained nurses being left in charge of wards at night 'and' long hours, poor pay, and the old fashioned attitudes of some Matrons who rule with a rod of iron". Indeed it was felt that the training course offered little intellectual stimulation. The National

Association of Head Teachers argued that "For entrants of high academic ability there must always be enough intellectual work to stop the nursing students from feeling bored". "There is no point in raising the standards of qualification unless the course of training is geared to the intellectual ability of the trainee". They support this by asserting that 'Bright students do less well in some nursing schools than in others'.

It was found that trainees approved of the practical element of their training and they 'Were frequently told that nurses must train among people needing nursing skills and not in the classroom'. Another complaint was that work in the ward and teaching in the nursing school did not match. Methods taught by nurse tutors took too long and were impracticable on the wards. The committee suggested that as a result trainees probably develop two standards one to keep tutors and examiners happy and the other for the benefit of the patients. The committee on nursing also commented on the student dissatisfaction with the amount and quality of instruction on the wards from Sisters and Staff Nurses. They also found that reasons for this were mainly due to insufficient time, (a comment mostly supported by the Sisters) or because the staff cannot be bothered (a comment sometimes supported by people in training). A tendency to demonstrate the quickest rather than the correct way of doing things was noted.

Whilst it was found that trainees approved of the practical element of their training it was reported by a third of all nursing grades that too much time was spent on the wards the other two-thirds feeling the balance was right. Around 56% found that there was too much working and the rest (42%) felt the balance between working and learning was right. Nobody felt that there was too much learning. In this total picture it was found that

70% of students felt there was too much working and 28% felt that the balance was right. It is also interesting to note that in the personal interview survey, on aspects of training; dissatisfaction was expressed by only 16-29% of respondents on each point. When asked about the aspect of training which most needs improving; 32% said quality of teaching on the wards, 18% said link between theory and practice, 17% the supervision of practical work, 12% balance between learning and working and only 4% on quality of teaching in the classroom.

On teachers and teaching methods the committee comments on the shortage of nurse tutors and on the poor preparation for teaching of ward staff. They suggest that 'the future pattern of learning must aim at bringing teaching and clinical staff closer together. It was also found that mature entrants were not catered for by the adaptation of teaching methods to meet their needs. The committee also commented on the lack of use of educational technology in nurse education (programmed learning, film, television) and they advocated the promotion of such methods.

The phenomenon of rigid discipline was also discussed:

"There is a clear difference of opinion between students and pupils who are overwhelmingly in favour of a 'friendly atmosphere' and registered nurses who are far more cautious about the abandonment of discipline".

The committee encapsulated the unfavourable aspects of training by summing up the comments of one student who had left the training course after nine months:-

"Living conditions were not good. Rules were not sensible, there was too much harshness over trivia and lack of perspective. The preliminary training course was not stimulating, but exhausting. Communications were poor. Questions were not welcome. The typical day was too long, there was too little time for real care. Everything was institutionalised".

One of the commonest complaints from unsolicited letters to the committee was to do with the attitudes and behaviour of nurses to students. Some selected comments include:-

"There seems to be a complete disregard for the human being beneath the nurses".

Training tends to destroy initiative, discretion, common sense and dampens the enthusiasm which most nurses have to get to know and look after ill people.

The report also finds that the Sister is a fundamental influence in creating an atmosphere most conducive to happier nurses and patients. The committee in addition say as one of their concluding comments that "There is often not enough emphasis on 'care' in nurse education".

Pomeranz (1973) The Lady Apprentices

This work has been briefly abstracted earlier when referring to MacGuire's study in which she describes the interim report on this study (MacGuire

1969). Some additional comments in the final report are worthy of additional reference.

Pomeranz found, as many other researchers had, that the methods and procedures which were taught in the School of Nursing were, 'not only not practised in full on the wards, but were actually criticized there as pernickety and unrealistic'. The students, however, found their introductory course largely beneficial and were horrified to contemplate beginning nurse training without it. Pomeranz makes some interesting observations on discipline in the School of Nursing

"On the subject of discipline, which recurs, one may wonder whether Schools of Nursing, even progressive ones, have perhaps changed their attitudes more slowly than the Schools from which their students come. Certainly many of the respondents gave the impression of having had more freedom and independence in their sixty forms than they found in the Introductory Course".

Referring to the control group (traditional course), Pomeranz reported differences between the wards and the School in the way the students were required to carry out nursing procedures. It was also found that the theoretical work in block did not relate directly to either the ward before or the ward after it.

In addition student nurses were found to have carried out many procedures which they had not been taught during their first period of clinical experiences.

"Although they were normally given a demonstration and help, trained staff were not always available for this and the procedures were not always basic or minor".

The implications of the gap between tuition in the School and the realities of practice are succinctly described by Pomeranz in the following way

"They spend five times as much time on the wards as in the School of Nursing, and they simply do not have the authority or standing to resist a locally accepted routine in the name of academic standards - which in any case they often find impractical. This leads to anxiety especially as the final examination approaches, about whether their practical work will be found acceptable, for all their experience of working as a part of a team of nurses".

In the control group (traditional course) there was widespread dissatisfaction with ward teaching most subjects either reporting it as inadequate or making no favourable comment about it.

It was obvious in data from the control group, however, that there were as many favourable comments about training as unfavourable. All was not bleak.

When referring to the experimental group it was found that there were no great differences, between them and the traditional group, in their reactions to early ward experiences or their work satisfactions.

"In the first year, relationships with other staff on wards made or marred assignments for everyone".

In the experimental group the importance of peer support was more evident because group cohesion was enhanced by the chosen teaching methods. The matching of theory and practice, in chronological terms was found advantageous by the experimental course. One of the major findings from the experimental course was that the shorter course (2 years) along with a one year internship had a number of advantages. Experimental students did almost as well as control students in final examinations, even though the former undertook them after two years, and the former after three years training. The experimental students were however much more relaxed in their approach to clinical work during the intern year. Their practical clinical standards were also found to be satisfactory and most Sisters agreed that their preparation had been adequate.

Lelean (1973) Ready for Report Nurse?

The author was interested to discover if "The effectiveness of patient care on the day-shift was dependent upon the system of formal group communications between the Ward Sister and the Nurses". In order to identify patterns of communication she used the method of direct non-participant observation. Dependency assessment was carried out on all of the patients so as to determine the effect of workload on nursing performance as a confounding variable. Six wards, two from each of three hospitals, were chosen from the then Metropolitan Regional Board areas. All the hospitals were recognised as Nurse Training Schools by the General Nursing Council.

During this study it was still the case that learner nurses (students and pupils) made up the majority of each ward team, only on one ward did learners make up 50% of the ward team on others they were as much as 66% of the ward team.

The ratio of trained nurses to learner nurses in total, on the six wards, was approximately 1:2 taking account of nursing auxiliaries in the ward teams. The amount of communication between Sister and Student Nurses tells us something of the learning process on the wards at that time. The Sister communicated with 1st year student nurses for less than 2% of her time. Informal communications were less than 2 minutes in 80% of occasions and for half of the possible days Sister did not speak to 1st year nurses and they did not speak to her on half of the days she may have done.

The researcher found it difficult to classify the Sisters' instruction "usual nursing care" into the dependency categories and also found that student nurses had the same problems, indicating possible areas of communication breakdown.

Dodd (1973) Towards an Understanding of Nursing

The purpose of this research was to "Identify the phenomenon known as the Nursing problem". The central task given by the researcher was to "Account for nursing as it is" with a possibility of "exploring the logical possibilities of change and their necessary prerequisites". In describing the methodology the researcher states that the overall concern was to assess the hospital as a learning environment for trainee nurses".

A great deal of this large thesis is concerned with processes of nurse education and the most important findings will be described here as briefly as possible.

Dodd used both objective and subjective tools to elicit data using an emergent theory approach to her research. The data collection tools included formal records, diary accounts from 1st and 3rd year students, questionnaire survey of Sisters, semantic scales, unstructured interview and ad hoc observation. The study took place in two hospitals approved for student nurse training by the General Nursing Council, and was able to draw contrasts and comparisons between the two hospitals because they were described as being 'poles' apart.

Findings in hospital one will be given first. Dodd found that students had highly negative attitudes to theoretical education and in addition reported that the nursing course did not encourage thinking. She refers to this as "Intellectual decadence". Some were actually relieved to be out of the "Formal educational system".

The reported reality of the introductory course was that of shock at the low level of theoretical content. Dodd submits the following quotations to demonstrate this:-

"In three days I was reduced to the level of a five year old".

"God, 'A' levels, don't make me laugh".

"The nearest thing to Nursery School I can remember".

Emphasis fell on behaviour rather than skill or knowledge. "How to behave, dress, walk and address others. Procedures were ritualized. The emphasis was in knowing your place and the whole was justified in the interests of the dependent patient". Dodd sums this up by saying that the trainee was therefore quickly reduced on two dimensions by the induction process, one intellectual and the other social.

Four trends were elicited in interview data.

- i) Trainees found a low correlation between the ideal which was taught in the introductory course and the real situation as experienced.
- ii) The real situation posed something of a confrontation.
- iii) Trainees redefined the role of the school and tutor during their first experience and this was enhanced by their absence on the ward. They became the purveyors of ideal nursing for examination purposes and irrelevant to the actual practice of nursing. Knowledge and practical experience thus served different purposes.
- iv) Status hierarchy was so pronounced that normal social intercourse could not cross these status limitations.

The fact that questioning and the pursuit of knowledge were not evidenced or encouraged is supported by the student nurse interviews. A consequence of this was that information flow occurred mainly amongst trainees.

At one point Dodd was forced to consider that the question in terms of student nurse survival is not "Why do they leave?" but "How do they survive?". The main props appear to be the understanding and gratefulness of patients and the support of peers.

The importance of the Sister was emphasised in as much as students felt that their role, future, and eventuality was completely determined by the Sister. The Sister most favoured by Students was one who made the 'going' most predictable for them. The main dimensions by which students gauged their success were firstly a positive dimension, skill acquisition, and second a negative dimension which was survival, that is, still being here and not getting into trouble.

Sisters rarely seemed to give positive feedback on performance but Staff Nurses seem to do this more often. The interim practical assessments on the ward were reported as being something of a farce in which a game was played where all assumed that the chosen practical task was always in reality carried out in what transpired to be a modified form of daily activity.

This was all a part of a general trend by which the school was associated with knowledge and skill which was not related to the knowledge needed to carry out nursing in practice. But it was needed to pass the examination. Learning abstracted from doing was seen as largely irrelevant. Being in school had nothing to do with nursing. The knowledge which was given was also reported as not being up to date. Criticism was levelled, by those with more non-nursing studentship experience, that the presentation of

material (teaching methods) was not up to standard. All of the respondents reported a sense of total disorder in the learning programme. The weekly tests were a source of pressure and students resorted to rote learning in order to 'survive' in the School of Nursing without drawing undue attention to themselves. Giving the tutor what she wanted seemed to be the main watchword. Dodd points out that the effect of the tutor's role is not unlike the effect of the Ward Sister. In both the School and the Ward one had to do what the boss 'likes'. According to Dodd "For the trainee the process in both areas defied objectification". There was strong support in students' comments for the assertion that there is a process of continuous control going on in the School of Nursing by School staff. In addition students also objected to wearing uniform in school which also represented a control orientation. The irony of tutors preaching responsibility but always 'breathing down your neck' was well perceived by the students. On the few occasions when students reported satisfaction with experiences in school it was found that the underlying factor was relevance to ward work. This was particularly attached to the utility of information given "Knowledge was validated by trainees solely on the basis of its instrumental status". Dodd suggests that because of the inherent variety of clinical conditions, manifest in individual patients, clinical knowledge tends to be atypical and along with the effects of medical specialisation, the knowledge required to care for most of the patients lies outside the range of the nursing syllabus as prescribed nationally. A preference for Doctors' lectures by the students and a description of the ideal tutor, reveals both a preoccupation with the acquisition of knowledge as a basic value and its direct relevance and application to patient care as another. Any knowledge not seen as directly related to patient care is seen as superfluous. An additional factor associated with 'good doctors' and 'good

tutors' was the 'they treat us as human beings' factor. The following description of good teaching behaviour encapsulates some of these findings and reveals some interesting pointers for an effective learning process.

The good tutor:-

"Knows what to teach and how to teach it. Comes in and says this is what you need to know to nurse patients with this condition, anything else is superfluous. Uses notes, clearly knows what's what, likes interruptions, cross connections, examples, gets you really involved".

It was pointed out by Dodd that the tutor, given as an example of this behaviour, was completely atypical in the School of Nursing under scrutiny.

Students generally wanted teaching to be built into the process of actual delivery of care yet when asked who could do this clinical instructors were clearly preferred and tutors were not considered at all. Sisters and Staff Nurses were also rejected. When asked if tutors should go to wards to teach, students dealt with the suggestion flippantly and felt that it couldn't be done 'Tutors would be lost'. 'There commitment to the ideal would bring the workload to a halt'. The conflict between the Tutor and ward staff particularly the Sister was also seen as a constraint. The presence of Tutors was disturbing, Sister did not want them, their appearance caused anxiety in students, Sisters avoided them, the Tutors were defensive when they enter the ward. It was also found that Sisters have a number of contingency strategies to minimise the length of their encounters with tutors.

The preference for clinical teachers was based in the following points:

1. They knew the Ward.

(Knows how Sister likes things done).

2. They fit in with Sister.

(They accept the reality situation as defined by Sister).

3. Teaching took place in these two contexts.

(Avoiding the destruction of the main aim, that is, completing the workload).

4. Teaching set was one of demonstrating, explaining and discussing.

(Rather than evaluating, criticising and reducing the learner).

Another finding was related to the emphasis on learning content over the three year training programme. It was found that the basic difference between 1st and 3rd year student learning related to ritualism in procedures and status. This brought about a state of affairs whereby the relational component to the patient is high in the first year (domestic/manual) and low in the third year where skilled/technical learning took the emphasis. As a consequence there was a shift from a moral to an instrumental approach as training progressed. Students reported that 'Learning the Ropes' was the main survival strategy and a great deal of effort went into this. Submission was a major feature of this. Knowing your place helped one to remain safe. In the second year the trainee could begin to take calculated risks and begin to reject part of the imposed order. Indeed they learned a number of subtle strategies to influence Sister or Staff Nurse, but they were always tentative, subtle, tactful and

cautious. Students begin at this point to break the rules in order to maintain the overall work system.

Students were also asked about their preferred sources of support when in great difficulty. The following list gives these preferences:-

Friends in own set	52%
Parents	40%
Social Secretary in Hospital	4%
Staff Health Doctor	2%
Senior Nursing Personnel	2%

The Sister and Tutor were not seen as relevant at all.

An additional feature reported by Students was that of the impersonal working context and hierarchical control. Trainees, however, were not unhappy with hierarchy per se, rather with a hierarchy which did not allow spontaneous social intercourse. Authority was seen as power and an inordinate sense of being controlled. In addition social status was stripped from the student, being as they were at the bottom of the hierarchy. The trainees often found their relationship with the patient as a useful coping mechanism. They were after all in a similar position as they both experienced exclusion and information denial. Dodd states that this 'fellow feeling' was evidenced by the data. She says "The role of the patient in sustaining the trainee was incontestable". In fact the hospital ideology of 'we are all here for the patient' tended to fit very well the students rationale for tolerating the adversity, for example.

"I wouldn't stay here two days, but for the patients".

Dodd comments on this in the following way:-

"Every time the trainee made this statement she was inadvertently underpinning the very system which she so plainly detested. In a way the total trainee, discontent was indirectly legitimating the regime of control".

An interesting consequence of this was that many students in reply to the question 'What will you do when you have finished your training', said "Get out of here fast" (70%).

Questions on a long term commitment to nursing revealed a distinct lack of even a rudimentary professional awareness of nursing, e.g. nearest hospital, enumerating current nursing problems, or even knowledge of the National Health Service.

The general feeling about interpersonal skills in nurse training was that they could not be taught. You either had them or you didn't, there was little time to spend on them during normal working and there seemed no obvious teacher to teach them. Dodd concluded that the "Initiation of the neophyte was firmly underpinned by a behavioural and non-involvement philosophy. Relational sets are structured in advance".

"The issue of relating was therefore quite rightly (as a consequence) restricted to the problem of patient control.

Dodd was also encouraged to conclude that there was a total absence in the (diary) records of any evidence that could be interpreted as a trainee participation in the organisation of the patient care process. Such words as discuss, evaluate, decide and try out are nowhere to be found. Further

exploration on this finding discovered the nature of communications in student learning on the wards. Of those items listed as teaching events, 90% related to hand-over ward reports or end of round reports, 5% to formal teaching by Registrars, 5% students individual efforts to read case notes. It was also evident that slack periods in the work brought about rather unproductive behaviour in the students.

"When trainees had no real tasks to perform they tended to overcome the situation in two distinct ways when Sister was actually on duty. One, complete for available tasks and two, escape from main ward area, into sluice, bathroom, and linen cupboard...".

Being busy was a valued attribute yet it seems that the students acknowledge that this is sometimes a fabricated state of affairs. Dodd suggests that being busy limits information flow to report times and leads to non-participation of patients in their own recovery and the maintenance of their independence. As a consequence of many of these findings Dodd states that "The training process per se tended to prevent the individual trainee from acquiring experience in communicating, deciding and evaluating experience essential to the role of the Staff Nurse".

It is also interesting to note that Sisters generally reported that students were 'all right' and 'quite satisfied' with their training.

Sisters made no differentiation between doing as you are told and progressing as a trainee. Staff shortage was the main reason for diminished learner supervision, yet this was a cause of concern because students needed more supervision or else standards would drop. The perception of Tutors, as reported by students, was supported by the almost

identical reported attitudes of Sisters. Toleration of tutors by Sisters rested on the implicit assumption that neither would violate each others domain. Tutors indeed needed to legitimate their existence in the ward area and were observed as obviously uncomfortable there. That the Sister was the key person in the ward area is supported by the data on many occasions.

Findings from Hospital two data show some similar trends to those of Hospital one. In the introductory course conformity was emphasised and the use of formal tests and examinations was a means of control. In this hospital, however, the intelligence of the trainees was taxed but not insulted. At this hospital there tended to be high quantitative and qualitative demands in the real context but there was still a low support/supervision level which created noticeably high levels of stress. Students described themselves as workhorses and also highlighted the sheer waste of their time in an atmosphere of being too busy. One student commented that:-

"The situation could be vastly improved by making everyone pull their weight and dropping a load of ritual".

At this hospital, however, what the School of Nursing taught was not seen as irrelevant, although they did go beyond that required by 'reality'. Though nursing school activities were not criticised by trainees or seen as irrelevant, there was criticism of the ability of some tutors to make the materials understandable. The limited theoretical environment on wards and emphasis on manual activity prevailed. Sisters were seen as practically competent but not theoretically knowledgeable. Blocks were out of phase

with clinical experience and this caused the learners great difficulty in retaining theory which was of significance for examinations.

When asked who was best to carry out applied teaching, Tutors and Sisters were found unsuitable, the former because of their inability to access the ward and the latter because of their lack of knowledge. It was once again reaffirmed that authority relationships prevail. Clinical instructors were once again the natural choice of Ward Teacher. One insightful post psychiatric student went on to give some insight into nurse tutor activity.

"I was really shocked you know I didn't realise such a set up existed. The tutor standing out in front of a class, chalk and talk. The whole thing was set out to establish her status and our status. There wasn't one iota of communication either between us and her or between ourselves".

Some comments point to the impact of the socialisation process and a lack of tutor/student communication.

"Imagine a training in nursing that never tries to find out what sort of person a student is or help her".

The fact that tutors were hardly seen on the wards was again reported by students. There was also a reported a lack of relationship between what the school was doing and what the ward was doing.

It was found that the general opinion of Sisters was that students were inadequate. Sisters rejected the then current training philosophies which they felt gave more emphasis on theoretical knowledge than practical ability. Sisters said that they knew of the need to teach trainees but

felt that this could not be done under the current conditions. The students tended to separate the 'school from the ward conceptually and generally cast the tutor in the known role of school teacher'. Connecting teaching with working thus became a problem. Tutors were discussed in terms of examination passing.

On the tutors' perception of her role, Dodd discovered three points:-

- i) Tutors were doing their own thing and doing it as if others didn't exist.
- ii) Tutors did not refer to the trainees when describing their role.
- iii) Conflict was the most outstanding feature. School staff seemed to be permanently engaged in the intergroup conflict and extra group conflict.

Dodd says "They were fighting on two fronts".

A particular tutor reported that she had no problems with clinical instructors as long as they didn't act like tutors. She believed in clinical teaching by tutors but "was highly unpopular for holding that opinion".

Dodd felt that the teaching staff in the School of Nursing were split into two subgroups with different orientations roughly described as the academic and the clinical. Both were described as polarised and in no way complementary.

Nursing meant something different to the two groups. In the minds of the academic group it was a 'mark of stupidity to be clinically minded'. The dominant drive in tutors seemed to be to obtain control over the selection, and sanction of knowledge. This set her apart from other groups both within and without the School of Nursing. The notion that examination performance was the main aim of nurse tutors was supported in the way they described their role. Dodd says:-

"How does it come about that a group of teachers whose expressed task is to teach people how to give a service known as nursing, a doing active interpersonal thing, can exist in virtual isolation from the task and postulate on both the necessary requirement and best ways at arriving at its fulfilment?".

In summary Dodd suggests that the tutors use of knowledge and control of examination procedures is an ultimate sanction on student behaviour. Sanction in this knowledge domain was aimed mainly at enhancing her power position. The tutor in fact creates the need for herself.

Dodd summarises the key elements in the extant educational structure as the following:-

- i) Knowledge was based towards physical sciences.
- ii) Skills were basic/manual and taught by ritual procedures and technical skills which were also highly ritualised.
- iii) Trainees were given their place in the authority structure and told how to behave in that structure. Authority was not

negotiable but pre-structured. Behaviour patterns were delineated by unquestioning obedience and courtesy.

- iv) Students saw examinations as sanctions and rarely felt that as a person she may make any kind of contribution to the organisation.

Lamond (1974) Becoming a Nurse

Lamond was one of the first researchers to concentrate on the educational role of the Ward Sister. The study was based on role theory and thus took a sociological perspective. The study attempted to analyse the perceptions of hospital-based Registered Nurses on the socialisation of recruits into the occupation of Nursing. She collected data by structured interview using a comprehensive interview schedule. Interviews lasted between 1 hour 40 minutes to 8 hours including appropriate breaks. The total number of people interviewed was 124 and they included Nurse Managers, Teachers, Ward Sisters, Surrogate Sisters and Staff Nurses.

One of the findings suggests that there was little consensus in any of the nursing groups on the point that the Ward Sister was the most suitable teacher in the ward situation. 37% of Sisters themselves agreed and only 27% of teaching staff agreed with the assertion. This provides an accurate range of opinions reflected by the different groups of nurses. Other student nurses were often chosen as the first choice of ward teacher, teaching staff were almost invariably low on the list of preferred teachers. Lamond was forced to conclude that the "Student is not encouraged to develop a constant expectation of a particular teacher in the ward situation". Lamond felt that nurse/patient interaction was in itself

a process whereby the transmission of a specialised skill or knowledge took place. Accepting this however she does point to various inadequacies which occur in practice:-

"It would appear, however, that it is necessary to introduce explicitly and render as effective the value of 'Impartation of knowledge and skills' as is that of 'caring for the patient', in the present image of nursing".

An important finding is that the authoritarian attitude that Sisters adopt to their subordinates is waning. One must remember however that it is qualified nurses who are saying this. Another curious finding is that the first-year of training was chosen, on 49% of occasions, as the period in which students could reasonably expect to attain proficiency in the specific skill in question. Many of the ward teachers are expecting to inculcate nursing skills in this year.

On the subject of the best venue for learning 78% of respondents said that the main bulk of training should take place on the ward, and yet the ward leader (The Sister) was least frequently (17%) chosen as the first choice of teacher.

Hunt (1974) The Teaching and Practice of Surgical Dressings

The author of this paper was 'concerned with the observation of particular procedures as taught in the 'practical classes' and as they were carried out on surgical wards by nursing staff'. The author guessed that such differences did exist and that student nurses would find it a problem having to deal with such discrepancies.

The researcher used observation methods to analyse the procedures as they were taught and the nurses as they carried out these procedures on the wards. Observation took place in three hospitals on the basis of opportunity sampling. Sixty four nurses were observed in action, (3 Sisters, 19 Staff Nurses, 23 third year Students, 9 second years Students and 10 first year Nurses). In the main study only dressing technique was observed using a self-devised 'dressings' checklist to collect data. From the pilot study it was decided to abandon attempts to observe steam inhalation and bed-making procedures as originally envisaged because of the unhandleable volume of fieldwork.

The hypotheses which were supported can be summarised as follows.

- (1) When carrying out procedures on the ward, nurses deviate from the method taught to them in the classroom. Almost every nurse deviated to some extent and most nurses deviated quite considerably.
- (2) That the nurses' deviations and/or ward methods may contravene the principles on which that procedure has been based. It was found that it was possible to establish deviations which constitute suspected dangerous practice.
- (3) Deviations from the taught method can be analysed in terms of both quality and quantity.

Ricks (1974) A Survey of First Year Nurses' Opinions

In this paper the Author Margaret Ogier (nee Ricks) undertook a questionnaire survey of some 50 1st year student nurses in one School of Nursing. Though the author readily admits to an inexperience in research methods during the time of the study, the findings are given here because of the plausibility of the findings and the usefulness of the paper in building up a picture of the processes of nurse education. Bearing in mind some weaknesses in methodology the most significant findings will be given, remembering that they are selective and represent the responses with most face validity and relevance. It is shown in this paper that senior student nurses are given most frequently as the people who give most help and encouragement on the ward. They were mentioned on average by 31% of respondents. Staff Nurses were also mentioned in 31% of responses. Sisters were only chosen on average by 15% of respondents.

When asked to make suggestions that might improve support and encouragement the most common suggestions were, more supervised work on wards and better communications (ie clear instructions/aware of each other in the team). Reasons for insufficient support were given as poor communication and being too busy. The most common response to a question on support from nurse tutors was that it was adequate (45 - 67%). The methodology used however encourages one to wonder whether this is an exaggerated finding.

There is some indication that the students valued patient contact time in that they suggested 'giving more time to the patients, not just rushing around', as the second most frequent suggestion for improving patient care

(averages 28%). Trying to understand why patients and relatives act the way they do (average 47%) was given in preference to improving knowledge and skill (15%). The researcher also found that learners on their first ward experience had been asked to help in or actually carry out a 'vast variety' of procedures which they had not been prepared for. The commonest procedures were:-

Caring for intravenous infusions

Catheterisation

Nasogastric feeding or aspiration

Assisting with special procedures

Maintaining special charts, ie neurological

Ricks (1975) Results of a Questionnaire to Student Nurses in Final part of 3rd Year of Training.

In this survey Margaret Ogier (nee Ricks) looks to the opinions of 114 3rd year students on their training. They represented 4 groups (intakes) of students. The results of this questionnaire indicated that just over half of the respondents in 3 groups felt that they had been given sufficient support, encouragement and guidance (51%, 55%, 65%), 1 group largely felt that they had not (67%). Overall it seems that half the students were not happy with the support they had been given. Experiences which they found most beneficial were ward teaching and special experiences. When recalling stressful instances 'ward staff personality' was the most frequently given followed by 'heading the rota' and 'special areas'. When asked who gave most help and support, in the first year the Staff Nurse and 3rd year student were always given more frequently than Sister. In the 3rd year

however Sister (43%) was given more frequently than Staff Nurse (24%) and the Nurse Tutor became more important being mentioned almost as frequently as Staff Nurses (20%). The most significant suggestions for improving support and encouragement to student nurses was, in the 1st year, 'approachable staff' followed closely by 'more clinical teaching', in the 2nd year 'more preparation to head rota' and 'more clinical teaching', and in the 3rd year, 'more guidance on ward management'. The students were asked how they would improve the help and support given, they gave the following list of suggestions. The mean number of times the responses were given by the total sample is given:

Careful allocation of ward work	8%
Teach/supervise her practical work	9%
Encourage	7%
Be approachable	11%
Good ward atmosphere	12%
Remember how it felt to be junior	4%
Patience and explanation	15% ←
Be aware of them and their needs and problems	15% ←
Respect knowledge they have	6%
Set a good example	5%
Work <u>with</u> them	5%

The significant suggestions on improving morale and standards of patient care were, respectively, better communication within the ward team and more teaching/explanation.

When asked if they felt there was a division between what is taught and what is practised in the clinical field 92% of the responses confirmed this statement.

The most frequent suggestion for alleviating this problem was that tutors and clinical teachers should go to wards more often. Yet when asked how the learning environment could be improved, more teaching on wards by ward staff was given most frequently (40%) in deference to tutors teaching on wards (8%).

In conclusion Ricks suggests that "The amount of teaching and supervision given in the wards appears to be an important aspect of the student nurses' views on the help, support and guidance they received or needed during training."

Abdel-Al (1975) Relating Education to Practice

Abdel-Al was interested in the nurses' role and how to prepare her for this role. As a consequence she investigated the 'relatedness' of theory to practice. The methodology involved a survey of tutors and student nurses, an analysis of the General Nursing Council syllabus and an experimental course of teaching. Student nurses undertaking training programmes in Scotland were the subjects for this study. The following are the major findings which have relevance to the process of learning. The survey was concerned with the perceptions of students and tutors on the nature and relatedness of theory and practice.

Abdel-Al found that theory and its relevant practice were not related by time. Study blocks were fixed in content but practical experience was not. A great deal of variety occurred in practical experience. In her study she found that the school decided on the theory but the hospital administration decided on the ward allocation as well as the amount of responsibility the student was allowed. In school the teaching was geared to subjects and procedures, in the hospital work was geared to tasks and management, the latter being more the province of the senior qualified nurse. Direct patient contact was largely allocated to students. There was one similarity between the school and the hospital, and this was that the relationships between nursing staff and tutors to patients and students were basically functional and impersonal.

In terms of the content of learning students and tutors reported a poor match between what is taught and what is practised. Methods, techniques and principles differed. In hospital more than one thing happens at a time (multidimensional) yet the school does not teach how to deal with this complexity because it teaches one thing at a time (unidimensional). An analysis of workload showed that in the school there was too much to cover in the time available and work on the wards limited the opportunity for students to study between blocks. In terms of expectations versus preparation it was found that the syllabus was biased towards biological sciences. Whilst being expected to take responsibility the student was not prepared for responsibility. She was not encouraged to think for herself or take initiative. In school she was treated like a student yet on the ward she was treated as an employee. Whilst receiving little help she had to rely on her own judgement yet this skill was not consciously developed by tutors or hospital staff. It was also interesting to find that the

least trained teachers in the School of Nursing were given the responsibility of relating theory to practice. (Unqualified Tutors and Clinical Teachers). Abdel-Al sums this all by saying that the General Nursing Council syllabus is not related to the time allocated for its execution.

The syllabus by the mechanism of its inception, was static and slow to change compared to 'practice' which was changing and less restrained. Abdel-Al makes the following comment on the content of the syllabus:

"Emphasis on details gives a picture of nursing which is technical and fragmented, which automatically makes knowledge of secondary importance".

In such a climate it is difficult to see how the tutor can meet the needs as described by the syllabus and the needs of the students to practise.

Abdel-Al utilised an experimental course on five groups of seconded psychiatric students to see if relatedness of theory and practice could be minimised by increasing the 'students awareness of the practicality of knowledge', developing her 'inferential ability' and giving an opportunity to think about the situation in terms of management. The analysed data did not reach any statistical significance and the method could not be strongly supported. With respect to the method she used the following extract gives some possible clues to the insignificant and indifferent effects.

"Both nursing and Doctor's lectures were along the same lines that they had been used to during their general training. Unlike their general training, they were helped by having a 'concrete' and available source (the handouts) from which to know what to expect

during the secondment and received some guidance. The lectures were also given at the same time as the practice.

"Some students expressed anxiety about a lack of 'specific' knowledge. Even though they seem to have started to develop an intellectual ability as well as a practical frame of mind, they were not fully aware of such a change".

It suffices to say that a bias towards theoretical knowledge is evident. Abdel-Al found that non-nursing subjects held more prestige than nursing theory both in the clinical area and in the school.

In her overall conclusion she resolved that the problem of relating theory and practice was based in the 'lack of representation of the reality of the practical situation in teaching, rather than in terms of the sequence of theory to practice'. Some of her other conclusions are of particular interest to this research. She suggests that the approach to teaching in the experimental study 'corresponded to the way of examination'. It is also surprising to find that she makes the rather questionable assertion that meeting (these) problems does not necessarily mean a radical change of system, yet her experimental course did not seem to bring about significant effects.

Birch (1975) To Nurse Or Not To Nurse

This study was concerned with the causes of withdrawal during nurse training. The researcher used the following instruments to obtain data from 85 student nurses and 51 pupil nurses.

- i) Otis quick scoring mental ability test.
- ii) California test of personality.
- iii) Cattells 16 p.f. questionnaire.
- iv) Rotter incomplete sentences blank.
- v) Kirk attitude inventory.
- vi) Background information questionnaire.

In addition a nurse learners rating instrument was devised and completed by Sisters. Student 'stayers' and 'leavers' were also interviewed.

Much of this paper is concerned with individual learner characteristics. The most useful data in the paper, relating to the process of learning to nurse, is that found in the opinions of learners elicited during the interviews with student stayers and leavers. The students in training expressed unhappiness about 'unfriendly and impersonal attitudes in the nurses residence'. A feeling of frustration was expressed with certain inconsistencies particularly those associated with 'not being credited with ability one day' and then 'assuming full charge on night duty' literally the next evening. Birch quotes a number of statements from learners which express fear, on night duty, of death, of a new ward, lack of preparation for practical and academic responsibilities, 'specialing patients' and emergency situations. Students expressed dissatisfaction with 'cramming in blocks' and procedures differing in classroom and ward. Students also stated that teaching was rarely carried out on wards. On the subject of 'personal relationships' students were 'scathing in their comments' when it came to describing their nurse tutors.

Interviews with learners who had withdrawn from training also describe the darker side of the learning context. The most marked reason given by 98% of those interviewed was 'poor staff relationships', followed in second rank order by the way in which the students weekly duty rota was decided and given (53%). Lack of ward teaching and differences of ward/classroom practice were given by 38% of respondents.

Less common reasons were listed as follows:

Lack of supervision	32%
Social life affected	32%
Discontent with nurses home	25%
Lack of someone to talk to	25%
Non-nursing duties	25%
No tutors seen on wards	25%
Being physically tired out	21%
Not enough time to study	21%
Cramming in blocks	17%
Inadequate ward reports	17%
Too many bosses	14%
Excessive movement between wards	14%
Night duty	14%
Staff shortages	10%
Rebuke in front of patients/staff	10%
Carrying out procedures without preparation	10%
Lack of organisation	7%
Being treated like children	7%

Case histories give some indication about the effects of the students ward progress reports. These are appraisals received by learners at the end of each clinical experience. They were the subject of some discontent. More specifically there was some suggestion that feedback from the Sister was lacking during the experience because appraisal reports at the end of training were often received with surprise or dissatisfaction by the learners, particularly those containing negative comments. The case histories also give many examples of excessive authoritarianism from senior nursing personnel and a general thwarting of the students wish to spend time and consideration on patients.

Bendall (1975) So You Passed Nurse

Bendall was concerned with the measurement of the learners' proficiency, particularly with the efficiency of the written form of examination common at the time. A job analysis of student nurses work was carried out, by observation, to provide a checklist of regular activities which could be tested by some form of verbal test.

Twenty-two nursing activities were selected for study and classified as either basic, technical, relational and informational. In doing this the author was able to confirm that nurses worked on a 'job' rather than a 'patient' basis. She also found that an average of 6.75% of trainees time could be described 'as being' taught on the ward. In the main study Bendall drew her sample from 19 training schools (321 nurses) approved by the General Nursing Council. In addition to observation, questionnaires were used to elicit biographical data, motivation and students perceptions of the situation. A verbal recall test was also designed.

The research design involved firstly collecting data on each learners' application and recall faculties. Each individual was categorised as a correlator (what they said and did correlated), an applier (those whose behaviour was positive but less often recalled), a recaller (those who recalled positive behaviour more often than did it) or non-correlator (those who did not fit any of the other groups). This done, the individual data was then compared to environmental data.

Responses to the questionnaire provide some interesting comments on the process of learning. Respondents generally felt that theory in school either helps (35%) or sometimes helps (57%) with ward work. 54% felt that teaching varies from ward to ward, 17% felt there was very little teaching given on wards and only 8% said a great deal of teaching was given. Most learning on the wards was reported as received from other learners (41%), Sisters (27%), Staff Nurses (28%), tutors and clinical instructors (4%). Relationships between the school and wards was reported as good or very good (67%) and not very good or awful (33%). Students were largely happy with their progress (85%) and most appreciated feedback from patients (66%), Sister/Staff Nurse (27%), Tutors (6%) and Doctors (1%). In terms of their main interest 83% said being a good nurse, 9% passing exams and 8% getting to the end of training. When asked about what mattered to them most 60% said helping the patients, 33% doing things properly and 7% getting the work done. Bendall also administered questionnaires to tutors to ascertain their perception of their teaching on an ideal - non-ideal continuum. In terms of their main function, helping students adapt to the real situation was most frequently chosen 40%, followed by teaching ideal standards (27%) and help learners improve standards on wards (24%). When reporting on their job 81% said it was to teach principle rather than

detail, 18% said teach what is right whatever the cost, 1% teach detail rather than principle and none to help learners pass their exams. The perceived power of their effect was also interesting. 75% agreed that without tutors nursing standards would vary from ward to ward and 20% said standards would be completely lost.

The most important of her findings was related to the correlation between recall and application of learning. She found that only 27% of learners could be classified as correlators and comments that:-

"In only 27% of subjects could the written answer be a reasonable guide to practical performance".

In addition 63% were found to be non-correlators, meaning that:-

"63% of subjects the answers (in an examination) would be no guide at all".

Roper (1976) Clinical Experience in Nurse Education

This paper reports on a study into the clinical nursing available in 31 wards of 3 hospitals and 12 community districts used for placement of general student nurses in 1 School of Nursing in Scotland. Using activities of daily living as a basis, Roper designed a 'patient profile' to be used as a data collecting instrument. One of the more significant findings was that 29.5% of patients have multiple diagnoses. This prompted Roper to conclude that nursing care may require modification when a patient has several medical labels. This confirms the suspicion that practical nursing is more complex than the simplified situation presented in the School of Nursing. 30% of patients in the general hospital had medical

labels which did not fit those used in the school or GNC Syllabus. Diagnostic labelling was also deprecated in education for its constraints in preparing the student for the 'unexpected'. Some of the communication problems in the clinical situation were also highlighted. Reported meanings of common instructions involving washing or bathing, mouth cleaning, dressing and undressing, excreting and feeding, were shown to have as many as 11 to 30 different 'shades of meaning'. This gives rise to confusing communication of patients care requirements.

Hargreaves (1976) Empathic Functioning of Nurses in Training

This study compared the empathic functioning of students at the end of their training with those at the beginning of their training in the same training school. The sample consisted of 134 student nurses in four training schools, who completed Carkhuffs' index of communication (recorded on audio tape) and the data analysed using Carkhuffs' accurate empathy scale. His hypothesis was that there would be a difference in empathy scores in the two groups and if there was a difference the scores would be highest near the end of training. He found that mean group scores on empathic functioning were low and there was no significant difference in the score of the two groups. Responses were below level 3 and were either hurtful, irrelevant or prescriptive.

"The student nurses in this study did not attend to the feelings contained in the helpee expressions, they appeared to respond by giving advice or stereotyped answers..."

"Except 12, in which the helpee feels depressed because the helper does not appear to be helping her and confronts the helper with this

fact, elicited a large number of angry responses from the student nurses".

Hargreaves suggests that the training course did not develop the empathic skills which the literature suggested was essential for them to function effectively.

House (1977) Survival of the Fittest

This study attempted to compare students on experimental and traditional schemes of nurse training. The experimental schemes involved combined SRN and Degree or Diploma in Nursing or shortened and part-time training. House used test data, (eg Intelligence) questionnaire data, (eg Cattells 16 PF, study of values, attitude scales) tutor ratings, interview data and exam results to identify differences.

She found that one difference between the two groups of students was in the level of motivation. Orthodox students were found to be more likely to attach importance to money, status, security, adventure and travel.

Experimental students tended to be more critical of their training yet more impressed with their tutors. They did however receive more support from tutors and clinical teachers on the ward. This increased their persistence in training and helps them to overcome the 'culture shock' from college to wards. Experience in educational establishments other than the School of Nursing appears to sharpen the students critical faculties. House highlights the significance of these findings in the following way:-

"To the extent that orthodox training courses may lack adequate tutorial support and the opportunity for development of critical thinking we may have identified an important difference between the schemes rather than the groups".

Exam performance was no better in either group and House was forced to conclude that the different treatment of experimental course students does not impair their performance.

The differences in the two groups were found to be mainly attitudinal. This was thought to be due to curriculum effects which emphasised theoretical frameworks, critical thinking and integration of theory and practice. More often than the orthodox courses.

"The impact of this seems to be that experimental course students value theory more and are better equipped to review their own training".

Pepper (1977) Professionalism, Training and Work

Pepper was concerned to find out the answer to three questions which were basically:-

What is Nursing?

How is it carried out?

To what extent is it regarded as a profession?

In doing this she elicited a number of findings which add an understanding of the nurse training context.

The fieldwork was carried out in one hospital situated in rural South of England. She used methods of participant observation, interviewing and questionnaire with a view to adopting an 'Open, unrestricted perspective'. The sample consisted of student and pupil nurses undertaking experience on gynaecology and male surgical wards. Patients on these wards were also interviewed.

One of the most interesting findings was that Schools of Nursing had characteristics which she described as bureaucratic as well as those which are professional.

"The main bureaucratic element is that nurses in training are taught to carry out nursing procedures according to methods which are routinised. Each procedure is taught as a series of interdependent steps: none of these steps can be omitted, and they must be performed in their correct order".

Pepper also confirms that "Ward nurses often do not carry out nursing procedures according to the methods they have been taught in the School of Nursing. The procedure methods which nurses are taught are based on academic and theoretical principles". She also confirms that tutors tend not to visit hospital wards and they teach ideal reasons for practice and procedures. The main reason given for procedural differences between school and ward was shortage of staff or time on the wards. The second most frequently given reason was that variations in the patients condition made it difficult to follow what the school prescribed. The real patient and the typical case obviously did not match.

On the students response to this state of affairs, Pepper makes the following comment on her impressions received as a participant observer.

"They (Nurses in training) seemed to regret the fact that they were unable to nurse their patients in the way they believed to be correct. This feeling appeared to persist throughout their training, but at the same time, they came to accept the deviations which were adopted on the wards, and to perceive the wards as more significant to them than the School of Nursing".

Pepper also found that some work practices may not be in the patients' best interests:

"Sometimes the nurses were aware that strict adherence to the ward routines could be disadvantageous to the patient; but if I tentatively questioned their behaviour they usually said something like, "I've got to do it, its on the worklist".

"It became clear during participant observation that the junior nurses' reluctance to approach the Ward Sister could have a detrimental effect on the patients. For example, there were occasions when the junior nurses were aware that the Ward Sister had forgotten to do something or had made a mistake, and that patients were suffering because of this. But I found that they only alerted the Sisters attention to her error if they could phrase their approach so tactfully that she had made a mistake. They were so reluctant to suggest openly to the Sister that she had made a mistake that they tended to do nothing, although patients were suffering, if she could not think of a tactful approach."

In her deliberations on nursing as a profession Pepper found that nurses on the ward had a different view of nursing to the leaders of the profession.

"Additional steps in substantiating the claims of nurse leaders, that nursing is an academically distinct and autonomous occupation, have been the expansion of nursing research, the creation of university education for nurses, and the development of theories for nursing. Nursing indeed, is now regarded as a profession"

This is quoted here to highlight Peppers' findings on the antithetic views of practising nurses. She found 'suspicion of intellectualism in nurses' based in a belief that the 'academic' nurse is slow in completing the work.

She discovered that the reality of the wards conflicts with the nurse leaders professional view of nursing in two significant ways:

- a. "A large proportion of the nursing staff were untrained or in training".
- b. "There is a great deal of work which must be completed within a limited period of time".

"These have a significant influence on the way the wards can be organised".

Pepper also found evidence of the obedience ethic in nursing and describes historical and organisational reasons for its occurrence. Indeed nurses and patients were seen to be both subject to control and submission. On nurse/patient relationships it was found that 'getting involved' was

frequently deprecated and nurses as they progress through training and working life become hardened to 'some things'.

Kershaw (1978) Ward Sisters' awareness of Nursing Practice and role of Nurse Teacher

Kershaw surveyed the opinions of 67 Sisters from 3 hospitals. Data was collected using a questionnaire on opinions towards the nurse teachers' role in the clinical area. In addition she used previously rated lists of statements from the nursing press to elicit opinions on the giving of care and all forms of nurse education, basic and continuing. Some of the most important findings for this study are found in the questionnaire results.

There were 54 respondents to the questionnaire half the Ward Sisters generally agreed that the clinical teacher was part of the ward team (47%). Only 18% disagreed, 25% were undecided or not specified.

There responses to the statement 'The Ward Sister is responsible for teaching methods of care to students' brought 66% agreement. 54% reported that the clinical teacher visited the ward at least weekly and 31% two or three times a month. In response to the question 'Does the tutor ever visit the ward?' 79% said Yes the rest saying No.

Birch (1978) Anxiety in Nurse Education

This paper reports on a study into the anxiety levels of some 207 student and pupil nurses in 4 Schools of Nursing. Birch measured anxiety in the first 2 years of training using the IPAT anxiety scale and identified

stressors in the hospital environment using a self-devised questionnaire including some 56 areas of clinical practice.

The students were tested during introductory course and at 8-monthly intervals. Birch predicted that levels of measured anxiety would diminish as training progressed. In addition he analysed study block timetables to identify academic course content, interviewed learners and administered a questionnaire to tutorial staff.

Birch found that a high percentage of learners exhibited a degree of anxiety which Cattell would describe as 'borderline high and requiring careful follow-up'. A third of the learners over the four test administrations showed scores which suggest 'definite psychological morbidity'.

At eight months of training the rank ordering of stress areas revealed in the questionnaire showed that, of the top 50 stress areas, 9 of the top 25 had to do with patients and the rest were concerned with personal feelings, training and relationships with staff.

In terms of the process of training the following have been selected from the rankings to demonstrate areas of concern to the learner. (Rank order at 8 months and 24 months are given in brackets). Being shown up on the wards in front of patients and other staff was ranked second at 8 months and 24 months. Progress tests in block were also an area of consternation (3 and 6). Changing wards was given a fairly high rating as well. (8 and 13), as was understaffing (10 and 1). Carrying out procedures before being taught in school was ranked 12 at 8 months and 15 at 24 months.

Differing procedures in classrooms and wards was also ranked in the top 20 (15 and 19). Availability of study time was ranked 18 and 14 in respective questionnaires. The only other item in the top half rankings related to the educational process was 'Your own progress report from Ward Sisters'. (20 and 21). It is interesting to note that all of these, with the exception of 'Understaffing' and 'Availability of study time', improve in their rank order as training proceeds.

In the lower half of rankings, dealing with Sister/Charge Nurses was generally mid-range (25 and 34) which also demonstrates improvement as training proceeds. Dealing with tutors was relatively low in ranking (34 and 36). Dealing with Staff Nurses (39 and 41). Enrolled Nurses (46 and 44) and more senior students (45 and 45) even lower.

Another interesting finding was that 5 of the top 11 ranked items had to do with death and bereavement. This is notable mainly because these rankings did not reduce as training proceeded and this seems to suggest that training may have no significant influence on this single aspect of personal/emotional adjustment. The fact that around half the students reported having no preparation to deal with these issues gives some indication of why there is no demonstrable change in the perceived threat of these situations. In contrast tutors more frequently reported that training was in fact given on these issues. Clearly what tutors thought they had taught was not matched by the learners' perception.

Analysing particular topic areas Birch found that in the instance of one subject deemed to be necessary, that is psychology, students and tutors

felt that insufficient time was spent on this topic for student nurses and pupil nurses. What's more only tutors (45%) felt that they were equipped to teach psychology. A similar finding was reported by students about the Ward Sister's inability to teach 'psychological care', though the general opinion was a high degree of confidence in the Sister's ability to teach nursing skills and medical knowledge.

With respect to the tutors' dissatisfaction with the teaching of psychology Birch raises the following concern:-

"One must raise the question, that if so many tutors were dissatisfied with the amount of psychology taught, why did they not remedy the situation by revising the block content?".

Birch suggested an answer to this question in the following way:-

"One answer may be in the suggestion that a broad based framework on the subject has never been a feature of general nurse training and therefore tutors are limited in the extent to which behavioural patient care can be emphasised, except in the most superficial of ways".

Further analysis of the curriculum indicated that teaching was not based on behavioural objectives and the probability is that the curriculum was guided by subject matter rather than educational aims. By using a measure of conflict (Rotter incomplete sentences blank) Birch discovered the measured conflict in a learner was a good indicator of her likelihood to withdraw from training. Using the IPAT Test he found that pupil nurses scored higher on the anxiety scale than student nurses. There was also a tendency for students, with high measured I.Q. (Otis), to withdraw from

training. The 2 students with the highest I.Q. at 130+ both withdrew from training, and a fifth of those of I.Q. 110+ withdrew.

Orton (1979) Ward Learning Climate and Student Nurse response

Orton was interested to see if wards differed in their 'Learning climate' and how this related to the role of the Ward Sister and student nurse satisfaction.

Opinions of Student Nurses, Ward Sisters, Clinical Teachers and Nurse Tutors were explored using the questionnaire method involving a 'Likert-type response scale'.

In her literature review Orton highlighted the common themes in the process of education hitherto unidentified.

They were:

- i) Relationships between Student and Sister.
- ii) Ward atmosphere.
- iii) Integration into the ward team.
- iv) Teaching on the ward.
- v) Differences between ward and school methods.
- vi) Service versus training needs.

She also demonstrated the validity of the concept of 'climate' by drawing from the work of the organisational psychology discipline.

Orton surveyed the opinions of 325 student nurses. 13 tutors and 14 clinical teachers were also involved in the study. Sisters on 30 hospital wards assisted by responding to items on a questionnaire devised by the researcher. Factor analysis revealed two short scales but neither proved to be 'particularly strong' measures. Two particular questions provided the researcher with a fruitful avenue to explore. They were:-

"What did you like least about the ward?".

"What did you like best about the ward?".

These questions yielded a great deal of comment and Orton describes how she used this in the following way:-

"The resulting comments yielded a series of vivid word pictures portraying very different ward profiles. Six particular wards were identified by the uniformity of descriptions, three being located at one end of a hypothesised dimension and three at the other. Between these two extremes were 15 other wards which were described in intermediate terms. However, there was a much lower level of agreement amongst independent reports for these latter wards and this variability suggested that no identifiable climate existed".

The two groups of wards were labelled, 'high student orientation' and 'low student orientation' respectively and Orton states that these labels are 'indicative of the Ward Sister's attitudes and behaviour in relation to the student nurses passing through her ward. Indeed as this work develops

Orton provides strong support for the assertion that ward learning 'climate' is a valid concept and furthermore it is a 'property of the environment as distinct from an individual response variable'. It is however of interest to note that the results of her questionnaires paint a picture of learning processes and preferred Ward Sister behaviours as perceived by student nurses. Some of the responses are statistically too 'chancy' to rely heavily on them as characteristics of 'good' and 'bad' learning climates and only those of $P < 0.001$ will be mentioned here for the sake of brevity. The percentage responses of both groups and the degree of statistical significance will be given in brackets with each item. Students on H.S.O. wards were more likely to agree with the statements 'all staff on the ward, from Ward Sister to the newest recruit, feel part of a ward team'. (HSO 89%, LSO 30% $P < 0.001$) and 'The Ward Sister attaches great importance to the learning needs of student nurses' (HSO 74%, LSO 30% $P < 0.001$). They were however more likely to disagree with the statements 'The Ward Sister regards the student nurse as a worker rather than a learner' (HSO 82%, LSO 21% $P < 0.001$) and 'The Ward Sister is not concerned about what a student nurse is thinking or feeling as long as she is getting on with her work' (HSO 89%, LSO 36% $P < 0.001$). Again the following comments provoked agreement from students on HSO wards when compared to their LSO counterparts.

'The Ward Sister devotes a lot of her time to teaching students'.

(Agreement HSO 79%, LSO 0% $P < 0.001$)

'The Ward Sister has a teaching programme for students on this ward'.

(Agreement HSO 68%, LSO 19% $P < 0.001$)

'Ward report is used as an occasion for teaching student nurses'.

(Agreement HSO 89%, LSO 12% $P<0.001$)

'In planning the ward duty rota allowance is made for student nurses to gain the widest possible experience.

(Agreement HSO 66%, LSO 19% $P<0.001$)

'If a student nurse is in any difficulty she goes to the Ward Sister to discuss the problem'.

(Agreement HSO 76%, LSO 30% $P<0.001$)

'Student nurses learn more from the Ward Sister than from anyone else on the ward'.

(Agreement HSO 18%, LSO 0% $P<0.005$)

'Patient allocation, rather than task allocation, is practised on this ward'.

(Agreement HSO 50%, LSO 15% $P<0.005$)

'This was a happy ward for both patients and nurses'.

(Agreement HSO 87%, LSO 41% $P<0.001$)

'The patients needs really are given first priority'.

(Agreement HSO 79%, LSO 48% $P<0.025$)

There was approximately 92% agreement from all students with the following statement:-

"The Ward Sister is the key person influencing the morale of ward staff'. (87% $P < 0.005$)

Ward Sisters and Nurse Tutors were even more emphatic about this. An interesting finding which contrasts with previous research was the percentage disagreement with the statement that 'The theory learnt in school is only really useful for passing exams', (72% Average $P < 0.001$). There was also strong agreement with the statement that 'Tutors tend to teach an idealised version of hospital work (90% average $P < 0.005$). Ward Sisters and Nurse tutors also agreed with this. There was strong agreement that there should not be any differences between procedures taught in the school and those used on the wards (87% $P < 0.005$). Orton found general disagreement from students on low student oriented wards with the following statements:-

'Student nurses are sometimes kept busy just for the sake of appearing occupied'.

(Disagreed HSO 40%, LSO 78% $P < 0.005$)

'Procedures used on the ward are sometimes different from those taught in the school.'

(Disagreed HSO 32%, LSO 74% $P < 0.005$)

'The Ward Sister does not usually explain to subordinates instructions coming from a higher level'.

(Disagreed HSO 24%, LSO 78% $P < 0.001$)

'Conferences of ward staff to discuss personal or clinical problems are not a feature of this ward'.

- c. Whether their teachers encourage creative personalities.

The researcher used the following tests:-

- i Problem identification test (and nursing history)
- ii Nursing interventions test
- iii Torrance favoured student characteristics test
- iv Convergent and divergent thinking tests
 - Guilfords utility test
 - Thurstones nonsense syllogisms test.

In the main study, 22 'Bachelors' students and 18 'traditional' students participated as subjects. Crow found the 'bachelors' students did identify more actual problems ($P=0.25$ level) and they also identified more psychological and social problems than their 'traditional' counterparts. There was no difference however in the two groups abilities to identify biological problems or potential problems. She also found that respondents who were able to utilise divergent thinking ability (as opposed to convergent thinking) were better able to identify actual and potential as well as bio-psycho-social nursing problems.

Crow also elicited some support for the assertion that the teachers on the 'bachelors' course were more likely to encourage their students to be creative personalities and she attributed this as the cause of their greater ability to identify actual problems and psycho-social problems. In terms of ability to suggest interventions, Crow found no difference in ability attributable to training scheme or teachers encouragement to be

creative. There was however some evidence to suggest that divergent thinkers are better able to suggest interventions than convergent thinkers.

One aspect of the data which can be extracted by the reader is that the mean divergent thinking scores of the 'bachelors' students (53.4) is higher than that of the 'traditional' students (42). Scores on ideational fluency however show no appreciable difference. The two mean average scores on the utility test for 'bachelors' students is 10.5 and 12.9 respectively and for 'traditional' students 11.2 and 12.6 respectively. It looks as if 'bachelors' courses either select or encourage divergent thinking abilities. We cannot be sure which of these is the case.

FRETWELL (1980 & 1982) SOCIALISATION OF NURSES

Fretwell was interested to examine the teaching/learning situations in the hospital wards of two general hospitals. She was keen to identify a 'good' ward learning environment. The study was designed in two stages, the first stage attempted to:-

1. Rank and identify wards with 'good' and 'less good' learning environments by using the opinions of learners who had previously worked on wards.
2. Describe characteristics of wards identified as having 'good' learning environments.
3. Describe the Sister's perception of her management and teaching role.

The first of these ventures was undertaken by the use of rating questionnaires devised by the researcher, using a Likert type scale. The sample consisted of 87 learners who were referring to 14 training wards. About two thirds (62%) of the sample were first year learners. A process of cluster sampling was used. Fretwell found learners' perceptions of how much they could learn on a ward was related to:-

- The variety of diseases.
- Length of patient stay.
- Variety of procedures performed.

The preferred wards were more likely to be specialist or surgical wards, "where nursing would be of a more technical nature".

Fretwell also says that:-

"Wards tended to be ranked high where learners did a variety of technical procedures and low where they did basic work. Thus the ranking could be explained in terms of 'mainly technical to mainly basic nursing' and 'cure to care'".

Work on high ranked wards was also more likely to be reported as interesting. Work on lower ranked wards was described as 'boring and monotonous'. Fretwell summarised her inferences on the data in the following way:-

"These data suggest that nurses are socialised to believe that highly technical procedures are a necessary part of their training while the repetitive, basic nursing activities are not".

On the subject of the learners perception of teaching and learning Fretwell found that Sisters on highly rated wards were favourable rated for teaching and "between one and two thirds of learners on low rated wards indicated Sister hardly taught me anything". Sister was expected to be a key teacher in the ward, though on eight of the high ranked wards "there were a higher percentage of comments indicating that 'everybody' taught". Where Sisters were rated low on teaching the staff were also generally reported as unwilling to teach.

Staff relationships and ward atmosphere were mentioned by a lot of students but it appeared to be especially important to learners who did not like their ward. She also found that Ward Sisters teaching correlated significantly with good staff relationships/ward atmosphere.

"Comments suggest that what nurses learn on a ward is affected by the attitude of permanent staff towards them".

Fretwell summarised the characteristics of a ward atmosphere conducive to learning with the following list:-

"Sisters and trained nurses:

- Show an interest in the learner when she starts on the ward;
- Ensure good learner/staff relationships;
- Are approachable, available, pleasant yet strict;
- Promote good staff/patient relationships and quality of care;
- Give support and help to learners generally;
- Invite questions and give answers
- Work as a "team".

Another summary by Fretwell is also illuminative:-

"In such an environment, learners felt they could ask questions without fear of ridicule or rejection, and were given detailed answers. But learners on other wards were less fortunate and were segregated from trained staff who either remained in the office or tended 'to be aloof'".

Students were found to prefer discipline but still felt that this could be achieved in a context of friendly relationships. A relaxed attitude on some wards was felt to encourage bad habits.

It was also discovered that 'good' Sisters were appreciated not only because of their own 'teaching' behaviour but also because they were instrumental in encouraging others to teach.

The characteristics of the formal teaching situation on the 'ideal' ward were described as:-

- "All trained nurses on the ward teach regularly.
- Outsiders teach regularly, that is Doctors, Clinical Teachers.
- Senior students teach.
- Trained staff assess learners.
- Non-job teaching comprises lectures and discussions about patients.
- There is a programme of job instruction.
- Sister maintains good communication with staff and learners.
- Trained nurses teach during the drug round.
- Trained nurses teach 'by example'.
- Sister initiates teaching".

Students expected trained staff to teach and when they were disappointed in this expectation learning was found to be irregular and learner initiated. Tutors and Clinical Teachers were missed more on wards where staff did not teach. Communication and free flow of information were important but on occasions it was found that even though learners welcomed full explanations on their work, sometimes they were given no handover report and felt that these reports were inadequate. There were examples of contrasting leadership styles. Though some senior ward staff 'taught by example' some Sisters "hardly came out onto the wards" and were described as 'Office Sisters'.

It was felt that Sister provided learning opportunities in the following ways:-

- Everybody works.
- Sister and trained nurses give learners the opportunity to watch or perform new procedures.
- Sister accords teaching and learning activities a place in the routine.
- Sister allows learners to go on Doctors rounds.
- Sister gives learners the opportunity to read case notes and text books.
- Sister gives learners responsibility.

Fretwell interviewed eleven of the senior Sisters on wards which had been rated by the learners. One surprising finding was described by Fretwell in the following way:-

"What was surprising was the way Sisters described the learning opportunities in the wards in terms which placed the patients' psychological and special needs uppermost, but when asked to name the six most important things they expected nurses to learn, specific procedures and techniques were the items most mentioned".

It was also found that only one of the Sisters had been on a teaching course, but the majority had been on management courses. Fretwell concluded that this confirmed the emphasis given by policy makers to the Sister's management role.

Sisters reported that they taught the following subjects, (% of Sisters mentioning subject in brackets).

Skill and practical procedures	(82%)
Patient care and diseases	(73%)
Drugs	(27%)
Anatomy and physiology	(19%)

Some of the Sisters freely expressed feelings of, "insecurity and doubts about their knowledge and teaching ability (which) may have prevented them from taking up opportunities to teach informal groups".

Fretwell felt that to many Sisters teaching was a "Regeneration process" demonstrating this with the following definition of teaching given by one of the Sisters:-

"Handing down to the younger generation all the knowledge I've gained over the years."

It was also confirmed that learners were primarily seen to be needed as workers rather than learners. There was some evidence that nurses were 'afraid' to ask Consultants questions even though this group were thought to be good sources of learning. Access to the Consultants was also carefully controlled by Ward Sisters. 45% of the Sisters reported the fact that 'interruptions' were frequent and this often prevented them from doing what they wanted to. Staffing and workload were also factors which affected their work. Some Sisters said that time was a constraint on student teaching but most felt that the order of priorities was the main reason. Doctors come first.

"These and other comments indicate that when there was a conflict of needs, teaching was the activity that was sacrificed".

It was also found that Sisters felt that liaison with the school was quite good and the clinical teacher was attributed with the credit for this.

In the second stage of the study the researcher was keen to describe teaching/learning situations and "identify and describe" activities undertaken by the Sister which could account for differences in ward learning environments. In this stage she used observation and interview methods. The former was achieved using an observation schedule and time sampling techniques.

Fretwell found that students reported a confident competence with the physical performance of two thirds of their work activities. These were repetitive tasks carried out frequently. Those which they required help with were those which were either done infrequently or had to be carried

out on 'different patients'. These different patients were those with uncommon disabilities or who were 'difficult' patients.

Only a small percentage of learners felt fearful or insecure with their activities (2.3%). Learners felt most confident with basic (ordinary, everyday, routine) activities but reported needing either practice, supervision or teaching with over half of the technical activities. Fretwell felt that learners were also socialised to believe that technical work was more important than basic work for their education. As early as the first two weeks on the first ward learners could be found to report on tasks which could be done 'without thinking'. These activities were seen to play 'no part' of their education. Basic activities were seen as work and technical activities as education.

Fretwell also discovered that job teaching 'how' was on every one of the six wards more frequent (22%) than job teaching 'why' (13%). Teaching nursing theory which was not job related was also fairly frequent (21%) and more common than job teaching 'why'. On the six wards however an average of 41% of responses reported no teaching or learning at all. Teaching described as relating to the social background of the patient and the patients reaction to illness and his feelings were reported in only 3% and 5% of activities respectively. There was also discovered a perception of two kinds of teaching situation 'active' and 'passive'. The types differ in that the former describes overt teaching activity the latter describes teaching in which learners are aware that something is to be learned but it is not made explicit by the teacher. This type of teaching depends on the learners awareness. Fretwell found that during the bulk of the work only a small percentage of teaching was passive or 'by example'. On high rated

wards more teaching was carried out by trained members of staff rather than untrained. It was also shown that the Sisters teaching role extended beyond the actual teaching that she did.

Fretwell concluded that ideal ward learning environment is one in which Sisters were democratic rather than autocratic and patient oriented rather than Doctor or Administration oriented. Hierarchy and routine were found to inhibit teaching and learning but Fretwell also comments that:-

"By implication an ideal learning environment may inhibit work".

MELIA (1981) STUDENT NURSE ACCOUNTS OF THEIR WORK AND TRAINING

Melia was interested to find out what student nurses thought was important in nursing, how they see their world, and why they held the views they did. She interviewed forty student nurses at various stages of their training (8 months, 18 months and 30 months) who all volunteered to participate. The interviews were guided using an interview agenda drawn up on cards but a free and open style was offered to the interviewee. Probing was also a feature of the interviewers strategy mainly adopting 'Why' questioning in report to some responses. Analysis was carried out in the paradigm of 'grounded theory' whereby theories are generated from the data. melia says that 'central to this method is the simultaneous collection and analysis of data... It is necessary to analyse early data... in order to establish the main themes to follow up in later data collection'.

It is interesting to note that whilst gaining access to students the researcher had problems in instilling an air of informality because 'so many tutors seemingly destroyed any hope of informality'.

Melia began her interviews with the following open question:-

"What matters to you most in nursing - What do you think is really important?"

One feature of student life which was precipitated by Melia was the 'just passing through' phenomenon associated with practical experience and the transient nature of the student's encounters with permanent members of ward staff. What was more interesting was the 'casual acceptance' of this and the considerable adjustments they had to make as they moved from ward to ward. The fact that students only stayed on one ward for 6 - 8 weeks also had a positive side to it. On a 'bad' ward the student could cope in the knowledge that she would not be there for very long. Students also used this 'transiency' as an excuse when ward experience did not tally with what they had been taught in the College of Nursing. The feeling that they were workers was constantly reinforced by having to 'subordinate their knowledge and position to a favoured routine of an unqualified member of the permanent staff'. Melia comments that the students became adept at fitting in with the expectations of different members of the permanent staff.

"The students view of nursing can be seen to be one of getting on and getting through".

Whilst students were not in any way flattering in their comments of the permanent staff they did sympathise with their position. melia quotes one student who said:-

"It must be very irritating for trained people as well. A new student to get into the way of things every eight weeks, but at the same time they forget you are another individual person".

Melia suggests that this constant movement "provides an unrealistic introduction to nursing..... making the students reluctant to settle down". Students often describe how they intended to avoid settling down as Staff Nurses.

Melia also confirmed the tendency to task rather than patient orientation in nursing. She found students commenting that good care depended on the student nurses on the ward at the time. The Ward Sister was described as the person who sets the general tone of the ward and decides how the ward should be organised. Although the Sister 'controlled' the ward it is obvious that nursing at patient level may not always be happening according to her directives. Evidence of control was also obvious. Students were seen as a malleable breed who are used to obey Ward Sisters instructions. She also comments that the Ward Sister 'dictates' how patient care will be given. Effects on patients were also illuminated by students:-

"Oh yes, college is obviously to the book. You go to the ward and everybody does their own thing. I find that as well, as long as you get through the work; it doesn't matter about the patient, you've done your work".

Melia also discussed the effects of routinised prescribed care which:-

"To a large extent obviates any need for the exercise of professional judgement on the part of the care giver. If the nursing work is organised along individualised patient allocation lines, then the question of use of professional judgement and discretion on the part of the nurse are more likely to arise".

Communication between the senior staff and students was also highlighted as a problem. They were left short of information and some reported that they were 'in the dark about patients progress'.

One consequence of this was reported by Melia as the "Guarded, evasive approach which the students were sometimes forced to adopt".

"The students had to develop coping mechanisms and face saving strategies in their dealings with patients".

As one student put it:-

"You do feel ignorant, you do feel that you don't really know enough about the person to really judge for yourself what you should say".

Students found it difficult to obtain information and were 'placed in a position of having to do something when the patient asks his questions!

"The fact that the students position is not one which they adopt voluntarily does not make the evasion, or as the students put it 'fobbing patients off' any easier to come to terms with".

It was felt that students did not get enough training on how to speak to patients. As one student put it:-

"We get psychology lectures but nothing really on how to just sit down and speak to somebody".

The students discussed nursing work and professionalism. It was found that 'basic nursing' was dismissed as not very prestigious work, they felt that anybody could do this sort of work. Work was described as routine and in

terms of 'workload'. Leaving student nurses to do more mundane work was also a common feature of their descriptions. The students often implied that nursing work required little specialised skill, let alone knowledge. An interesting point is made about nurse management with reference to professionalism. Profession was used in a kind of 'professional conduct' sense.

"Once students had been taught the ways in which a nurse is expected to behave, appeals to professional behaviour' can then be made and these become the mainstay of discipline within the nursing service".

"Claims to 'profession' by the Managers can be seen to be no more than a device for controlling the workforce".

Melia also comments on the 'academic' leadership of the occupation suggesting that the growing literature and body of knowledge is produced by and serves the needs of a professionalising elite in academic nursing. This elite is remote from mainstream.

MARSON (1981), (1982) BEHAVIOURAL CHARACTERISTICS OF EFFECTIVE WARD TEACHERS

The aim of this study was to isolate those behaviour that trainee nurses consider help them learn from their work experience. The work was carried out in four small acute general hospitals and two geriatric hospitals in a two district area health authority. The study was carried out in three phases.

Phase One involved the collection of information by interviewing a randomly selected group of trainee and Sisters.

Phase Two consisted of the administration of a questionnaire on good teacher findings.

Phase Three was the observation and analysis of verbal interactions between trained and trainee nurses using Rackhams behavioural categories as the research tool. Marson considered 'that the service environment provides the trainee with many role models', but she asked, 'How does she pick an appropriate one? Wrong attitudes and skills can be acquired'.

"What is learnt on the ward is likely to be a practical solution to a practical problem. The solution may be a good one but also it may be only the best available at the time".

The major focus of the study was on the learners and their perceptions of teaching and learning, on the basis that the trainees spent 80% of their training time in the relatively unstructured environment of the work place. An interesting point made by Marson is that there was little evidence in the nursing literature of the study of ward learning and teaching as a process.

During the interviews Marson found that the main reasons for disliking a ward, (56% disliked at least one work experience), were relationship problems, that is, staff attitudes. Others mentioned lack of stimulation and boredom. When asked who did they go to for help, 62% said the Sister for the answers to theoretical questions. For practical skills Sister, Staff Nurse and Enrolled Nurse/Auxillary were mentioned equally as frequently. In terms of personal problems 12% said they would approach Sister, Staff Nurse or Enrolled Nurse but 67% said that they would not approach anybody on the ward. When asked what is learning? acquiring

knowledge and 'giving information' was most frequently given as the definition of teaching.

The students were also asked if procedures should be practiced as taught in school and only 5 out of 24 gave an unqualified 'Yes' in response to the question. Students were mostly agreed that theory can not be taught on the wards and qualified staff and Sister were chosen most frequently as the people who should teach on the ward. When asked to describe 'learning' experiences the following were given by percentage in the 24 incidents described:-

Life threatening emergencies or management problems.	38%
Correction by authority figures.	20%
Teaching learning experiences (and support of a more experienced nurse).	42%

Marson found that few of the experiences recalled had actually involved didactic instruction.

"The majority, that is 58%, could be described as self-initiated or internal learnings arising out of the experience itself rather than someone elses intention to teach".

When asked Who they had learned most from over half said Ward Sister and a quarter the Staff Nurse.

The greatest inhibitors of learning were seen as mainly lack of interest on the part of trained staff and a general insensitivity to the learners needs. Other inhibitors included personality clashes, emotional stress.

over-anxiety, boredom, overwork and lack of time to follow up a line of enquiry. Marson found an apparent lack of communication between trainees and Ward Sisters.

"The orientation interview was superficial and didactic in nature with little investigation of the learners true needs".

"Trainees also reported receiving little constructive feedback on their progress during their stay on the ward and on the whole were unaware of or unable to verbalise, their specific strengths and weaknesses".

Sisters seemed to associate the word teaching with didactic instruction.

"Their construct of teaching is probably based on their own experiences of being taught.

When asked about their teaching most Sisters on acute wards rated technical nursing competence as most important, Sisters on long term wards rated changing attitudes most highly.

"Higher level skills inherent in the management of patient care, interpersonal problem solving and decision making skills were rarely mentioned".

The Sisters were also asked about the assessment of the students learning. 62% were reasonably satisfied that trainees had learned what was expected and 10% reported nurses failing to learn at times. Assessment of learning on the ward was found to be a very subjective activity.

In stage two of the study a 70 item questionnaire was provided mainly from interview data and completed by 96 trainees (1st, 2nd, 3rd year students and 1st, 2nd year pupils). Marson identified 7 characteristics strongly related to good teaching by more than 70% of respondents and 5 by 80% of respondents. They were :-

<u>CHARACTERISTICS</u>	<u>% RESPONDENTS RELATING IT STRONGLY TO GOOD TEACHING</u>
Displays high standards.	92
Shows care and concern for patients needs.	90
Sets a good example at all times.	82
Always has time for trainees.	81
Gives hints and tips to help learning.	80
Is able to explain things simply.	78
Enjoys his/her work.	77
Gives correction quietly and in private when needed.	73
Always there when help is needed.	71
Capable and competent.	71
Is respected by staff and patients.	71
Is knowledgeable about nursing.	71

Some characteristics mentioned frequently in interviews were not rated highly in the questionnaires.

<u>CHARACTERISTICS</u>	<u>% RESPONDENTS RELATING IT TO GOOD TEACHING</u>
Takes every opportunity to tell/show.	42 (Strongly related)
Communicates person to person.	42 (Strongly related)

Is a motherly/fatherly sort of person.	40 (Moderately related)
Is quiet and reserved.	31 (Moderately related)
Is open about his/her feelings.	44 (Moderately related)
Encourages trainees to express his/her own opinions and ideas.	50 (Strongly related)
He/she has trust and confidence in trainee.	64 (Strongly related)

Marson comments that:-

"It would seem that individual preferences for particular personality traits and interpersonal behavioural styles is operating here: personality counting less than interpersonal behaviour".

Marson found the pattern of responses to characteristics related to instructional skills of interest.

<u>CHARACTERISTIC</u>	<u>% RESPONDENTS STRONGLY RELATING IT TO GOOD TEACHING</u>
Gives feedback on progress.	40%
Gets trainee to work things out for herself.	42%
Sets goals for trainee to achieve.	42%
Prepares and uses teaching aids.	29%

It seems that some behaviours which nurse educators value are not highly valued by all trainees. Some exceptions were found in terms of the theory and practice relationship.

CHARACTERISTICS

% RESPONDENTS STRONGLY
RELATING IT TO GOOD
TEACHING

Teaches the way of nursing care as well as the how.	85%
Related teaching to real life experience.	60%

Factor analysis of the responses to the 70 items showed that two factors emerged, "one concerned general values, behaviours and attitudes towards learners, the other to personality variables. In summary, Marson concluded that stage two identified three components of learners view of ward teaching. They were:-

- a. The power of the role model presented to the learner.
- b. Skill in forming and managing interpersonal relationships.
- c. The art of being a good communicator.

In the third phase Marson used Rackhams (1977) method of analysing and categorising person to person verbal interactions. The finding from this work was based on an autocratic/participative dimension of communicative style. In essence she found that Sisters and Staff Nurses tended rather heavily towards the autocratic pole and Enrolled Nurses more to the midpoint of the dimension. Identified good teachers were further towards the participative dimension. The autocratic style describes a tendency to "Do lots of telling with proportionately little asking! to communicate in the form of instructions or commands and to disagree with or point out snags in other peoples' suggestions. The participative person seeks other persons' opinions and ideas and asks lots of questions for clarification. They support and develop other peoples' ideas rather than squash them".

ALEXANDER (1980). (1982) INTEGRATING THEORY AND PRACTICE

Alexander devised a social experiment in teaching and learning to Nurse. The aim of the experiment was to facilitate the integration of theory and practice in nursing. The independent variable was a college and ward-based method of teaching, the experimental group being compared to a control group of peers who received teaching of similar material 'by means of the more conventional college-based methods'. Alexander used the method of illuminative evaluation to evaluate the experiment using all who had participated directly in it. Alexanders' contention was stated as follows:-

"The problems of a perceived lack of integration of theory and practice in nursing are more likely to be a function of the methods of teaching and learning, than of the formal organisation of the training programme".

She designed an experimental teaching programme which departed from the control in the following ways:-

- a. Student's learning needs decided the nursing care they would give.
- b. Direct relevance of care to course of theoretical teaching.
- c. Students freedom to concentrate on care of chosen patients.
- d. Supervision of practical experience by the theory teachers.
- e. Presence of registered nurse teacher at bedside.
- f. Identical role of two grades of nurse teacher.
- g. Negotiation between teachers and ward staff to identify appropriate patients.
- h. The elements of control for the teacher.

- i. Flexi-time operated by teachers.
- j. Teaching and learning followed active experiential learning.

Alexander used a survey followed by a test/experiment/retest design for the experiment. The experimental group were compared to a control group.

Survey data was collected from 119 student nurses, 224 trained ward staff and 72 teachers.

Students confirmed that they learned more in the ward than they did in college (77%). In ranking eight commonly used learning methods the ward tutorial was most frequently preferred. Guided study and self-directed study was least liked.

Alexander describes the climate of teaching and learning in study blocks in the following way:-

"There was also little evidence of study being done by students outwith block hours. The evidence was of an emphasis, by teachers, on 'covering' the content of the course, and for the students, of a somewhat passive, recipient role, rather than an active searching role in regard to learning - they did not appear to like methods which called for a certain amount of independent organisation and initiation and responsibility for their own learning in that they disliked both methods which involved study".

On the ward it was found that most of the teaching was carried out by Staff Nurses, mainly taking the form of supervision, demonstration of practical procedures and tutorial sessions. A similarly significant group was fellow student nurses, who provided a similar amount and type of contribution. 80% of students had never received supervision from the Nurse Tutor and 91% had not received ward tutorials from her. This was also supported by the teacher responses. Whilst almost all Ward Sisters considered they taught frequently on their wards 70% did not know what theoretical preparation their students had had and 83% had rarely or never met teaching staff or communicated with them. Only 45% of Staff Nurses had had contact with Nurse Teachers and they were the greatest contributors to teaching on the wards. It was also interesting to find that most of the Ward Sisters (90%) and two thirds of the Tutors felt that ward teaching was the responsibility of the ward training staff if Clinical Teachers were not available.

There were frequent reports of differences in the role of the Tutor and Clinical Teacher the Tutor was the 'theoretician' and the Clinical Teacher was a practitioner of nursing. It is interesting to note that half of the trained teachers did not perceive that the functions of the two grades of teacher differed at all.

The priorities of the two grades were however seen as different. The Clinical Teacher had few commitments other than the ward and the Tutor had a considerable teaching commitment in the college. Both grades operated as a generic rather than specialist type of teachers. The Clinical Teacher was also generally seen to have different priorities

to the Ward Sister. Her priorities were predominantly with the student, the Sister's with the patient.

There was also data on the difference between practice and teaching. More than half (60%) of the students recollected instances where practice differed from the taught method. The following conclusions were made from these instances.

There was evidence of:-

- a. Failure to grasp principles of nursing or not having been taught the principles.
- b. Many nursing practices still in use being contraindicated by research findings.
- c. Careless and sometimes dangerous practice.
- d. Frequent rather than rare instances of difference between theory and practice.

In addition Alexander was encouraged to comment that:-

"Only 5% of comments referred directly to a patient; 95% referred only to procedures, and it was evident that a majority of students were working as part of a system of ward organisation which was task orientated rather than orientated towards individualisation of patient care".

On the subject of integrating theory and practice the students considered that their training programme lacked integration when:-

- a. Practice was not depicted realistically in the teaching.

- b. Theory was not followed by relevant ward practice.
- c. Ward staff appeared unaware of the students stage of training and experience.
- d. There was evidence of conflicting values between college and ward.

After the experimental block a number of advantages were reported by respondents. The most frequently reported advantage was that of active experiential learning.

The experimental students approved of the less formal teaching methods and the increased contact with tutors and with patients. Students had more time to 'learn how to learn' and more time to devote to one patient. Teachers benefited by being able to observe students at work, rectifying faults immediately and co-ordinating theory and practice. 84% of students felt that they had learnt more as a result of the experiment. Most teachers considered the teaching method feasible in the current system of nurse education and training. Tutors and students, however, felt that there was insufficient time for students to carry out all the nursing care of their patients, consult case and nursing notes and make their own notes. Some students were worried because they had fewer notes than normal particularly as the control group were taking notes prolifically during the experimental period. It was reported by all groups of respondents that patients had enjoyed and benefited from the experimental situation. More of their higher order needs had also been met. Some students found the amount of supervision by Tutors to

be over awing, even though they felt that supervision was usually lacking. Most students preferred a tutor supervision ratio of one Tutor to four students. When Tutors and ward staff were asked to rate the objectives which were set for the experiment, the highest mean score was given to the objective:-

"Improve standards of nursing by supervising the student nurse in giving planned and individualised patient care".

A concluding comment by Alexander sums up the students feelings:-

"It was clear, however, that the students, by a considerable majority of opinion, had enjoyed the method of teaching and learning about nursing, and felt it should be repeated for some other subjects in their curriculum".

Alexander found however that both 'experimental' and 'control' courses were effective, and both improved on the post-test conditions. This was felt to be attributable to a 'Hawthorne' effect on the control group. It was also interesting to find that most of the members of the control group preferred the methods they had been subjected to even though they had been randomly allocated to this group. In addition they felt threatened by the prospect of having to change to the methods experienced by the experimental group at some time in the future.

ATTREE (1982) CREATIVE AND PROBLEM SOLVING ABILITY IN STUDENT NURSES.

Attree hypothesised that creative thinking is related to nursing problem-solving ability. She administered four tests of creative thinking (Torrance 1966) and three nursing problem-solving tests to 106 first year and 100 third year general student nurses. The student nurses' teachers were surveyed (n=19) and Torrance's student characteristics checklist was also used to identify the characteristics they encouraged or discouraged.

Attree discovered a strong relationship between creative thinking and nursing problem-solving ability. In addition it was found that first year students demonstrated greater flexibility and originality than the third year students on tests of creativity. Attree suggested that certain variables operate over the training period which reduce creative thinking ability. In addition the results of her nursing problem-solving tests show that third year students suggest more numerous nursing interventions but less original solutions than first year students. This indicates that the learning process adds to the stock of interventions available but encourages conformity to those interventions acceptable to the socialising agents.

Some of the factors possibly responsible for these effects were postulated and they are:-

- a. Socialisation processes.
- b. Behaviourist learning principles.
- c. Teacher dominated teaching methods.
- d. Examination and assessment procedures.

e. Student personality variables (selection).

There was no evidence to suggest that teaching methods or teachers perceptions of favoured student characteristics had any influence on creative thinking ability.

Attree felt that a great deal of the effect comes from the influence of clinical areas rather than the School of Nursing.

PARKES (1980) OCCUPATIONAL STRESS AMONG STUDENT NURSES

This study was designed to investigate in more detail the evidence that nursing work was a high stress activity which was, in some cases, responsible for high incidences of psychiatric outpatients consultations, suicide, self-poisoning and smoking.

Two intakes of student nurses from two hospitals yielded a sample of 101. The Eysenck personality questionnaire, Spielberger state-trait anxiety inventory, level of psychological distress checklists, work satisfaction, work environment scale and sickness/absence rates were the assessment tools used. Students were assigned to wards which were one of a possible combination of four types determined on the basis of a male/female and surgical/medical classification.

Parkes found that medical wards were associated with significantly higher levels of anxiety and depression than surgical wards. Work satisfaction

was, however, significantly higher on surgical wards compared to medical wards. This was even more pronounced when the medical ward was the second of the two allocations.

Measures of social climate yielded some interesting findings related to the learning milieu. In both types of ward the levels of staff support, clarity of work organisation, and innovation were relatively low, yet, work pressures and control were high. Surgical wards were higher than medical wards on levels of involvement, staff support, autonomy, task orientation and innovation. Work pressure was equal on both types of ward. Surgical wards were thought to be more rewarding for the nurses because they were more inclined to the 'instrumental' role of the nurse emphasising active intervention, the use of technical procedures and specific skills to master. Parkes also suggests that the general aspects of the ward environment were responsible for the more positive effects of surgical wards.

"Organisational aspects of the work environment, and relationships between students, qualified staff and patients, which are reflected in the social climate profiles, are influenced by factors such as staffing levels, the particular style of the Ward Sister, and the nature of the nursing care involved".

Wards which showed greater differences in levels of distress also showed greater differences in social climate profile.

The comparative analysis of wards on the male/female dichotomy, showed that male wards tended to be higher on peer cohesion, staff support, involvement and relationships between senior nurses and students.

Students reported a higher level of work satisfaction on male wards, and although they attributed this in part to the fact that male patients were more appreciative and helpful, it was found that male wards produced a higher level of measured anxiety.

Parkes concluded that the 'ideal' ward was "Higher in support, clarity and innovation and low in work pressure".

"In both sets of data the relationship between staff support and work pressure was a strongly negative one; thus in general, the higher level of work pressure, the lower the level of staff support.

CLINTON (1981) TRAINING PSYCHIATRIC NURSES

Clinton was also keen to look at the integration of theory and practice, but in a psychiatric setting (particularly psychogeriatric nursing).

The author was interested to examine the ways in which knowledge in the classroom is related to the day to day concerns of the ward staff. A single group of student nurses (and those involved in their training) were subjects for study over two years. Clinton felt that the training system polarised theoretical and experiential knowledge and:-

"Attempted to combine information which was collected in classrooms and wards, comments made by learners, tutorial and ward staff and accounts of nursing education and nursing practice, publications by other researchers in a way which makes explicit how the socialisation of student nurses in Nurse Training Schools influence the care of patients".

The approach used was openly declared as interpretive. The author found that there was a gap between what nurses were taught and what they did and attributes this to the hidden curriculum in classrooms and wards. Compliance in classroom prepares students for hierarchical relationships in wards and vice versa. The author concludes that the relationships which learners form with tutorial and ward staff are the key determinant of the breakdown between classroom theory and ward practice.

Using informal self-report techniques Clinton used transcripts of interviews, recordings of classroom sessions and field notes to elicit information on psychiatric nursing perspectives and the ways in which these are revealed in classrooms and wards. The author found that 'processes of cultural transmission are key factors in the breakdown between theory and practice in Nurse Training Schools'. The teaching styles used in the classroom and the division of labour on the wards seemed to have unintended consequences, which included, interrupting the transmission of patient-centred care, the internalising of superior-subordinate relationships and the perpetuation of task-centred routinised care. This resulted in a lack of sensitivity to what were called in the classroom "patients social and psychological needs". One conclusion which Clinton arrived at was that:-

"Theory and practice could only be integrated at the level of individual practitioners if nurses were able to work with other staff in ways which were predicated upon a reflexive orientation to their work".

The author identified professional ideology and occupational identity as opposite sides of the same coin. Professional ideology is an important constituent of classroom teaching and occupational identity of ward work.

The former does not usually influence the care of the patients in the wards but it is generally used by nurses to justify the care that they provide. The author felt that learners, by the way they are taught, learn to "Compartmentalise their classroom and common-sense knowledge in ways which establish repertoires of sensori-motoric knowledge which are difficult to change". "The study showed that teaching styles used by tutorial staff mirror the 'curriculum as fact' approach to teaching subjects for examination in schools". Learners expectations encourage tutorial staff to do this and their expectations being that the classroom role requires them to assimilate information and to reproduce it during tests and examinations.

"Learners' preferences for formal teaching styles are reinforced and when these cannot be brought-off, opportunities for informal learning are dismissed as a waste of time".

In essence he summarises that:-

"The organisation of nursing curricula, the teaching styles used by tutorial staff and the methods of assessment used in Nurse Training Schools have been identified as key factors in the breakdown between theory and practice, as have what passes for nursing knowledge, wider social values and the division of labour in health care".

The author continues his description of nurse training in the following way:-

"Nurse tutors apply the habits that they learned in the wards to the classroom instruction of learners, and learners reproduce the hierarchical structure of the classroom in their care of patients. The organisation of task centred care provides the logic for classroom

instruction and vice-versa. The 'one-offness' of classroom sessions reproduces the tendency for nurses to think of their work in the wards as a series of tasks. The lack of variation of teaching styles echoes the lack of variation in ward routines. The lack of time for private study reflects the ethic that nurses should always be occupied."

"In the same way the ward routines ensure that tasks start and finish 'on-time' rigid timetables ensure that the what of what gets done in the classroom is given more importance than the how. Just as the fact that patients are taken to the toilet in the wards takes precedence over the indignity of 'block treatments', the fact that learners are taught takes precedence over what they learn".

Clinton concludes his findings in the following way:-

1. What passes for nursing knowledge is little more than a classroom rhetoric which has its origin in a patient-centred ideology.
2. The formal teaching styles used in nursing classrooms encourage learners to be dependent on a 'curriculum as fact' approach to learning.
3. The hierarchical organisation of classroom sessions and the routinisation of nursing care socialise learners into an occupational identity which perpetuates task-centred ward routines.

Clinton also found evidence that the experience of teacher-centred approaches to classroom instruction and subordination to task-centred routines in general encourages an authoritarian style of thinking.

He further discovered that third year psychiatric student nurses:-

1. Were more likely to prefer informal teaching methods than their first year colleagues.
2. Are also likely to be far more vehement in their preferences than their first year colleagues.
3. Are equally likely to be more vehement in their preferences than third year B.A. (Nursing) students, third year B.Sc. (Psychology) students and first year diploma in nursing students.

Clinton thus discovered that the highest dissatisfaction with formal teaching methods are experienced during the final year of training but that this falls off after registration. He adds however that:-

"There is nothing wrong with the teaching styles used by Nurse Tutors and Clinical Teachers. Their approach to teaching and learning is firmly embedded in our culture".

Further he states that classroom sessions cannot serve as a basis for patient-centred nursing practice unless there are concomitant changes in the organisation of care.

WILES (1981) EARLY SOCIALISATION OF THE STUDENT NURSE

Wiles was interested in the effects of socialisation on the Student Nurse during her first ward allocation.

She utilised questionnaire, observation and interview methods to collect data from seventeen Student Nurses.

Wiles found that the sample showed a more positive attitude to nurse-patient communication as a result of their first clinical experience. This was supported by their observed behaviour in the clinical setting as well as their expressed attitudes as determined by questionnaire. This change was found to be related to the system of work allocation used on the ward. Patient-allocation brought about more positive changes than the task allocation of work. The reliability of the attitude scale was however found to be poor but some specific questionnaire items are of interest. On the basis of expressed satisfaction most students said that they gained most satisfaction from knowing that their patients were comfortable (11), others by gaining more knowledge about nursing (3), knowing their work was well organised (2), and carrying out technical tasks (1). Following ward experience 13 subjects said that they gained most satisfaction by learning about nursing. Three subjects were most satisfied by gaining more knowledge, but not the same individuals who expressed this in the pre-questionnaire. This, however indicated a general preference for nurse patient interaction over the acquisition of knowledge during clinical experience.

It was also interesting to find that 6 of the students had worked on wards with patient-orientated work systems and 11 on wards with task orientated work systems. It could be concluded that two thirds of ward may at that time have been involved in task allocation in one particular hospital. Two

thirds of students were satisfied with their introductory course whether they had been working in patient or task orientated systems.

Wiles also found that ward experience increased the students perceived importance of the nurses practical skill in deference to her personal qualities which were found most important before the clinical experience.

She also found that students perceived that patients most expected from nurses: communication and attention to their physical needs. Ward experience increased the importance of communication in their perceptions.

Wiles found that helpful colleagues and a good ward atmosphere were the most important features of ward experience in deference to communication with patients which was also an important feature.

Gott (1982) Learning Nursing

Gotts' aim was to study the effectiveness and relevance of teaching provided during the student nurse introductory course.

she utilised a number of methods, the analysis of introductory course syllabi, observation in both wards and classroom, and interviews with students.

Subjects were drawn from three hospitals and included student nurses, patients, nurse teachers and trained ward staff. The total sample consisted of some 120 individuals. A Chi Square test was used to estimate the significance of the statistical methods used. Gott was particularly

concerned to discover a need for the planned development of social skill. She found at all three Schools of Nursing the teaching of practical skills was a stated goal for the introductory course but the teaching of social skills was not. She found that teaching methods were largely traditional and teacher centred. The students main reason for discontent was that they were unable to practice the skills which had been taught. In addition students were rarely allowed to input into their learning activities and as such feedback to the did not occur. When on the ward they learned to nurse the 'ward way' even when they recognised the methods as wrong. This was due to lack of information about learning objectives given to clinical mentors/instructors and the inability of nurse teachers to attend and give support of any planned teaching on social skills students resorted to imitating role models in the clinical setting. During the introductory course nurse teachers were the first role models students encountered but the relatively ineffective.

"She presented as negative, rather than a positive model, having a limited and inhibitory communication style".

In the second stage of the study the performance of practical skills on the ward was observed. Neither technical or basic skills were performed as taught by the School of Nursing and this caused the students a great deal of anxiety. In fact the 'School way' was frequently impossible to implement in practice. It was discovered that once a student had been taught a skill, ward staff expected that she should be able to perform the skill on the ward. Gott comments on this in the following way:-

"This is a manifestation of the learner/worker conflict: teachers expect learners to undergo ward experience to consolidate skill

learning; senior nurses expect learners to work on wards to perform nursing duties".

The end result was that students rejected the School teaching of basic skills because they did not work in practice. It was accepted that the 'best way to learn a nursing skill is to work with a skilled practitioner of that skill, under decreasing instruction and supervision', but this did not occur in two of the hospitals. There was very little planned teaching on the ward and that which was provided was mainly of a technical nature.

There were also a number of findings associated with nurse/patient communication; the most important of which was that, whilst patients placed the highest value on the nurses 'social' role, teachers did not prepare students for this role. Six communication categories were used during the observation of 32 students on 16 wards. The majority of communications (85%) were found to be 'inhibitory to the communication process', and the majority were function (concerned with treatment and care). It was also found that the student nurses controlled the length of 90% of communications with patients. The lowest levels of communication were found to occur during the performance of technical tasks. It seemed that students, qualified nurses and nurse teachers did not recognise the value which patients attach to communication skill.

"The evidence suggests so far that, even if social skills were taught, they may be regarded as low status by student nurses as they are neither glamorous or technical: the implication being that anyone can talk to patients. If this is indeed so, one is prompted to ask why they do not?"

Some interesting points were also made in this thesis about the roles of the various teachers to the course.

"Tutors saw their job as either trying to meet syllabus requirements or as setting standards of care or both".

"Clinical teachers saw their job as trying to link school and ward practice".

"Teachers made very little use of trained nurses as a teaching resource".

Some teachers and service nurses felt that 'teachers didn't teach current practice because they did not know what it was. Trained nurses understood little of what was taught in the School. The expectations of teachers were also found to be different to those of the Ward Sisters and this was compounded by the fact that there was very little contact between School and ward staff. There were also reports on effects on patients of this devaluing of social skill by nurses.

"That some patients did not feel at ease or free to voice their concerns was indicated by their response to the question "What did you do (about feeling worried or afraid)?" Their response was that they did nothing (told no-one)".

"Patients did not perceive their demands as legitimate if they were not involved with treatment or care; they did not perceive nurses as having a social (as well as a functional) role".

"Patients and nurses agreed that patients communication needs were not always met".

Gott also concluded that teachers were unsuccessful as influencing nursing practice. The School staff subscribed to a professional ideology and ward staff to a bureaucratic ideology. Conflict between these causes role stress in student nurses. Further it was concluded that Tutors did not prepare students for communication skill and thus did not prepared student nurses for their job on the ward, and a call was made for a student centred (problems solving) approach to the education of nurses.

SPECIMEN MODULAR PLAN.

		MODULE 1.																									MODULE 2.																																										
WEEK		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45																							
Able	INTRODUCTORY COURSE	Holiday							Preparatory Block							MEDICAL WARD							SURGICAL WARD							Consolidation Block							Holiday							Preparatory Block							PSYCHIATRIC WARD							ELDERLY CARE WARD											
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SYLLABUS FOR THE CERTIFICATE OF GENERAL NURSING

I. PRINCIPLES AND PRACTICE OF NURSING, INCLUDING FIRST AID

Introduction

Outline of the history of nursing as a background to the present day.

Outline of the Health Service.

The Health Area/District; its hospital and community services and relationship with social services.

Personal qualities, beliefs and attitudes of the nurse.

Code of professional practice.

Relationship between the nurse, patients and relatives.

The place of the nurse in the hospital team, relationship with medical staff and other health workers.

International agencies for health care.

General care of the ward unit

Plan of patients' day.

Organisation of ward routine.

Ventilation, heating and lighting.

Reduction of noise.

Cleanliness of the ward as it affects the safety and comfort of patients.

Prevention of spread of infection.

Care of linen; disposal of soiled and infected linen.

Storage and custody of drugs.

Storage and preparation of lotions and poisonous substances.

Care and use of equipment.

Care and storage of food.

Fire precautions.

General care of patients and nursing procedures

Reception, identification and admission of patients.

Reception of relatives.

Transfer and discharge of patients.

Recording of necessary particulars.

Care of patients' clothing and property.

Observing and reporting on the general condition and behaviour of patients.

Responsibility for the general cleanliness and hygiene of patients.

Bed and cot making with modification of method for special conditions.

Methods of warming the bed.

Moving and lifting patients, helping patients to get in and out of bed.

Relief of pressure and prevention of skin abrasions.

Care of patients confined to bed.

Bathing and feeding of infants.

Care of ambulant patients.

Serving meals and feeding patients.

Measuring and recording fluid intake and output.
Taking and charting the temperature, pulse, respiration and blood pressure.
Recording weight and height.
Giving and receiving reports.
Observing and reporting on sputum, vomit, urine and faeces.
Disposal and/or disinfection of sputum, vomit, urine and faeces.
Care of infested patients.
Care of patients requiring isolation.
Care of incontinent patients and prevention of incontinence.
Care of patients in plaster or on traction.
Care of unconscious patients.
Care of paralysed patients.
Care of the dying and of the bereaved.
Lost offices.
Care of patients before and after anaesthesia.
General pre- and post-operative nursing care.
Principles of asepsis, sterilisation and disinfection.
Aseptic technique.
Conduct of surgical dressings and other sterile procedures.
Methods of securing dressings.
Methods of disposal of soiled dressings.
Administration of oxygen and other inhalations.
Nursing of patients requiring assisted respiration.
Intravenous, subcutaneous and other parenteral infusions.
Artificial feeding.
Peritoneal dialysis.
Gastric aspiration and washout.
Preparation and administration of enemas and suppositories; passing of a rectus tube; rectal washout.
Vaginal irrigation; perineal care; insertion of pessaries.
Catheterisation, irrigation and drainage of urinary bladder.
Treatment of the eye; bathing, irrigation, instillation of drops, application of ointments and dressings.
Treatment of the ear; swabbing, instillation of drops, insufflation, syringing, application of ointments and dressings.
Treatment of the mouth, nose and throat.
Uses and application of heat, cold, medicated preparations.
Care of patients with pyrexia and hypothermia.
Principles and methods of treatment by baths and sponging.

Human behaviour in relation to illness
Preparation of patients for coming to hospital as in-patients or out-patients.
Effects on patients and their relatives of coming to hospital.

The nurse-patient relationship.
The nurse-relative relationship.
Visiting of patients in hospital.
Family participation in care.
Relationship between emotional status and physical conditions.
Death and bereavement.

Administration and storage of drugs

Requirements under current legislation.
Weights and measures.
Rules for the storage of drugs.
Rules for and methods of administration of drugs.

Tests and investigations

Collection of specimens of sputum, vomit, urine, faeces and discharges.
Urine testing.

Preparation and care of patients and preparation of apparatus for:—

- (a) Examination of ear, eye, nose, mouth, throat; of respiratory, alimentary, urinary and genital tracts; neurological examination; x-ray examinations;
- (b) Procedures including the examination of body fluids, gastric analysis, renal and liver efficiency tests, investigation of endocrine activity; biopsies, venepuncture; lumbar puncture; cloacal puncture; bone marrow puncture; aspiration of the pleural cavity and drainage of the peritoneal cavity.

Nursing care in the operating theatre

Observation and care of patients during anaesthesia and immediate after care.
Safe care of the patient in the operating theatre.

First aid and treatment in emergencies

Aims and principles of first aid treatment.
Improvisation of equipment.
Methods of moving and carrying injured persons.
Resuscitation.
Haemorrhage.
Shock.
Asphyxia.
Fractures.
Bites and stings.
Burns and scalds.
Poisoning.
Fits.
Emergencies, e.g. fire and accidents in the ward.

Preparation for professional responsibility

Skills of communication, organisation of care and the elementary principles and skills of learning and teaching.

An introduction to personnel policies and employment legislation.

Appreciation of nursing research.

II. STUDY OF MAN AND HIS ENVIRONMENT

Normal growth and development of the human individual, physical and mental.

General structure of the body in relation to function; how the body works.

The skeleton and its functions. How joints and muscles function.

Exercise, fatigue, relaxation and recreation.

Need for oxygen and supply to the tissues.

Basic dietary requirements; the use of food and fluid.

The circulation of the blood; the functions of lymph and tissue fluid.

Heat regulation; clothing.

Elimination of waste products.

Reproduction.

Control of activity by the nervous system and hormones; rest and sleep.

The appreciation of environment; the senses of sight, hearing, smell, taste and touch.

Development of mind and personality.

The basis of health.

Family relationships and security. Social and cultural influences on the development of the individual during infancy and pre-school years. The importance of play and leisure activities.

Social development at school, during puberty and adolescence, at work, in courtship, marriage, and parenthood. How communities are formed.

Differences in urban and rural life. Personal and interpersonal behaviour in groups. Influences of group membership in social and institutional life.

Maturity. Re-adjustments needed in middle age and old age.

Effect of the environment on health.

Provision of a safe environment.

Personal responsibilities for health.

III. THE NATURE AND CAUSES OF ILL-HEALTH: PRINCIPLES OF PREVENTION: NURSING CARE AND TREATMENT OF SICK PEOPLE

The nature and causes of ill-health

The following headings set out in the broadest terms an approach to the study of the nature and causes of ill-health and can be applied to the study of all types of conditions, general and specialised, affecting all age groups.

Congenital abnormalities, inherited and acquired, physical and mental.

Nutritional disorders; deficiencies or excesses in diet; failure in absorption.

Metabolic and endocrine dysfunction.

The inflammatory response: local and general effects.

Infections: types of organisms; pathways of spread; specific infections. Immunity.

Allergy: auto-immune phenomena.

Emotional stresses.

Trauma: types of injury including non-accidental and self-inflicted; processes of healing.

Poisoning and self-poisoning.

New growths: types and characteristics.

Degenerative conditions.

Conditions of undetermined cause.

The promotion and maintenance of health

Factors contributing to the maintenance of health, including health education.

Personnel contributing to the maintenance of health and co-ordination of the health care and other services.

Factors contributing to the breakdown in health.

The influence of the patient's cultural, home and economic background in the prevention of ill-health and as an associated cause of disease.

Nursing care and treatment of sick people

The nursing care of patients should be studied and practised in the sequence of the nursing process:—

Observation of the patient in his total environment.

Assessment of need.

Making a plan of care.

Giving care.

Evaluating the effectiveness/suitability of care.

Ability to interpret the observations made, to understand the significance of disturbed function and to know the pattern of defined diseases and the patient's response to treatment will be part of the equipment needed to carry out the nursing process intelligently. The following headings may be useful in this context, applied to any condition from which the patient may be suffering:—

Relevant knowledge of normal function and structure.

Causes of the disease.

Symptoms and well-known signs.

Reasons for and methods of investigation.

Normal course of illness; possible complications.

Medical treatment.

Social aspects; convalescence and rehabilitation.

SYLLABUS FOR ADMISSION TO THE GENERAL PART OF THE ROLL OF NURSES

I. PRINCIPLES AND PRACTICE OF NURSING INCLUDING FIRST AID

Introduction

Outline of the history of nursing as a background to the present day.
Outline of the Health Service.
The Health Area/District; hospital and community services and relationship with social services.
Personal qualities, beliefs and attitudes of the nurse.
Code of professional practice.
Relationship between the nurse, patients and relatives.
The place of the nurse in the hospital team, relationship with medical staff and other health workers.

General care of the ward unit

Plan of patients' day.
Organisation of ward routine.
Ventilation, heating and lighting.
Reduction of noise.
Cleanliness of the ward as it affects the safety and comfort of patients.
Prevention of spread of infection.
Care of linen, disposal of soiled and infected linen.
Storage and custody of drugs.
Storage and preparation of lotions and poisonous substances.
Care and use of equipment.
Care and storage of food.
Fire precautions.

General care of patients and nursing procedures

Reception, identification and admission of patients.
Reception of relatives.
Transfer and discharge of patients.
Recording of necessary particulars.
Care of patients' clothing and property.
Observing and reporting on the general condition and behaviour of patients.
Responsibility for the general cleanliness and hygiene of patients.
Bed and cot making with modification of method for special conditions.
Methods of warming the bed.
Moving and lifting patients, helping patients to get in and out of bed.
Relief of pressure and prevention of skin abrasions.

Care of patients confined to bed.
 Care of ambulant patients.
 Serving meals and feeding patients.
 Measuring and recording fluid intake and output.
 Taking and charting the temperature, pulse, respiration and blood pressure.
 Recording weight and height.
 Giving and receiving reports.
 Observing and reporting on sputum, vomit, urine and faeces.
 Disposal and/or disinfection of sputum, vomit, urine and faeces.
 Care of infested patients.
 Care of patients requiring isolation.
 Care of incontinent patients and prevention of incontinence.
 Care of patients in plaster or on traction.
 Care of unconscious patients.
 Care of paralysed patients.
 Care of the dying and of the bereaved.
 Last offices.
 Care of patients before and after anaesthesia.
 General pre- and post-operative nursing care.
 Principles of asepsis, sterilisation and disinfection.
 Aseptic technique.
 Conduct of surgical dressings and other sterile procedures.
 Methods of securing dressings.
 Methods of disposal of soiled dressings.
 Administration of oxygen and other inhalations.
 Intravenous, subcutaneous and other parenteral infusions.
 Artificial feeding.
 Gastric aspiration and washout.
 Preparation and administration of enemas and suppositories; passing of
 flatus tube, rectal washout.
 Catheterisation, irrigation and drainage of urinary bladder.
 Uses and application of heat, cold, medicated preparations.
 Care of patients with pyrexia and hypothermia.
 Principles and methods of treatment by baths and sponging.
 Special nursing procedures used in specialist clinical units, depending
 upon experience.

Human behaviour in relation to illness

Preparation of patients for coming to hospital as in-patients or out-patients.
 Effects on patients and their relatives of coming to hospital.
 The nurse-patient relationship.
 The nurse-relative relationship.
 Visiting of patients in hospital.
 Family participation in care.
 Relationship between emotional states and physical conditions.
 Death and bereavement.

Administration and storage of drugs

Requirements under current legislation.
 Weights and measures.
 Rules for the storage of drugs.
 Rules for and methods of administration of drugs.

Tests and investigations

Collection of specimens of sputum, vomit, urine, faeces and discharges.
 Urine testing.
 Preparation and care of patients and preparation of apparatus for:—
 examination of ear, eye, nose, mouth, throat; of respiratory, alimentary,
 urinary and genital tracts; neurological examination; X-ray examinations.

Nursing care in the operating theatre

Observation and care of patients during anaesthesia and immediate after-care.
 Safe care of the patients in the operating theatre.

First aid and treatment in emergencies

Aims and principles of first aid treatment.
 Improvisation of equipment.
 Methods of moving and carrying injured persons.
 Resuscitation.
 Haemorrhage.
 Shock.
 Asphyxia.
 Fractures.
 Bites and stings.
 Burns and scalds.
 Poisoning.
 Fits.
 Emergencies, e.g. fire and accidents in the ward.

II. THE STUDY OF MAN AND HIS ENVIRONMENT

The individual, his development and his relationship with the family and other people.

An elementary knowledge of the human body and its functions.

The basis of health, its promotion and maintenance; personnel contributing to the maintenance of health and the co-ordination between the health care and other services.

**III. CAUSES OF ILL-HEALTH: THE COURSE OF COMMON
ILLNESSES; NURSING CARE AND TREATMENT OF SICK
PEOPLE**

Causes of disease.

Symptoms, signs and methods of investigation.

The course and treatment of common acute and long-term illness.

Nursing care, based on the sequence of the Nursing Process:—

Observation of the patient and his total environment.

Assessment of need.

Making a plan of care.

Giving care.

Evaluation of care.

THE ROYAL COLLEGE OF NURSING

AGREEMENT

and

STANDING ORDERS

for

SISTER TUTORS

Further copies of this leaflet, price 6d., post free, obtainable from: The General Secretary, The Royal College of Nursing, Henrietta Place, Cavendish Square, London, W.1.

INTRODUCTORY

It should be recognized that the Sister Tutor holds an important and responsible position which demands special educational qualifications in addition to wide experience in the practice of nursing. Since the number of women suitable and prepared to hold such a position is likely to be limited, and in order to retain the services of the Sister Tutor in her specialised field, she should be accorded her position as senior educational officer, responsible to the Matron only (as head of the nursing services of the hospital).

The Sister Tutor should have a well-equipped office, and clerical assistance as required. If resident she should have a flat or equivalent accommodation.

While realising that the amount of annual leave is laid down by the national negotiating machinery, it should be recognised that teaching makes particular demands upon the teacher's mental energy and that, therefore, additional leave is advisable. Breaks in the teaching year will be provided by public holidays. Long leave, i.e. three months' leave after each five years of teaching, is of particular benefit.

The Sister Tutor should be given assistants according to the number of nurses under her care. There should be a ratio of one Sister Tutor to every 40 student nurses in training, with a higher proportion of Sister Tutors in the preliminary training schools.

It is appreciated that the following will require adjustment to meet different types of hospitals and Nurse Training schools, but it is recommended that all the points enumerated should, as far as practicable, be embodied in:

(A) THE AGREEMENT

Appointment

The Sister Tutor is appointed on the recommendation of the Matron by the appropriate Board or Committee. The appointment may be terminated at any time by three months' notice on either side or by payment of a quarter's salary in lieu of notice. Salary and conditions of service, shall be as laid down by national machinery. The Sister Tutor shall have the option of retiring from office on reaching the age of 55 years, or at 60 years if she elects to continue under the Local Government Act pensions scheme.

(B) STANDING ORDERS

1. *Responsibilities*

- (a) The Sister Tutor is responsible directly to the Matron^a for the School of Nursing within the hospital. She should have the opportunity of discussing with the Matron the allocation of student nurses to different wards and departments in relation to their practical training.
- (b) It is the duty of the Sister Tutor to see that all student nurses in her charge receive the instruction laid down by the General Nursing Council as necessary for State Registration.
- (c) The Sister Tutor is responsible for the drawing up of the time-tables of lectures and classes.
- (d) The Sister Tutor is responsible for arranging visits of professional interest within and outside the hospital in order to make the nurses' training as comprehensive and practical as possible.
- (e) The Sister Tutor is responsible for the arrangement of all courses of lectures given by the medical staff of the hospital. She should discuss with the lecturers the subject matter to be covered. She is responsible for conducting such tutorials, revision classes and discussions as are required.

^aOr where responsible for male nurses, to the Chief Male Nurse.

- (f) The Sister Tutor is responsible for giving lectures on the theory and practice of nursing throughout the nurses' training. Practical demonstrations and practice classes should be arranged in conjunction with these lectures.

2. *Records of Practical Work*

The Sister Tutor should from time to time examine the records of the teaching done by the Ward Sisters as entered on the nurses' charts of practical experience.

3. *Examinations*

The Sister Tutor is responsible for the preparation of the entry forms for the State examinations, and for keeping a record of attendances at lectures and of examination results. She is also responsible for all nurses' examinations conducted in the hospital.

4. *Committee Work*

The Sister Tutor should be a member of the Education Committee of the Nursing School or other nursing committee responsible for the nurses' education and training, and may act as secretary.

5. *Nurses' Library*

The Sister Tutor should be responsible for the upkeep of the nurses' professional library and should receive an adequate annual grant for this purpose.

6. *Administration*

The Sister Tutor is responsible for the professional and general administration of her department and for keeping the equipment up to date and in accordance with the standards required by the General Nursing Council for use at State examinations.

7. *Co-operation with Ward Sisters*

The Sister Tutor should visit the wards frequently in order to keep her knowledge up to date, and discuss matters of mutual interest with the Ward Sisters.

General

The Sister Tutor should be given the opportunity to attend refresher courses and lectures, and be encouraged to participate in such other activities as may be of advantage in her professional career.

NOVEMBER, 1949.

[P.T.O.]

Job description: E.1
(school of nursing)

Top management

Role: Principal Tutor in *control* of the Teaching Division
Grade: Principal Nursing Officer (Grade 9)
Responsible to: Chief Nursing Officer (Grade 10)
Reports to: Chief Nursing Officer (Grade 10)
Minimal qualifications: Registered on the general part of the Register
 Experience as a Tutor (Grade 7)
 Top-management course.

Functions:

A. Professional

1. Informing the Chief Nursing Officer (Grade 10) of the implications for nurse training of developments in educational methods and in the content of nurse training.
2. Informing the Chief Nursing Officer (Grade 10) on educational methods for in-service training of nursing staff.
3. Participating, as member, in the Nurse Education Committee; and in meetings of officers.
4. Classroom teaching of some subjects in the syllabus.
5. Participating in in-service training.
6. Giving guidance to Senior Tutors (Grade 8) and Tutors (Grade 7) on teaching methods.
7. Publicising nursing as a career.
8. Acting as an examiner in statutory and non-statutory examinations (or as assigned to other tutors).
9. Advising on structural alterations and new building and equipment.

B. Administrative

10. *Controlling staff of the division.*
11. Reporting requirements of staff and teaching equipment.
12. Preparing annual school programmes (study blocks/days, etc.) after consultation with nursing and non-nursing staff outside the school.
13. Organizing the preparation of detailed training programmes (lectures, etc.).
14. Preparing annual estimates for the training school for approval.
15. Organizing the general administration of the school, e.g., library, equipment, arrangements for examinations.
16. [Organizing the obstetric nurse training scheme.]

Job description: E.2
(school of nursing)

Middle management

Role: Senior Tutor
Grade: Senior Nursing Officer (Grade 8)
Responsible to: Principal Tutor (Grade 9)
Reports to: Principal Tutor (Grade 9)
Minimal qualifications: Registered nurse
Experience as Tutor (Grade 7)

Functions:

A. Professional

1. Class room teaching; demonstrating nursing practice both in the training school and in hospital wards and departments; teaching application of theory to practice.
2. Acting as consultant to Tutors (Grade 7) and Clinical Instructors (Grade 6) on implementation of teaching policy.
3. Participating in in-service training.
4. Preparing examinations and tests and assessing results.
5. Participating as member, in the Nurse Education Committee; and in meetings of officers.
6. Publicising nursing as a career.

B. Administrative

7. Co-ordinating the work of Tutors (Grade 7) and Clinical Instructors (Grade 6) teaching a group of subjects.
8. Preparing the detailed training programme for the introductory course and study blocks in consultation with teaching staff, Charge Nurses and others.
9. Undertaking part of the school's administration, e.g., the library, records of student and pupil nurses, arrangements for examinations.
10. [Co-ordinating the activities of nursing and midwifery staff concerned with obstetric nurse training.]
11. Convening meetings of Tutors (Grade 7) and Clinical Instructors (Grade 6) teaching a group of subjects.
12. Reporting to the Principal Tutor (Grade 9) on the possible effects of teaching policy and the results of the teaching programme.
13. [Deputising for the Principal Tutor (Grade 9)].

C. Personnel

14. Participating, as member of selection panel, in the appointment of Tutors (Grade 7).

Job description: E.3
(school of nursing)

Middle management

Role: Tutor
Grade: Nursing Officer (Grade 7)
Responsible to: Principal Tutor (Grade 9)
Reports to: Senior Tutor (Grade 8)

Minimal qualifications: As specified by the General Nursing Council^o

Functions:

A. Professional

1. Classroom teaching; demonstrating nursing practices both in training school and in wards and departments; teaching application of theory to practice.
2. Participating in in-service training.
3. Preparing examinations and tests, and assessing results.
4. Participating [as member, in the Nurse Education Committee and] in meetings of officers.
5. Publicising nursing as a career.

B. Administrative

6. Arranging clinical teaching for student and pupil nurses in consultation with Charge Nurses (Grade 6), medical staff and others.
7. Reporting to the Senior Tutor (Grade 8) and the Principal Tutor (Grade 9) on the possible effects of teaching policy and the results of the teaching programme.

C. Personnel

8. Counselling a group of student and/or pupil nurses throughout their training.
9. Taking all steps possible to safeguard the welfare and safety of student and pupil nurses while they are in training.
10. Discussing the clinical progress of student and pupil nurses with Charge Nurses (Grade 6) and/or Nursing Officers (Grade 7).
11. Reporting on student and pupil nurses to the Senior Tutor (Grade 8) and giving merit-rating to outstanding student nurses according to the established procedure.

^oAt present:—

Registered on general part of the Register.
Experience as a Ward Sister.
Sister Tutor's Diploma.

Job description: E.4
(school of nursing)

First-line management

Role: Clinical Instructor
Grade: Charge Nurse (Grade 6)
Responsible to: Senior Tutor (Grade 8)
Reports to: Senior Tutor (Grade 8)
Minimal qualifications: Registered nurse
 Experience as a Staff Nurse (Grade 5)
 Post-registration course in clinical teaching

Functions:

A. Professional

1. Instructing student and pupil nurses, in conjunction with Charge Nurse (Grade 6) in *units*, in accordance with the programme.
2. Participating in in-service training.
3. Assisting with hospital examinations and tests.

B. Administrative

4. Keeping records of student and pupil nurses in the *unit*.

C. Personnel

5. Counselling student and pupil nurses in the *unit*.
6. Reporting on student and pupil nurses to the Senior Tutor (Grade 8).

EXTRACTS FROM THE CATALOGUING OF CONCEPT CATEGORIES
DURING ANALYSIS OF LITERATURE ABSTRACTS.

- A.**
- ① AUTHORITY & RANK
 - ② ANXIETY IN STUDENT MINDS
 - ③ AUTHORITY & RANK. CONTD

- B**
- ① BETTER STUDENTS
 - ② BEST TEACHERS ON WARD - PARENTS
 - ③ BEST WARD

- C**
- ① CURRICULUM QUALITY & EFFECTS
 - ② COMMUNICATION OF WARD
 - ③ CHANGE

- ① DECISION MAKING.

D

- E**
- ① ENVIRONMENT — WARD LEARNING
 - ② EXAMINATIONS -
 - ③ EFFECTS OF TRAINING IN TOTAL.

F

- ① FORMAL TEACHING - ON WARDS

- ① GRADUS OF TEACHING

G

- H**
- ① HELP & EMOTIONAL SUPPORT IN DIFFICULTY

EXTRACTS FROM THE CATALOGUING OF CONCEPT CATEGORIES
DURING ANALYSIS OF LITERATURE ABSTRACTS
 (Continued)

ENVIRONMENT - WARD LEARNING.

WARD MOST IMPORTANT LEARNING EXPERIENCE (REVANS 1964)
 STUDENTS OFTEN TRANS FROM WARD TO WARD (OPPENHEIM 1955)
 TEACHERS APPROVING OF THE PRACTICAL RESULTS OF
 THEIR TRAINING. (BRIGGS 1972)
 PRACTICE ASSISTANCE A FORCE ACTIVE NOT DONE IN REALITY (1963)
 78% RESPONDENT SAID MAIN OVER OF TRAINING SHOWED THE PRACTICE ON
 WARD. (LAWSON 1974)
 EXPERIENCES WHICH THEY FOUND MOST BENEFICIAL WERE WARD TEACHING
 AND SPECIAL EXPERIENCES (1974 RICKS)
 STUDENTS CAME TO ACCEPT DEVIATIONS WHICH WERE NOTED ON
 WARD & TO INCLUDE THE WARD AS MORE SIGNIFICANT
 TO THEM THAN THE SCHOOL OF NURSING (PEPPER)
 STUDENTS SAID THEY LEARNING MORE ON WARD THAN THEY DID
 IN COLLEGE (ALEXANDER)
 CLINICAL AREAS CAUSE AROUND CROWDING STRESS (AMMER)
 CLEAR EVIDENCE THAT WARD-BASED TEACHING & LEARNING IS
 IMPORTANT TO STUDENTS. (ALEX 1977)
 77% SAID THEY LEARNING MORE ~~ON~~ ON WARD THAN THEY DID
 IN COLLEGE (ALEX)
 LEARNING ABOUT WARD METHODS BY 8TH WEEK GOTT (1982)
 (NOT ASSESS
 4TH 77)
 FURTHER - LEARNING SYSTEMS & STAFF DID NOT TRAIN WITHIN

E
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X
Y

INTERVIEW PROFILE FOR EXPLORATORY INTERVIEWS.

EXPECTATIONS	Occupational values - needs met by occupation Occupational stereotypes - image of nurses
SCHOOL V. WARD CONFLICT	Values of tutors and ward sisters Gap between theory and practice Idealism v reality Animosity and misunderstandings
RELATIONSHIPS WITH TRAINED STAFF	Guarded or open responses of staff Approachability of trained staff Ambiguity between friendly and status responses of trained staff
LEARNING AND TEACHING ON WARD.	Amount of guidance - supervised or trial and error learning Commitment to teaching/providing learning situations Assumptions about learners ability/capability Response of staff to questioning
PERSONAL/EMOTIONAL NEEDS	Recognition as a person or non-person Need for feedback/praise/encouragement Availability of help for personal problems
STRESS AREAS AND FEARS	Death and dying Distressing incidents Harmony/conflict in other team members (between)
ATTITUDES TO PATIENT CARE	Patient or staff oriented nursing team Patient or task oriented nursing team Quality of nursing care
WARD SISTER	Authoritarian /didactic leadership Involvement in practical work or office work Being rebuked, humiliated, reprimanded in public Attitude to change/innovation
TUTORIAL SUPPORT	
INTROSPECTIVE INFORMATION	Students emotional responses Self concept/image Values attitudes

OPINION SURVEY

INTRODUCTORY COMMENTS AND SET QUESTIONS (Pilot study)

INTRODUCTORY COMMENTS TO GROUP AS A WHOLE.

I am Peter French I am a nurse tutor at Darlington Memorial Hospital.

I am doing a course with Durham University and I need the help of just two of you, one resident and one non resident to find out some information.

All I want to do is have an informal talk for about half an hour on what its like to be a first year student nurse, and if you are all willing to help I will draw two names out of a hat.

Is that OK, do you want to ask me anything?

The interviews will be at(time) and in room..... (description of room)

Before I draw the names out of the hat can I just say that I will want to tape the interview only because I won't be able to remember all that you have said. I won't be writing your name down and as soon as I have written down what is on the tape I will erase it because I need it for the next people I interview (or to tape top of the pops).

INTERVIEW : STUDENT NURSES OPINIONS DURING FIRST YEAR OF TRAINING.

INTRODUCTORY COMMENTS AND SET QUESTIONS.

I am studying with Durham University and I have to do a project on some aspect of nurse training. I have become interested in what it feels like to be a student nurse nowadays. It has been a long time since I was a student nurse and there have been many changes since then.

One of the problems I have when wanting to help my students is that I have a different idea of what its like to be a student nurse in comparison with thier ideas. It is difficult for me to ask my own students because they may not be completely honest or they may worry simply because I am thier tutor. So I was hoping that you would be able to help by giving me an honest opinion and the benefit of your experience.

I have read a lot of articles on this subject to see if I can learn more about what its like to be a student nurse but the papers I have read all seem to give too many different and confusing descriptions. I have decided that the best way to find out is to ask the students themselves.

When I was a student we used to talk about all sorts of things to do with our training and experience, usually when we came into block, during coffee breaks or with our friends in the nurses home. Does that sort of thing still happen? (Allow student to talk and listen)

Sometimes we were really impressed with something or really disliked other things. There was some similarity in what some of us said and sometimes there were students who felt differently about various issues. Do you find that this still happens? (Allow student to talk and listen)

(Ask the following questions and record responses)

1. What would you say are the things which affect the students most in the first year?
2. I tend to think some students find that nursing is what they expected it to be, others don't. What do you and your friends say about this?
3. I know that some students seem to prefer medical wards and others surgical wards. What difference did you find between the medical and surgical wards you were on?
4. Some of my students like coming into the school for blocks, some dread it, What do you and your fellow students say about this?

All questions will be followed up by open ended probing questions or suitable encouragement to carry on talking.

Appendix A.V

OPINION SURVEY.

INTRODUCTORY COMMENTS TO POTENTIAL SUBJECTS (FIELDWORK)

My name is Peter and I am a Nurse Tutor at Darlington Memorial Hospital in County Durham. I am doing a course with Durham University and I'm here to ask for your help.

I have to do a project on some aspect of Nurse Education using research methods.

When I had to choose my topic it just so happened that I had had a lot of chats with my students. I realised that life as a student nurse had not changed much since I was a student twelve years ago.

I decided to find out what the journals and books said on the subject and found that they were either too old or said conflicting things

I thought that the best way to find out what were the most important things about the first year of training was to ask the students themselves.

I could have asked my own students but I thought they would be worried about being honest, so I decided to go round other Schools of Nursing

I was hoping that I could speak to just two of you, seperately for about half an hour.

All you have to do is give me your own opinions , what ever you say will be of help to me. You dont have to worry about saying the right thing or saying what I want. What ever you say is important. It really is easy.

Do you want to ask any questions? (take time answering them)

If you are all willing to help I will draw two names out of the hat. Please write your name on one of these pieces of paper and put it in the hat.

Has anybody left the group since you started training? (record)

DRAW NAMES OUT OF HAT - ASK TWO OF THE STUDENTS NEAR FRONT TO DO THIS.

The interviews will be in room who wants to be first.

I will just see that the room is ready and I will come along and collect you.

OPINION SURVEYEXPLANATORY COMMENTS AND SET QUESTIONS (FIELDWORK)

As I have said in the classroom I am doing a project on some aspect of nurse training. I have become interested in what it feels like to be a student nowadays. It has been a long time since I was a student nurse and there have been many changes since then.

One of the problems I have with my students is that I am sure I have a different idea of what its like to be a student.

It is difficult for me to ask them because they may not be completely honest with me.

So I was hoping that you would be able to help by giving me an honest opinion and the benefit of your experience.

When I was a student we used to talk about all sorts of things to do with our training and experience, usually when we came into block, during coffee breaks or with our friends in the nurses home.

Does that sort of thing still happen? (Allow student to talk and listen)

Sometimes we were really impressed with something or really disliked other things. There was some similarity in what some of us said and sometimes there were students who felt differently about various issues. Do you find that you all do this? (Allow student to talk and listen)

(BEGIN WITH QUESTION ONE ON EVERY OCCASION)

1. What would you say things which the students find most memorable or significant in the first year?
2. I tend to find that some students find that nursing is what they expected it to be, others don't. What do you and your friends say about this?
3. I know that some students seem to prefer medical wards and others surgical wards. What differences do you all find between the medical and surgical wards you were on?
4. Some of my students like coming into the school for blocks, some dread it. What do you and your fellow students say about this?

CONTENT ANALYSIS OF OPEN QUESTIONSRULES OF ANALYSIS

1. Only nouns and pronouns will be identified in the analysis. Of the nouns, only common, proper and collective nouns will be used in the analysis. Each will be underlined on the transcript.
2. Where proper nouns and pronouns are used the analyst (marker) will infer the target collective or common noun from the surrounding dialogue and sentence structure.
3. When a noun/pronoun is identified the marker will look down the list of categories and give a check mark to the category which reasonably applies.
4. When 'I' is identified it should only be check marked when the person is referring to themselves in the context of a particular incident rather than when an opinion is being expressed.

Categories include :-

- (a) I/me/my/self
 - (b) One/you (Colloquial)
 - (c) I mean/ I think/ I know
5. Ignore 'you know' statements. They refer to the interviewer and are habits in speech.
 6. Quotations from others will be ignored.

EXAMPLE OF TRANSCRIPTED INTERVIEW.

INTERVIEW 27 (Lives in)

IF YOU JUST THINK BACK OVER THE PAST YEAR, WHAT HAVE BEEN THE MOST SIGNIFICANT OR MOST IMPORTANT THINGS YOU CAN REMEMBER?

Well the first ward either junior surgery or junior medicine, so we just were general right! And we've done night duty (pause). Myself I like medicine better. I don't know why it just seemed more hectic than the surgical side theres nothing really.

AD Theres one girl she's left now, one of the reasons she left, like the hierarchy attitudes of the nursing staff. 'Cause on a lot of the wards you can't really approach the ones in the blue dresses very well. I mean some of them are approachable but others, you know the sort, they snap answers back at you, sort of thing, and also she said she didn't like the attitudes of, like, some of the nursesto the patients. Like, she worked with one nurse, it was a surgical ward, and there was this old lady and she arrested and died. An old lady and she didn't like the way she was handling the woman. Washing her and things. AG. Its just generally she didn't like the way that nursing changed AM people, er, and it does seem to be that nurses seem to fall into one category of type of person, mm mm , when they've finished.

AG I mean there's a difference on the ward, I mean, some staff will help you to learn. I mean, like, the ward I've just been on there was one Sister obviously she knew a lot herself and she was very helpful in answering questions and things. And then its just a lot of staff. There's the difference between some who will help and those who just won't.

H Theres nothing on the ward thats specifically stood out. Theres some you can tell, theres some Sisters aren't very good at organising the ward, but then you have to think what type of ward it is because I think there'd be differences in organising surgical wards. We've only been on one surgical ward, but it was very hectic and everybody was just doing bits, you didn't know what. It wasn't very well organised, really, it was very busy, so that might have been a factor affecting it. So I've only been on, so the first ward I've been on was classed like a medical ward, but it was like geriatrics. They were all over 65 and the last ward I was on was very involved in diabetes, like, I think I've enjoyed the medical wards best.

Erm CAN WE JUST TALK A LITTLE BIT MORE ABOUT THE MEDICAL AND SURGICAL WARDS etc. etc. etc.

RECORDING SHEET - CONTENT ANALYSIS OF INTERVIEWS

[illegible]

SUMMARY SHEET - CONTENT ANALYSIS OF INTERVIEWS

RESPONDENT CATEGORY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	TOTAL
I/ME/ MY/ SELF	2	83	58	31	49	37	31	51	13	1	6	6	1	20	8	7	2	37	28	40	14	16	4	9	55	10	15	6	640
YOU/ YOUR (ONE)	17	4	9	1	6	21	39	25	17	10	2	3	4	18	17	31	4	19	25	8	25	55	2	16	6	6	3	4	397
PATIENTS	0	1	17	12	1	0	25	9	1	0	0	1	0	0	0	3	1	0	4	4	2	1	2	14	0	0	13	1	102
TERMINAL STAFF/ THE STAFF	2	8	12	2	7	1	23	15	3	5	2	5	1	1	10	6	1	7	6	10	0	9	6	0	0	4	5	5	156
SISTER	0	2	0	0	1	1	20	4	5	0	2	5	0	0	1	3	0	4	0	0	0	0	3	0	1	0	10	0	62
STAFF NURSE	4	0	2	0	1	0	7	0	9	0	0	4	0	0	0	6	0	13	1	0	0	0	1	2	0	0	0	0	50
ENROLLED NURSE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ASSISTANT/ NURSE	0	0	0	0	0	0	4	0	1	0	0	0	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	0	12
STUDENTS/ PERS/ US/ ME	9	23	23	2	9	0	51	18	7	1	0	1	3	13	22	8	0	11	5	8	4	2	11	8	4	0	10	0	253
OWN FAMILY/ FRIENDS	0	0	3	0	10	1	0	2	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	17
PT'S FAMILY/ FRIENDS	0	0	3	7	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11
DOCTOR	0	4	0	0	0	0	1	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	12
TUTOR/ CLIN. TEACHER	1	0	0	0	1	0	12	0	0	0	0	0	1	4	1	1	0	0	0	0	3	4	0	0	0	0	0	0	28
NURSING OFFICER/ NUR	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	2
NURSES/ NURSE NURSE	0	1	0	1	0	0	2	0	0	0	0	0	0	3	0	0	0	0	0	0	1	0	0	0	3	0	3	0	14
THEY NON SPEC	2	3	1	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	8
OTHERS/ NON SPEC	0	4	4	1	8	5	10	9	1	0	0	0	0	2	3	1	0	4	4	3	3	5	1	8	5	0	3	0	84
HOSPITAL/ S	1	11	5	0	0	3	0	1	0	0	0	0	0	0	1	0	0	0	0	2	0	0	12	1	5	0	0	0	42
WARD	5	5	2	1	5	3	15	12	10	4	1	6	3	4	5	7	1	12	9	3	2	7	3	0	6	14	17	2	154
HOME	0	1	0	0	2	5	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	2	0	0	0	14
NURSES HOME	0	0	0	0	2	5	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	1	0	4	0	0	0	0	16
SCHOOL OF NURSING	0	0	0	0	0	0	2	7	0	2	0	0	1	4	0	3	1	0	3	0	3	6	0	0	0	0	0	0	32
EXAM/ TEST/ ASSESSMENTS	0	0	1	0	7	0	1	0	0	0	0	0	0	1	1	0	1	0	0	0	2	3	0	0	2	1	0	0	20
HOLIDAYS	0	0	0	0	0	4	1	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9
ITEMS OF EQUIPMENT	0	3	0	3	0	0	4	1	1	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	14
PAY/ SALARY/ MONEY	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	2
THEATRE	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
DRUGS/ DRUGS AND	0	3	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8
INTRODUCTORY COURSE	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	2	0	0	0	0	0	0	4
OTHER NON SPEC UNCLASSIFIED	0	2	4	1	3	9	18	9	6	7	1	4	2	9	3	10	0	14	8	4	3	19	6	0	10	2	0	2	156

STRUCTURAL ANALYSIS OF TRANSCRIPTS.Method of Analysis

1. Read through transcripts
2. Record content of main topic of conversation on recordsheet.
3. Label each topic of conversation with a letter of the alphabet = concept letter.
4. Enter on the record sheet the transcript number next to the concept category.
5. Utilise concept letter to identify statement on the transcript by marking in green pencil.
6. Enter repeated topics of conversation found in subsequent transcripts under similar concept headings utilising the same identifying concept letter.
7. Read through the record sheet and count the number of transcripts mentioning each concept.
8. Transfer the concepts mentioned by 20% or more subjects to honeycomb shaped boxes drawn on a sheet of paper, at the same time transferring alphabet labels so as to locate concept statements in transcripts.
9. Identify topics mentioned less frequently (by less than 20% of subjects but more than 2 transcripts) and enter in an already identified honeycomb if relevant. If not do not begin a new honeycomb.

See appendix XVI for examples of use of concept identification letter.

See following page for examples of record sheet.

STRUCTURAL ANALYSIS OF TRANSCRIPTSExamples of Concept Recording Sheet.

CONCEPT NOTES	TRANSCRIPT ORIGIN
<p>A</p> <p>Going on a different ward Changing wards - starting again</p>	<p>1, 2, 3, 8, 19, 22, 23,</p> <p>(7)</p>
<p>B</p> <p>Doing jobs not prepared for or shouldn't be doing.</p> <p>Not prepared for ward work</p>	<p>1,</p> <p>2</p> <p>9,</p>
<p>C</p> <p>You don't argue with staff nurse. Treading carefully. Bossy auxilliaries. Doing as your told.</p>	<p>1,</p> <p>3,</p> <p>4</p> <p>7,</p> <p>8,</p>
<p>D</p> <p>Getting labelled - the travelling label. Reputation going before you.</p>	<p>1, 3,</p> <p>2</p>
<p>E</p> <p>Ward differences - criteria Staff like to teach/teaching ops Boredom Insufficient work Not doing enough to learn Getting on with staff</p>	<p>4, 7, 8, 16, 15, 24, 26,</p> <p>2, 16,</p> <p>2,</p> <p>2,</p> <p>5, 6, 12, 17, 23, 28,</p> <p>(14)</p>
<p>F</p> <p>Coming into school Group identity /split up in clinical practice, like to see each other. Boring Not related to patients Very relaxed good attitudes. Stressful, forget school</p>	<p>5, 8, 16,</p> <p>16,</p> <p>16,</p> <p>19,</p> <p>21,</p> <p>5</p>

A PORTION OF THE RECORD OF STRUCTURAL ANALYSIS
OF GUIDED RESPONSES.



SENTENCES USED TO TRANSMIT HSO INDICATORS.Indicator
code letter

- A Teaching is an important part of our job
- B I'll show you our teaching plan sometime later today.
- C Your first concern here is to learn whilst you gain work experience.
- D Its important to see that your patients are comfortable and everything is done for them. That is why we give you a group of patients to look after.
- E Staff Allison work with Nurse Green, Nurse Evans work with Nurse Brown.
This is Nurse Green everybody. Do you know everybody else?
- F Hello Nurse Green come into the office for report.
- H We've had a rough day yesterday and it's just as well the students were so good when we are so short staffed.
- G Nurse Brown saw 5 endoscopies yesterday afternoon she was very good.
- I Keep asking questions like that. We are only too happy to answer question, its the only way to learn more.
- J Thats a good question. Well, people with severe cholecystitis need to rest the gall bladder and when he eats fat, the gall bladder pushes its contents into the intestine. Too much fat makes these patients vomit as well. Do you see now?
- K If you have any personal problems or worries, see me and say something, even if I look busy.
- L If you need help with something you can't do don't be afraid to ask me or the senior staff to help you.

- M Miss Telford, the unit Nursing Officer, has asked us Sisters to make sure that all nurses stop wearing jewelry, particularly ear rings. I think this is important because professional dress gives some patients more confidence in us, and the relatives as well. It has no use at work anyway. Don't you think so?
- N I will work with Nurse Smithers to look after the other patients
- O Mr Turner is very depressed today I'm worried about him. If any of you new students have any ideas about what we can do don't be afraid to say. We are all part of a team here.

SENTENCES USED TO TRANSMIT LSO INDICATORS

- A We haven't got time on this ward to do a lot of teaching.
- B The clinical teacher will tell you what you have to learn on the ward.
- C Remember that your main responsibility is to get the work done.
- D We like to make sure that all the main jobs are done before we do the nursing process.
- E Staff will you prep. the endoscopies. Enrolled Nurse, you do the medicine rounds and observations.
- F You must be the new first year. Go into the office for report.
- H We had a rough day yesterday and having so many student nurses on didn't help matters much, when we are so short staffed. The place was pandemonium when Nurse Brown was doing the endoscopies.
- G You'll have to do better today
- I We normally like to get through the report, so it's best if you save your questions until later.

- J At your stage of training, I would expect you to know that people with cholecystitis don't tolerate fat. It would be a good exercise if you looked it up and told us the answer in the report tomorrow.
- K Remember that a good nurse should learn not to bring her personal problems to work with her.
- L If you have any problems see your Tutor.
- M Miss Telford, the unit nursing officer, has asked us Sisters to make sure that all nurses stop wearing jewelry, particularly ear rings. So I'm telling you now and if anybody doesn't conform, then they will be for the high jump. You've been warned.
- N I have a lot of paper work to do, so ask Staff if you want anything.
- O Mr Turner is very depressed. It is very important to get him to do what you want.

WARD TEACHING BEHAVIOURS VIDEO PRESENTATION

H.S.O. SCRIPT

nce 1
Summoning)

FILM NEW NURSE ENTERING WARD AND STANDING IN CORRIDOR.

SISTER EMERGES FROM OFFICE AND CALLS NURSES FOR REPORT.

Sister Is everybody ready for the report?

SISTER NOTICES THE NEW STUDENT NURSE GREEN WHO IS STANDING
IN THE CORRIDOR, LOOKING APPREHENSIVE. SISTER TAKES NEW
NURSE INTO OFFICE AND SAYS BEFORE ENTERING OFFICE -

nce 2
New Nurse
ng)

Sister Hello, you must be Nurse Green. I am
Sister GIVE OWN NAME Come into the office
and sit down, you must be a little nervous on your
first day.

ALL NURSES ENTER OFFICE AND TAKE UP SEATS.

FILM FADES OUT.

SET UP VIDEO IN OFFICE.

FADE IN.

SCAN ASSEMBLED NURSES AND END FOCUS ON SISTER.

nce 3
Report
minaries)

SISTER MAKES PRELIMINARY COMMENTS TO NURSES - PASSES
TIME OF DAY - WELCOMES NEW STUDENT NURSE BY WAY OF
INTRODUCTION.

SPEAKS TO ALL ASSEMBLED.

Sister It's been a nice morning. Is it warm outside?

THE NURSES CAN ANSWER, WITH NODS AND SINGLE WORD ANSWERS.

Sister We had a rough day yesterday and it's just as well
the Students are so good, when we are so short
staffed. Nurse Brown saw to 5 endoscopies yesterday
afternoon, she was really good.

Oh, this is Nurse Green, everybody. POINTS TO GREEN.

This is staff Allison and Nurse Evans.

POINTS TO STAFF AND ENROLLED NURSE.

SISTER BEGINS TO READ FROM THE KARDEX. READS x 8 PATIENTS.

Script as written on Kardex.

FILM FADES OUT AT END OF 8TH PATIENT.

FADES IN ON A 9TH PATIENT AS THE LAST ONE.

STUDENT NURSE GREEN ASKS SISTER A QUESTION AND SISTER
RESPONDS.

Nurse Green Sister, can I just ask why Mr
can't have a lot of fat in his diet?

Sister That's a good question. Well, people with
severe cholecystitis need to rest the gall
bladder and when he eats fat, the gall bladder
pushes its contents out into the intestine.
Too much fat makes these patients vomit as
well. Do you see now?

Nurse Green Ah, yes.

Sister Keep asking questions like that. We are only
too happy to answer questions, it's the only
way to learn more.

SISTER GIVES INFORMATION ON WARD STATUS AND OTHER INFORMATION.

Sister We have twenty two patients at present, but two of
the endoscopies, Mr Turner and Mr Oliphant, are
going this afternoon. Miss Telford, the Unit Senior
Nurse, has asked us Sisters to make sure that all
nurses stop wearing jewelry, particularly ear-rings.
I think this is important, because professional
dress gives some patients more confidence in us,
and the relatives, as well. It has no use at work
anyway. Don't you think so? Does everyone agree?

ALL SAY YES.

SISTER ALLOCATES WORK TO THE NURSES.

Sister We like to do everything for a group of patients in pairs, whenever possible. (TO NURSE GREEN)
So Staff Allison, will you work with Nurse Green in Rooms 1 and 2? Nurse Evans with Nurse Brown in Rooms 3 and 4, and I will work with Nurse Smithers to look after the rest this afternoon.

Right, I think that's everything.

ALL NURSES GET UP AND LEAVE OFFICE.

Sister Nurse Green, can I speak to you for a moment?

Take a seat here.

NURSE GREEN SITS CLOSE TO DESK.

SISTER SITS AT HER CHAIR.

SISTER BRIEFLY INTERVIEWS NURSE GREEN - GIVES ADVICE ON HER SUBSEQUENT RELATIONSHIP WITH HERSELF AND SENIOR STAFF AND HOW SHE WILL BE ORIENTATED TO WARD.

Sister I'll see you at about 3 o'clock to do your preliminary interview and show you our teaching programme. I think that teaching is an important part of our job and the main reason you're here is to learn.

If you need any help with something you can't do, don't be afraid to ask me or the senior staff to help you.

Oh and by the way, if there's any personal problems or worries, see me and say something, even if I do look too busy.

Just do your best today. Come on and I'll show you round the ward.

BOTH LEAVE THE OFFICE.

WARD TEACHER BEHAVIOURS VIDEO PRESENTATIONL.S.O. SCRIPT

ence 1
Summoning)

FILM NEW NURSE ENTERING WARD AND STANDING IN THE CORRIDOR.

SISTER EMERGES FROM OFFICE AND CALLS NURSES FOR REPORT.

Sister Is everybody ready for the report?

SISTER NOTICES THE NEW STUDENT NURSE GREEN WHO IS STANDING
IN THE CORRIDOR LOOKING APPREHENSIVE. SISTER TAKES NEW
NURSE INTO OFFICE AND SAYS BEFORE ENTERING OFFICE -

ence 2
New Nurse's
ng)

Sister You must be the new first year. Go into the
office for the report.

ALL NURSES ENTER OFFICE AND TAKE UP SEATS.

FILM FADES OUT.

SET UP VIDEO IN OFFICE.

FADE IN.

SCAN ASSEMBLED NURSES AND END FOCUS ON SISTER.

ence 3
Report
minaries)

SISTER MAKES PRELIMINARY COMMENTS TO NURSES, PASSES TIME
OF DAY, WELCOMES NEW STUDENT NURSE, BY WAY OF INTRODUCTION.

SPEAKS DIRECTLY TO STAFF NURSE.

Sister It's been a nice morning. Is it warm outside?

STAFF NURSE CAN ANSWER WITH NOD OR SINGLE WORD ANSWER.

Sister We had a rough day yesterday and having so many junior students on didn't help matters much, when we are so short staffed. The place was pandemonium when Nurse Brown was doing the 5 endoscopies. You'll have to do better than that today.

Oh, this is the new junior nurse. POINTS TO GREEN.
You'll get to know the others later.

SISTER BEGINS TO READ FROM THE KARDEX. READS X 8 PATIENTS.

Script as written on Kardex.

FILM FADES OUT AT END OF 8TH PATIENT.

FADES IN ON A 9TH PATIENT AS THE LAST ONE.

STUDENT NURSE GREEN ASKS SISTER A QUESTION AND SISTER RESPONDS.

Nurse Green Sister, Can I just ask why Mr
can't have a lot of fat in his diet?

Sister At your stage in training, I would expect you to know by now that people with cholecystitis don't tolerate fat. It would be a good exercise if you looked it up and told us the answer in the report tomorrow.

Nurse Green Yes, Sister.

Sister We normally like to get through the report, so
it's best if you save your questions until later.

SISTER GIVES INFORMATION ON WARD STATUS AND OTHER INFORMATION.

Sister We have twenty-two patients at present, but two of
the endoscopies are going this afternoon.

Miss Telford, the Unit Senior Nurse, has asked us
Sisters to make sure that all nurses stop wearing
jewelry, particularly ear-rings. So I'm telling
you now and if anybody doesn't conform, then they
will be for the high jump. You've been warned.

SISTER ALLOCATES WORK TO THE NURSES.

Sister We like everything organised on this ward, so make
sure all the main jobs are done before you do the
nursing process. Staff, will you prep the endoscopies.
Enrolled Nurse, you do the medicine rounds and
observations. The new nurse and Pupil Smithers, do
the back rounds, fluid charts and transfusions.
Brown, will you see to the specimens and the patients
for x-ray this afternoon. I have a lot of paperwork
to do, so ask Staff if you need anything.

Right, I think that's everything.

nce 8
of Report)

ALL NURSES GET UP AND LEAVE OFFICE.

Sister Nurse, wait for a moment. I want a word with you.

NURSE GREEN STANDS CLOSE TO DESK. SISTER STANDS ALSO, ON
OPPOSITE SIDE OF DESK.

nce 9
tionship
ng)

SISTER BRIEFLY INTER NURSE GREEN - GIVES ADVICE ON HER
SUBSEQUENT RELATIONSHIP WITH HERSELF AND SENIOR STAFF
AND HOW SHE WILL BE ORIENTATED TO WARD.

Sister I'll see you sometime this week about your
preliminary interview. The clinical tutor will
tell you what you have to learn on the ward.
We haven't time on this ward to do a lot of
teaching. Anyway, that's what the tutors are
paid for.

Remember that you main responsibility is to get
the work done and if there is any time spare you
can get your books out.

Oh and by the way, I've noticed that some students
lately have had personal problems which they bring
to work with them. If you have problems, see your
tutor and please remember that a good nurse should

learn not to bring her personal problems to work
with her.

Right, if you get on with your work now, you'll soon
find your way around the ward.

NURSE GREEN LEAVES THE OFFICE.

NURSING ASSESSMENT

Appendix XXI II

CAPTIONING SEQUENCE FOR VIDEO PRODUCTION

<u>Caption Number.</u>	<u>Content.</u>	<u>Print Colour.</u>
1.	In this film you will see Ann Green	Blue
Exerpt.	(Ann Green standing in ward corridor)	
2.	She is a first year student nurse...	Blue
3.	and you will see her begin duty on a new ward	Blue
4.	She will be taking her first ward report	Blue
5.	from the Sister who is in charge of the ward	Blue
Exerpt.	(Sister in ward report session.)	
6.	This is a general medical ward.....	Green
7.	it deals with a lot of gastro- intestinal conditions.	Green
8.	Some of the patients have cancer	Green
9.	They also prepare patients for endoscopy.....	Green
10.	under general anaesthetic	Green
Exerpt.	(Patients in a four bedded room)	
11.	As you watch Nurse Green	White
12.	Ask yourself what she might think of the Sister	White
13.	What sort of person does she think that she has to work with?	White
Pause	(5 seconds blackout)	

CAPTIONING SEQUENCE Continued.

<u>Caption Number.</u>	<u>Content.</u>	<u>Print Colour.</u>
14.	During the report write some notes...	Red
15.	as if you were going to work on the ward as well.	Red
16.	You can use these notes to answer some questions	Red
17.	from eight patients who will be mentioned in the report	Red
Pause	(8 seconds blackout)	

VIDEO BEGINS.

PLEASE READ THIS SHEET CAREFULLY

Dear

Thank you very much for agreeing to help me with my work for a course I am doing with Durham University.

At this point in my studies I have to work out a framework for questions which could be used to measure attitudes. I want you to help me by judging my questions.

On the following pages you will find some questions which are the sort of questions a patient might ask a nurse. Following each of the questions you will find four things that the nurse might say. These things also indicate what the nurse will do.

Remember I am not interested in what you think is the best thing to do. You are not being tested. I just want you to give your opinion on how much each option shows a concern for the patient and his needs.

For each of the four options following the question please circle the number which indicates how far you think the option shows concern for the patient. Do not circle the No or Yes. If for instance you wanted to say very definitely, no, then circle the number 1.

Your responses should be recorded like the example given below.

Nurse can I have a blanket over my shoulders? The porter is taking me to X-ray and its cold.

Shows concern
for patient?

- | | | | | | | | |
|--|----|---|---|---|---|---|-----|
| - We can't really let linen leave the ward, ask the porter if he has anything. | No | 1 | 2 | 3 | 4 | 5 | Yes |
| - I'll see if we can use one from your bed and you can have a clean one later. | No | 1 | 2 | 3 | 4 | 5 | Yes |
| - Sister doesn't like patients wearing blankets but I'll get your scarf if you want. | No | 1 | 2 | 3 | 4 | 5 | Yes |
| - If I were you I would leave it, you'll soon be in X-ray and its warm down there. | No | 1 | 2 | 3 | 4 | 5 | Yes |

When you do this exercise please do not discuss it with anybody else I want your unadulterated opinion.

Nurse, I've forgotten to fill in the record of my bowel motions today and I can't remember exactly when I went. What can I do?

Shows concern
for patient ?

- I'll fill it in for you before sister finds out she'll go mad.
- Come on I'll help you fill it in as best we can, don't worry its no problem.
- Well I wasn't here so I can't fill it in for you, just do your best.
- I had better report this to sister so that she can decide what to do.

No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes

Nurse my wife has just told me that Bob, my oldest son, has travelled from London today to see me he has just arrived. Can he come in and stay for a while? I know visiting time is over.

Shows concern
for patient ?

- I'll go and get staff nurse she had better decide. I can't say.
- No sister will go mad, he'll have to stay for just ten minutes.
- That should be O.K. I'll pull the screens so that your not disturbed.
- I dare not say you had better ask somebody more senior in a minute.

No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes

Nurse, can I lay on my side for a moment. It eases the pain and I would rather not have my injection.

Shows concern
for patient ?

- I would advise you to have your injection if its time for it. Just relax I'll get it for you.
- Sister said you must sit up for your breathing. If it hurts you'll have to ask for your injection.
- I don't think that will help, I'll go and find the doctor to see if he can speak to you.
- Yes that will be better for you than an injection, but don't be afraid to let me know if it doesn't help.

No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes

Nurse, I know I'm supposed to stay in bed, but can you help sit me on the edge of the bed to pass water. My insides are bursting I can't wait.

Shows concern
for patient ?

- Come on sit on the edge of the bed before it gets any worse. It must feel terrible.
- Well I think I saw doctor on the ward. I'll ask him what he thinks. Just hang on.
- No you'll have to keep trying with a urinal. I've been told by sister that you have to stay in bed.
- Look don't worry if you wet the bed we don't mind cleaning it up. That's what we are here for.

No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes

5. Nurse this oxygen mask is suffocating me can I leave it off for a minute or two? It really is driving me mad.

Shows concern for patient ?

No 1 2 3 4 5 Yes
- I'll go and report this to sister so she can tell the doctor.

No 1 2 3 4 5 Yes
- Sister has said that you must keep it on. Its for your own good .

No 1 2 3 4 5 Yes
- Oh it won't do any harm for just a few minutes, here, take it off.

No 1 2 3 4 5 Yes
- O.K but don't blame me if you feel ill again and dont let anyone see.

No 1 2 3 4 5 Yes

6. Nurse I know I've only been out of bed for 2 hours, but will you please help me back to bed I'm dead tired?

Shows concern for patient ?

No 1 2 3 4 5 Yes
- Wait a little longer until I've finished this job.

No 1 2 3 4 5 Yes
- You do look tired lets have you back in bed.

No 1 2 3 4 5 Yes
- Sister said you have to stay up for 4 hours, I can't.

No 1 2 3 4 5 Yes
- Try to persevere for a little longer and if it gets worse I will

No 1 2 3 4 5 Yes

7. Nurse I'm sorry but I can't seem to get used to the food in here, can my wife bring me some in?

Shows concern for patient?

No 1 2 3 4 5 Yes
- Well its not really allowed, but I won't say if she sneaks some in.

No 1 2 3 4 5 Yes
- Its not really allowed in hospital its against the rules.

No 1 2 3 4 5 Yes
- I'd better ask sister or staff nurse, I don't want to get into trouble.

No 1 2 3 4 5 Yes
- O.K. but I'd like see what you have eaten and keep a record.

No 1 2 3 4 5 Yes

8. Nurse please can I leave my antacid tablets just this once they have been making me feel sick?

Shows concern for patient ?

No 1 2 3 4 5 Yes
- Well take it just this once and I'll report it to the doctor.

No 1 2 3 4 5 Yes
- Alright, I just have to make a note on your prescription.

No 1 2 3 4 5 Yes
- I can't I'll get into trouble if sister finds out.

No 1 2 3 4 5 Yes
- I'll ask the staff nurse who is helping me to see if its O.K.

No 1 2 3 4 5 Yes

9. Nurse can I have this drip out of my arm its hurting.
- Shows concern
for patient ?
- | | |
|---|------------------|
| - I'll let the doctor know, you'll just have to tolerate it for now. | No 1 2 3 4 5 Yes |
| - Let me see it, I'll take it out and the doctor will replace it later. | No 1 2 3 4 5 Yes |
| - The drip has to stay in as long as possible to stop dehydration. | No 1 2 3 4 5 Yes |
| - Just a moment I'll ask staff nurse to see you as soon as she can. | No 1 2 3 4 5 Yes |

0. Nurse can I have my pillow case from home on this top pillow, instead of this stiff one? I can't sleep at night.
- Shows concern
for patient ?
- | | |
|--|------------------|
| - Well you shouldn't, because it might cause cross-infection. Leave that one on. | No 1 2 3 4 5 Yes |
| - I'm not really sure if you can. You had better ask the night nurses. | No 1 2 3 4 5 Yes |
| - Good idea, I'll change it for you if you have it here. | No 1 2 3 4 5 Yes |
| - I'll see if there are any softer ones in the linen room that will be best. | No 1 2 3 4 5 Yes |

1. Nurse I've just had my tube aspirated by the other nurse but I feel sick. Will you do it again?
- Shows concern
for patient ?
- | | |
|---|------------------|
| - I'll go and ask her if she will do it again for you. | No 1 2 3 4 5 Yes |
| - I'll report this to the doctor and see what he decides. | No 1 2 3 4 5 Yes |
| - It should only be done hourly, don't worry the feeling will soon pass away. | No 1 2 3 4 5 Yes |
| - Try to relax, I'll get you the paper to try and get your mind off it. | No 1 2 3 4 5 Yes |

2. Nurse, I know its visiting time but my stoma has started to work. Will you help me change it?
- Shows concern
for patient ?
- | | |
|---|------------------|
| - Wait until visiting time no body will notice if you keep quiet. | No 1 2 3 4 5 Yes |
| - Sister doesn't like us changing stoma's at this time of day. | No 1 2 3 4 5 Yes |
| - Right then I'll get some stuff and I'll have to ask your wife to leave for a while. | No 1 2 3 4 5 Yes |
| - I'll get a pad to put over the top then nobody will notice the smell. | No 1 2 3 4 5 Yes |

13. Nurse I don't want this operation tomorrow. Will you get my clothes so that I can go home?

Shows concern
for patient ?

- Just a moment I'll tell sister you want to speak to her.
- Are you worried about something, will you tell me about it?
- You can't go until I inform the doctor and sister.
- Hold on then I'll get your clothes if you really insist.

No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes

14. Nurse can you leave my bed bath today I'm too tired?

Shows concern
for patient ?

- Don't worry I'll do it for you it won't take a minute.
- You'll have to have one now because we won't have time later when you feel awake.
- I'm sorry but we have to make sure that everyone is clean, sister says so.
- O.K. I'll just wash your face and tidy your bed, don't tell anybody.

No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes

15. Nurse can you sit and talk to me for a few minutes? I think I'm going to die and the doctor won't tell me.

Shows concern
for patient ?

- Wait a moment I'll get sister she knows more about you than I do.
- Don't worry, if the doctor hasn't said so you must be alright.
- We are very busy, but tell me what the problem is and I'll come back later.
- I'll ask the doctor to come and have a good long talk to you when he is free.

No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes

16. Nurse I've made a mess in the bed there must have been a hole in this urinal.

Shows concern
for patient ?

- Not so loud everyone will know, I'll get some linen.
- Oh its O.K your not the first today and you won't be the last.
- Hurry up and jump out of bed before sister finds out.
- Oh good grief! we'll have to get the doctor to see about your water works.

No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes
No 1 2 3 4 5 Yes

SUMMARY OF PATIENT CENTREDNESS
QUESTIONNAIRE RESPONSES.

Appendix XXVI

Item no. & Options		Subjects																			
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
ITEM 1	A	1	1	2	4	3	1	4	2	4	4	1	4	3	3	1	1	2	2	3	2
	B	3	5	5	5	4	4	5	5	5	5	5	5	4	5	2	5	4	5	5	5
	C	2	3	3	1	1	1	1	1	1	1	4	1	2	1	2	1	1	1	2	1
	D	3	2	1	3	1	5	1	2	2	2	3	1	3	1	2	1	2	2	1	3
ITEM 2	A	3	2	3	4	3	3	2	2	2	3	2	3	2	3	3	5	3	3	3	4
	B	2	1	2	1	1	1	2	1	1	2	1	2	2	1	1	2	1	2	4	1
	C	5	5	5	5	5	5	5	5	5	5	5	4	5	4	5	4	3	3	5	5
	D	2	2	2	1	2	1	3	3	1	3	2	3	1	2	1	1	1	1	1	3
ITEM 3	A	4	1	3	1	2	3	5	2	1	5	2	1	1	1	2	2	3	2	1	1
	B	2	2	2	1	2	2	1	1	1	3	1	2	1	3	2	1	2	2	2	1
	C	2	3	2	3	1	4	4	2	3	2	2	3	2	3	2	2	3	2	1	3
	D	4	5	5	4	5	5	2	5	5	5	5	5	5	5	3	5	4	5	5	5
ITEM 4	A	5	5	5	5	5	5	5	4	5	4	5	5	5	4	4	5	5	5	5	5
	B	2	3	4	2	1	1	3	1	1	1	2	3	3	1	5	1	3	2	2	4
	C	2	1	1	1	2	1	1	1	1	1	1	1	2	1	1	1	1	1	1	1
	D	1	2	3	3	1	1	2	2	1	2	2	1	1	1	2	1	1	1	1	1
ITEM 5	A	2	2	5	3	4	1	3	2	3	1	2	3	4	2	4	1	2	2	3	4
	B	1	2	3	1	2	2	1	1	2	2	3	4	1	2	5	1	1	2	2	1
	C	5	3	2	5	2	2	4	5	5	3	5	5	2	3	3	4	3	3	5	3
	D	1	1	1	2	2	1	3	3	1	2	1	2	1	2	1	1	1	1	2	1
ITEM 6	A	2	2	4	1	2	2	1	2	1	1	2	2	3	1	3	2	3	2	2	1
	B	4	5	5	5	5	5	5	5	5	4	5	5	5	5	5	4	5	3	4	5
	C	1	1	1	1	2	1	1	1	2	1	2	1	2	1	1	2	1	2	1	1
	D	3	3	5	3	2	3	3	3	4	3	3	3	4	3	4	2	3	4	5	5
ITEM 7	A	2	3	2	4	4	3	3	3	4	2	2	2	3	4	2	2	3	3	4	3
	B	1	1	1	1	2	1	1	1	1	1	1	1	1	1	3	2	1	2	2	2
	C	2	2	2	2	2	1	2	3	2	2	1	3	2	1	1	3	1	4	2	4
	D	5	4	5	4	3	4	4	4	5	4	5	5	5	4	4	4	4	5	5	5
ITEM 8	A	1	2	3	1	5	1	2	2	1	2	1	3	1	1	3	1	1	3	2	1
	B	4	3	1	5	5	5	4	5	5	3	5	2	4	4	5	5	4	3	4	5
	C	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	D	3	5	4	5	2	3	3	3	4	3	2	4	4	4	4	1	2	4	5	5

Item no. & Options		Subjects																			
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
ITEM 9	A	2	1	3	3	5	3	2	2	3	2	2	4	3	3	3	1	1	2	4	2
	B	5	3	2	2	5	3	4	5	5	3	1	5	5	4	4	3	3	1	3	1
	C	2	1	3	1	3	1	1	2	2	3	1	1	1	3	5	2	1	3	1	2
	D	2	3	2	4	3	5	3	3	3	2	4	2	1	3	4	3	2	4	4	3
ITEM 10	A	1	2	3	1	5	1	1	2	2	1	1	1	2	1	1	1	1	2	1	1
	B	2	3	1	1	3	2	2	2	2	2	2	2	1	2	2	2	3	2	2	2
	C	5	4	4	5	5	5	5	5	5	5	5	5	5	5	5	5	5	4	3	5
	D	3	3	5	4	5	4	3	4	4	5	4	4	5	3	4	4	3	4	4	4
ITEM 11	A	1	1	2	1	1	3	2	3	4	1	2	4	1	1	1	1	1	2	1	1
	B	2	2	3	3	1	2	2	2	3	1	1	3	2	2	5	1	2	1	3	1
	C	2	2	2	1	1	1	1	1	1	3	1	5	1	1	2	1	1	1	1	1
	D	3	4	3	2	1	2	5	4	4	1	2	4	5	3	1	1	1	1	1	1
ITEM 12	A	1	2	1	1	1	1	1	1	1	1	2	1	1	3	1	1	1	1	1	1
	B	1	1	1	1	1	1	1	2	1	1	1	1	1	1	1	1	1	1	1	1
	C	4	3	5	5	5	5	5	4	5	4	4	5	5	4	5	5	2	4	2	5
	D	1	4	2	1	1	1	3	4	1	3	1	3	1	3	2	1	1	3	4	1
ITEM 13	A	2	2	4	3	5	5	3	3	4	1	3	4	3	3	4	4	2	2	4	3
	B	5	4	5	5	5	5	4	4	5	5	5	5	5	5	5	5	5	4	5	5
	C	2	2	2	2	3	3	2	2	2	4	1	3	3	1	3	3	2	1	4	4
	D	1	1	1	2	1	1	4	2	1	1	2	1	2	1	1	1	1	1	1	1
ITEM 14	A	3	3	3	1	2	3	3	3	3	3	3	5	4	2	4	1	5	3	2	3
	B	1	2	2	1	3	1	1	2	1	2	1	1	1	1	2	1	2	1	1	1
	C	1	1	2	1	3	1	1	1	1	2	1	4	1	1	1	1	1	1	2	1
	D	4	3	3	4	5	1	5	4	5	2	1	3	3	5	3	5	5	4	2	3
ITEM 15	A	2	2	3	3	2	1	3	2	5	1	2	4	1	1	4	2	1	2	2	3
	B	1	3	2	4	1	1	2	2	1	1	1	2	4	1	2	1	2	2	1	1
	C	3	3	2	2	5	1	2	1	1	4	1	1	1	1	3	3	1	1	2	1
	D	3	2	5	4	5	5	3	3	4	4	4	3	3	1	5	5	2	5	3	4
ITEM 16	A	5	2	4	2	5	1	3	1	5	3	1	3	2	3	3	1	3	2	1	1
	B	1	4	5	5	1	1	4	5	2	3	5	5	3	2	5	3	3	2	2	3
	C	2	2	2	1	1	1	3	1	3	2	1	2	1	3	1	1	1	2	2	1
	D	1	1	1	1	1	1	1	1	1	1	1	1	2	1	2	1	1	1	1	1

INFORMATION INCLUDED ON EACH PATIENTS' KARDEX.

1. MR ARNOTT 48 years Ulcerative Colitis
John (Conservative treatment)

Note: Please stress in report that

'He must keep his own accurate
bowel chart'

2. MR EALES 53 years ? Irritable bowel and
Bertram investigations for hypertension.

Note: Admission precipitated by sudden
hypertension.

Has a long history of diarrhoea
and abdominal pain

Please stress in the report that
the nurses should:

'Ensure he stays on complete
bed rest today'

3. Miss HARDISTY 32yrs Hiatus Hernia
Jean (Conservative treatment)

Note: Observe for reflux pain

Please stress that:

'Doctor wants her to rest out of
bed in a chair for the next few days'

4. Mrs TROTTER 23yrs Cholecystitis
Mary Alice (Conservative treatment)

Note: Has been in hospital for 4 days,
but symptoms of acute cholecystitis
are not subsiding.

Please stress that the nurses should:

'Check that she does not order too
much fatty food on her menu sheet'

Light diet only

5. Mrs KEANE 54 years Abdominal pain ? adhesions
Daphne (Permanent colostomy 2 yrs ago)

Note: IN HSO ONLY explain what
adhesions are to the nurses.

Observe for abdominal pain

INFORMATION INCLUDED ON PATIENTS' KARDEX cont'd

6. Mr WATKINS 35 yrs Abdominal Colic and Diarrhoea
Terence Nigel (Sigmoidoscopy, biopsy and
colonoscopy.)

Note: Prep. for sigmoidoscopy ?
colonoscopy.
Gallytelly as regime.
Stool chart maintained.

7. Mr POWLETT 58 yrs C.A. Stomach and secondaries.
Eric Arnold Ascites.

Note: Family finding it difficult
to cope. Walks with minimal
help (but supervision necessary)

Paracentesis abdominus in progress

HSO ONLY Explain what P.A. means
Say that you will help the nurses
to deal with this.

LSO ONLY No explanation.

Tell them not to touch it only
trained staff can cope with it.

8. Mr HARRIS 24yrs Acute Gastritis
Robert Gordon for investigations

Note: Known to have high alcohol
intake

VIDEO FADE OUT WILL OCCUR HERE

9. Miss TURNER 18yrs Crohns' Disease
Joan

Note: Chronic diarrhoea
Abdominal pain.

HSO ONLY Say she has been depressed and you are worried.
Ask the nurses to find out what's causing it.
Ask nurses to suggest ways to brighten her up.
Say you appreciate suggestions.

LSO ONLY Say she seems depressed. Tell them not to feel
too sorry for her. Tell them to get her to
co-operate.

Say 'WE MAKE IT A RULE ON THIS WARD NOT TO GET
EMOTIONALLY INVOLVED WITH TH PATIENTS.

Minor observational notes were added by the actor during the filming.

MEASURING INSTRUMENT : Sequencing of Options
and Option Values for each item.

<u>Question Identifier</u>	<u>Option</u>	<u>Option from Patient centredness Questionnaire</u>	<u>P.C Quest. Score</u>	<u>Value</u>
ARNOTT	A	(b)	91	4.55
	B	(c)	31	1.55
TURNER	A	(d)	36	1.80
	B	(c)	93	4.65
EALES	A	(a)	96	4.80
	B	(d)	30	1.50
HARDISTY	A	(a)	39	1.95
	B	(b)	94	4.70
POWLETT	A	(d)	88	4.40
	B	(c)	42	2.10
TROTTER	A	(b)	40	2.00
	B	(c)	95	4.75
KEANE	A	(e)	86	4.30
	B	(a)	24	1.20
WATKINS	A	(e)	49	2.45
	B	(b)	96	4.80

STANDARDISED DIALOGUE TO POTENTIAL EXPERIMENTAL SUBJECTS.
(Pilot and Fieldwork)

Hello my name is Peter French, I am a nurse tutor in Middlesborough.

I need your help if you don't mind.

All I need you to do is watch part of a video for about ten minutes, and then answer some easy questions about it.

The purpose of this is to assess how useful the video would be for teaching purposes.

I want to make sure I don't run out of time and upset your Tutor so I will tell you in more detail what I am doing when we have finished.

Is there anybody who would rather not help me?

(Allow those who don't want to participate to leave or stay if they just want to listen)

In order to do the job right, I want you to watch the video in two groups because it is too long to take in all the information in one go.

I need to allocate you to groups by chance, so will you each take a mint from this packet. If you take a green mint would you are in the first group, a white mint in the second group. You can eat the mint if you want to so don't fiddle about in the bag your friends have to eat whats left.

You will need to bring a pen and some note paper.

If your all ready would the green's come with me.

PREPARATORY DIALOGUE FOR EXPERIMENTAL SESSIONSPREVIEW DIALOGUE.

Can you all see the screen well enough?

Please pay attention because the sound isn't as good as I would like it.

The first part gives you some instructions so read them carefully.

POST-VIDEO DIALOGUE.

OK thats it.

Is that what ward reports are like?
Was it like the real thing?

Can you think of any Sisters that you have worked for who are like her?

(Allow subjects to respond and give their opinions)

Well, I'll give you this set of questions. There are only eight and they are easy to answer. Just do your best.

You should use your notes to remember what Sister said about the patients.

I will read through the front sheet with you.

Don't turn to the next page until I ask you to.

(Read through)

Are there any questions? (Take time to answer them)

OK turn over and start now. Please sit quietly in your places until everyone has finished, it won't take long.

QUESTIONING SCHEDULE - POST EXPERIMENTAL PILOT INTERVIEWS

RESPONDENT - - - - -
VIDEO VIEWED - - - - -

0. DID YOU SEE THE VIDEO FIRST OR SECOND

0. LOOK AT THE QUESTION FROM MR. ARNOTT

(a) WHICH DID YOU CHOOSE - FIRST / SECOND

(b) WHY DIDN'T YOU CHOOSE THE SECOND

(c) IS THIS QUESTION DIFFERENT IN ANYWAY TO THE NEXT ONE?

(d) ANYTHING ELSE YOU WOULD LIKE TO SAY ABOUT THIS QUESTION?

3. LOOK AT THE QUESTION FROM MR EALES

(a) WHICH DID YOU CHOOSE FIRST/SECOND

(b) WHY DIDN'T YOU CHOOSE THE SECOND?

(c) ANYTHING ELSE YOU WOULD LIKE TO SAY ABOUT THIS QUESTION?

4. LOOK AT THE QUESTION FROM MR KEANE

(a) WHICH ONE DID YOU CHOOSE FIRST/SECOND

(b) WHY DIDN'T YOU CHOOSE THE FIRST?

(c) ANYTHING ELSE YOU WOULD LIKE TO SAY ABOUT THIS QUESTION?

- 965 -

		Subjects																																						
Item	Option	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	
Arnott	# 1st # 2nd	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Turner	# 1st # 2nd	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dales	* 1st # 2nd	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hardisty	# 1st # 2nd	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Powlett	# 1st # 2nd	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Trotter	# 1st # 2nd	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kearse	# 1st # 2nd	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Watkins	# 1st # 2nd	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Individual scores		23.70	23.60	29.55	31.90	36.95	25.75	31.80	23.95	36.95	33.65	20.65	31.80	29.05	31.90	31.80	36.95	29.05	34.60	34.65	23.06	25.75	31.80	29.05	26.30	26.30	29.05	29.05	20.00	31.10	29.05	31.90	34.20	29.15	26.05	31.35	29.05	31.10	36.95	

Key \Rightarrow High patient centred option.

SUMMARY CHART LEO SUBJECTS
EXPERIMENTAL RESPONSES

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Key = High patient centred option.

EXPERIMENTAL MEASURING INSTRUMENT

AGE:

Now that you have seen the ward report look at the following questions which Nurse Green was asked during her first day on duty.

The questions were asked by patients mentioned in the report and you should use your notes to help you recollect what had been said about each patient.

The name of the patient will be given in each case.

All you need to do is read the question and then choose what Nurse Green is most likely to have said to the patient.

You will have two replies which following each question.

Even though Nurse Green could have said lots of other things please place a cross in the box next to the answer you think she is most likely to give from the two provided.

Think about what was said in the video before you decide what Nurse Green would say.

Try the following example before you are told to begin.

QUESTION FROM MRS. TROTTER

Nurse please can I leave my antacid tablets just this once they have been making me feel sick?

What would Nurse Green say - tick one box only



- Alright, I just have to make a note on your prescription.
- I'll ask the staff nurse who is helping me to see if its O.K.

☐
☐

QUESTION FROM MR. ARNOTT

Nurse, I've forgotten to fill in the record of my bowel motions today and I can't remember exactly when I went. What can I do?

What would Nurse Green say - tick one box only

- Come on I'll help you fill it in as best we can, don't worry it's no problem. ☐
- Well I wasn't here so I can't fill it in for you just do your best. ☐

QUESTION FROM MRS TURNER

Nurse my ^{HUSBAND} has just told me that Bob, my oldest son, has travelled from London today to see me, he has just arrived. Can he come in and stay for a while? I know visiting time is over.

What would Nurse Green say - tick one box only

- I dare not say, you had better ask somebody more senior in a minute. ☐
- That should be O.K. I'll pull the screens so that you're not disturbed. ☐

QUESTION FROM MR. EALES

Nurse, I know I'm supposed to stay in bed, but can you help sit me on the edge of the bed to pass water. My insides are bursting I can't wait.

What would Nurse Green say - tick one box only.

- Come on sit on the edge of the bed before it gets any worse. It must feel terrible. ☐
- Look don't worry if you wet the bed we don't mind cleaning it up. That's what we are here for. ☐

QUESTION FROM MISS HARDISTY

Nurse I know I've only been out of bed for 2 hours, but will you please help me back I'm dead tired?

What would Nurse Green say - tick one box only

- Wait a little longer until I've finished this job. ☐
- You do look tired let's have you back in bed. ☐

QUESTION FROM MR. POWLETT

Nurse I'm sorry but I can't seem to get used to the food in here, can my wife bring me some in?

What would Nurse Green say - tick one box only

- O.K. but I'd like to see what you have eaten and keep a record. ☐
- I'd better ask sister or staff nurse, I don't want to get into trouble. ☐

QUESTION FROM MRS. TROTTER

Nurse can I have my pillow case from home on this top pillow, instead of this staff one? I can't sleep at night.

What would Nurse Green say - tick one box only

- I'm not really sure if you can. You had better ask the night nurses. ☐
- Good idea, I'll change it for you if you have it here. ☐

QUESTION FROM MRS. KEANE

Nurse, I know it's visiting time but my stomas has started to work. Will you help me change it?

What would Nurse Green say - tick one box only

- Right then, I'll get some stuff and I'll have to ask your husband to leave for a while. ☐
- Wait until visiting time is over, nobody will notice if you keep quiet. ☐

QUESTION FROM MR. WATKINS

Nurse I don't want this operation tomorrow. Will you get my clothes so that I can go home?

What would Nurse Green say - tick one box only

- You can't go until I inform the doctor and sister. ☐
- Are you worried about something, will you tell me about it? ☐